

DIGNITY IN MENTAL HEALTH

**PSYCHOLOGICAL &
MENTAL HEALTH FIRST
AID FOR ALL**



World Mental Health Day
10 October 2016





WORLD MENTAL HEALTH DAY
IS A TRADEMARKED PROJECT OF THE
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SECTION I: INTRODUCTION AND FORWARDS

MESSAGE FROM THE PRESIDENT

Professor Gabriel Ivbijaro MBE JP
President World Federation for Mental Health

As the 42nd President of the World Federation for Mental Health (WFMH) it gives me great pleasure to introduce and commend the theme of 2016 World Mental Health Day to you all. This theme is close to my heart because it continues the Dignity agenda and supports our aim of improving the visibility of mental health worldwide.

In April 2016 I had the honour and privilege of attending the joint World Bank/World Health Organisation (WHO) meeting in Washington DC USA entitled 'Out of the Shadows: Making Mental Health a Global Development Priority'. My take home message from this meeting is in alignment with what service users and carers have been telling us about the need to increase mental health visibility and making every encounter count in a positive way.

Our 2016 theme 'Dignity in Mental Health — Psychological & Mental Health First Aid for All' will enable us to contribute to the goal of taking mental health out of the shadows so that people in general feel more confident in tackling the stigma, isolation and discrimination that continues to plague people with mental health conditions, their families and carers.

The concept of Psychological and Mental Health First Aid is not new. It dates back to the aftermath of World War II when a process of prevention and management of mild conditions applicable to all individuals was developed in 1945.¹ However, the idea was not universally promoted until much later, probably as a result of mental health stigma.

Many people did not know that such first aid was possible until the resurgence of interest in mental health literacy in the 1990s² which led to the development of a Mental Health First Aid training course evaluated in Australia in 2002.³ A systematic review completed by the WHO in 2009 also supported Psychological First Aid.⁴ Psychological and mental health first aid does work. Many people who suffer from psychological and mental distress, personal crises and mental disorders can benefit from receiving psychological and mental health first aid from professionals and the general public.

At least one in four adults will experience mental health difficulties at one time or the other but many will receive little or no help when they present in an emergency. In contrast the majority of people with physical health difficulties who present in an emergency in a public or hospital setting will be offered physical health first aid. Since the introduction of Basic Life Support (BLS) and Cardiopulmonary Resuscitation (CPR) without equipment in the 1960's many people have benefitted from the intervention of a passer-by, and lives have been saved. Mental health crises and distress are viewed differently because of ignorance, poor knowledge, stigma and discrimination.

This cannot continue to be allowed to happen, especially as we know that there can be no health without mental health. Psychological and mental health first aid should be available to all, and not just a few. This is the reason why the WFMH has chosen Psychological and Mental Health First Aid as its theme for World Mental Health Day 2016.

We know that psychological and mental health first aid is understood differently by different people in the mental health professions and the general public so WFMH wants to develop a shared understanding of basic psychological and mental health first aid that will be understood worldwide by the general public, professionals, governments and non-governmental institutions (NGOs). **Our aim is that every member of the general public can:**

- **Learn how to provide basic psychological and mental health first aid** so that they can provide support to distressed individuals in the same way as they do in physical health crises
- **Address the stigma associated with mental ill-health** so that dignity is promoted and respected
- **Empower people to take action** to promote mental health
- **Spread understanding of the equal importance of mental and physical health** and their integration in care and treatment
- To work with individuals and institutions to **develop best practice in psychological and mental health first aid**
- **To provide culturally sensitive learning materials** to increase the skills of the general public in administering psychological and mental health first aid.

Lessons need to be learnt from the way professionals and the general public have been involved in developing the skills required to deliver BLS and CPR. To deliver Psychological and Mental Health First Aid properly, training is not enough. There is also the need for mental health promotion and good access to health providers. The world is going through a crisis. There are many disasters and wars, migration is a growing problem and many people require basic Psychological and Mental Health First Aid to prevent their health from deteriorating and to empower them to take action to improve their mental health.

Every 40 seconds somebody somewhere in the world dies by suicide, and the young are disproportionately affected. Providing more people with basic Psychological and Mental Health First Aid skills will help to decrease the rate of suicide. Psychological and mental distress can happen anywhere — in our homes, in our schools, in the workplace, on the transport system, in the supermarket, in public spaces, in the military and in hospital. Psychological and Mental Health First Aid is a potentially life-saving skill that we all need to have.

Help mental health come out of the shadows and support WFMH to make Dignity in Mental Health and Psychological & Mental Health First Aid for All a global reality so that we can make the world a better place.

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MESSAGE FROM THE AMBASSADOR

Honourable Minister Dr P. D. Parirenyatwa
Ministry of Health and Child Care, Harare, Zimbabwe

Key Messages:

- In line with the World Dignity Project and the WMHD 2016 -Dignity in Mental Health: Psychological and Mental Health First Aid for All, it is imperative that we involve communities and encourage their participation in this for the success of the project and mostly to remove stigma towards the affected clients
- Mental health disorders contribute significantly to the global burden of disease
- Mental health consumers are stigmatized and are discriminated against at the workplace, health care and in communities.

Mental health disorders contribute significantly to the global burden of disease. The adage, there is no health without mental health, speaks to the need to prioritize mental health. Mental health consumers are stigmatized and are discriminated against at the workplace, in health care and in communities. Due to the economic difficulties that Zimbabwe is currently facing, resource allocation to health has been reduced and little is left for mental health. HIV crisis, suicides and substance use disorders have become emergent health care needs that require mental health services and psychological first aid. Zimbabwe has been working on integrating mental health into other health care and promotional activities. There is work on including mental health curricula in all training activities. Mental health first aid and dignity can thus be incorporated when developing training curricula.

In line with the World Dignity Project and the WMHD 2016 – Dignity in Mental Health: Psychological and Mental Health First Aid for All, it is imperative that we involve communities and encourage their participation in this, both for the success of the project and mostly to remove stigma towards the affected clients. These efforts should be ongoing even after the campaigns to ensure that Psychological and Mental Health First Aid is acceptable and accessible to all those who need it at any given time.



THE TIME TO CHANGE IS NOW — MAKE IT HAPPEN

Alistair Campbell, Writer and Communicator, Ambassador of Time to Change,
and signatory of the equality for mental health open letter

Equality for Mental Health Campaign:

<http://mhinnovation.net/blog/2015/nov/3/global-equality-mental-health-call-action#.Vo59Ofncpmw>

Key Messages:

- This kind of campaign helps to eradicate the stigma and taboo which for centuries has surrounded mental illness and so helped to create profound discrimination against those who suffer mental ill health.
- We are still a million miles away from the parity of esteem between physical and mental health. Imagine lying in a ditch after a road traffic accident and being told that the ambulance would be along in a couple of weeks. Yet for severe mental illness, that long and much worse is taken for granted.
- We all of us have a role to play in breaking down the walls of stigma and taboo

As I write this, the British Broadcasting Corporation (BBC) is half way through a week of special programming dedicated to mental health and mental illness. This is good news. The very fact of this kind of coverage is good for the campaign to eradicate the stigma and taboo which for centuries has surrounded mental illness and so helped to create profound discrimination against those who suffer mental ill health.

This 'In the Mind' BBC week has happily coincided with the publication of a report by the National Health Service (NHS) Taskforce on Mental Health, chaired by Paul Farmer, CEO of the leading charity Mind, which laid bare the scandalous reality of poor mental health care and put forward a number of possible solutions, often requiring both institutional change and significant additional funding.

The extent to which mental health is now closer to centre stage of the political and media arena in the United Kingdom (UK) was underlined by the fact that Prime Minister David Cameron agreed to be interviewed by the BBC, despite at the time being in the midst of intensive negotiations about Britain's future in Europe. But for all the distance we have travelled, there was one section of the interview in particular which underlined just how far we have to go.

Mr Cameron was explaining that for the first time, we now have waiting time targets for mental as well as physical illness. He acknowledged that more needed to be done, and that, for example, he hoped that we could work towards a two week maximum waiting time for treatment of anyone with psychosis.

Now, as someone who has known what psychosis involves, and who is now actively involved in the campaign to deliver equality in awareness, understanding and services between physical and mental health, his two-week pledge got me thinking...what would be the physical health equivalent of a psychotic attack like the one that got me arrested and locked up for my own safety in 1986?

Given that at the time I was hearing voices and music in a discordant cacophony, and believed I was being subject to a psychological and moral test, for which the punishment for failure was death, the conclusion I reached about equivalence was this: it would be lying on a roadside having been propelled through the windscreen of a car following a multiple pile-up, unable to move because of broken bones, unsure whether life was coming or going.

Now, just think about that for a moment. Imagine lying in a ditch after a road traffic accident and being told that the ambulance would be along in a couple of weeks. Yet for severe mental illness, that long and much worse is taken for granted.

So though attitudes are changing, we are still a million miles away from the parity of esteem between physical and mental health which exists in the NHS Constitution, but not in the reality of services provided. And the UK, let us not forget, is far in advance of many other countries, as I know for example from a visit I made to look at psychiatric hospitals in Ghana, from where I came away thankful for what we have, but determined the developed economies must take a lead in improving services so that the poorer countries may hopefully follow.

Of course, governments must take that lead. But this is not just about legislation, nor even purely about funding. It is about attitude, about how people think. In Ghana, I saw the — to us — barbaric practice of chaining a mentally ill young man to a tree. But his family think they are doing the right thing. If he wanders off, he risks being maltreated by others who think he carries within him evil spirits — this is a country with thousands of faith healers and a tiny number of psychiatrists.

So yes, countries like the UK are in advance of that. But we still have attitudes that belong in a past age when the mentally ill were labeled 'round the bend' because that is where the asylums where we housed them were built — round a bend at the end of a road where nobody could see them, and the sane among us did not have to worry, or care. We still have employers who understand that if a member of staff gets cancer, they are entitled to take off the time they need to get better; but who when confronted with an employee's depression or anxiety, let alone something more serious, rely on the age old diagnosis that they should 'just pull themselves together.' And for all the success and profitability and the brilliant research minds of the pharmaceuticals industry, we still seem happy enough to live with the reality that the severely mentally ill will live on average twenty years less than the rest of us (and that is not just because of suicide).

There is a very simple insight which can help change all this for the better. It is this — we all have physical health; some days it is good, some days less so. And the same goes for mental health. As part of the campaigns to change attitudes, to show how widespread mental illness is, we have for years used the figure 'one in four' — one in four of us will have a mental health problem at some point. But for the next stages of the campaign, I think we need to change this — the figure is actually closer to one in one.

Has anyone ever got through life without seeing a doctor for a physical illness? So why, given the mind is more complicated than the body, do we imagine that seventy five per cent of us manage to navigate all the ups and downs of life without our minds occasionally needing outside support? It is a ludicrous assumption. And it is all part of the stigma and taboo that we think nothing about seeing doctors for the slightest physical ailment, yet resist — as I did for years — the idea that there might be something wrong up top, let alone seek out therapy or medication?

If we could all accept that mental illness can hit anyone at all, regardless of age, class, race, creed or wealth, then we might become better at dealing with it when we see it. In his spare time my son Calum organizes teams of volunteers to go out and talk to people living on the streets in London, sadly a growing number. I have been out with him and you don't need long to learn two things — many of those living rough are mentally ill; and for all that they might welcome food, clothing, toothpaste or any of the other things we give out, what they really welcome is having someone to talk to, and someone who listens.

These are people in crisis. They are people who watch thousands of their fellow citizens walk by on the other side, because we don't know the language. We don't know how to react. We don't know how to help. But it can change. I remember when I was about seven or eight, my mother told me our neighbour had cancer. But she swore me to secrecy. Cancer was 'The Big C.' Something to keep to yourself and your family and your doctors. But look what has happened since that taboo broke down — governments have done more, and hugely powerful charities have developed the expertise and the funding to make sure governments do more still, making sure the work for cures and better treatments continues and improves.

I work for a cancer charity, Bloodwise, the UK's leading leukaemia charity, and I work for mental health charities like Mind, and for the umbrella campaign to change attitudes to mental illness, Time to Change. I know how much easier it is to raise funds and awareness for cancer than it is for mental health and mental illness. That is because mental illness continues to be surrounded by the kind of stigma and taboo that used to surround 'The Big C.'

We all of us have a role to play in breaking down the walls of stigma and taboo. And I fully support the work of WFMH in seeking to develop a shared understanding of what mental health first aid would look and feel like.

If we are sitting on a train and a woman with just a few wisps of hair sits down opposite us, we now know the language, of empathy, of concern, of shared understanding, because we all know someone who has faced the cancer challenge. If we are walking down the street and someone collapses in front of us, we know at least how to assess the situation and how to call for help. But if we see someone in genuine psychological distress, do we really know what to do? Or do we inhale the decades of negative coverage about mental illness, the thousands of headlines about 'psycho killers' (when in fact the mentally ill are far more likely to be victims of violence than perpetrators) and hope that someone else knows what to do?

WFMH has a big goal — for everyone to learn how to provide basic psychological and mental health first aid. We are a long way from that. But there was a time when we were a long way from a proper understanding of first aid for physical ill health. The change can come, provided enough of us decide to make it come, and World Mental Health Day is a good moment to do just that. Decide that the Time to Change is now, and make it happen.

PSYCHOLOGICAL FIRST AID: PRESERVING DIGNITY IN CRISIS RESPONSE

Mark van Ommeren and Shekhar Saxena
Department of Mental Health and Substance Abuse
World Health Organization

Key Messages:

- Crisis events involving exposure to trauma and sudden loss occur in all communities of the world.
- Orientation in psychological first aid gives responders a framework for how to respond in a natural, supportive, practical manner.
- A common mistake in current humanitarian responses in many countries is to only make psychological first aid available in the absence of other care.
- Psychological first aid is feasible and appropriate during crises and should be complemented with other essential mental health and psychosocial activities.

Crisis events involving exposure to trauma and sudden loss occur in all communities of the world. Indeed, few villages or city neighbourhoods are immune to motor vehicle accidents, domestic violence, rape, or violent muggings, and many experience natural disasters. Trauma and loss at a large scale are hallmarks of war. Brutal conflicts in numerous countries currently ravage the lives of more than 100 million women, men, girls and boys with more than 60 million people displaced — the highest numbers since World War II.

The potential mental health and psychosocial consequences are well-known, as rates of mood and anxiety disorders, substance use, general psychological distress, social needs and impairments in social functioning increase among those exposed to crisis events.

The mental health and psychosocial response to these events should be multi-sectorial. In the long run, all communities need to have community mental health, social and educational services that address the long-term increase in needs, including clinical services for mental disorders. The acute response needs to be multi-sectorial as well. The initial response tends to be offered mainly by

people in local communities, for example by ambulance workers in case of vehicle accidents, by police in case of armed robbery, by local general health staff in case of physical trauma, by teachers if the events occur at school, by protection workers whether in case of recent child abuse or asylum seeking, and so on.

Many of these local responders respond naturally in a warm, supportive and practical manner when they help emotionally distressed people who have just survived a crisis event. However, others are uncomfortable with the emotional distress of survivors — or their own distress if they are also affected — and stiffen up. Others ignore people's emotional distress altogether, and again some even naively trample over people's dignity in the hurry to carry out their job.

Orientation in psychological first aid — an approach that perhaps would be better called psychosocial first aid or even social first aid — gives responders a framework for how to respond in a natural, supportive, practical manner, emphasizing listening without pressing the person to talk; assessing needs and concerns;

ensuring that basic physical needs are met; providing or mobilizing social support, and providing essential information.

Although psychological first aid is a term that has been used since the 1940s, it has become more widely known over the last 15 years. It has been recommended by the Inter-Agency Standing Committee (IASC), National Child Traumatic Stress Network and National Center for Posttraumatic Stress Disorder, National Institute for Mental Health (NIMH), National Institute for Health and Care Excellence (NICE), the Sphere Project, the Tents Project, and the World Health Organization (WHO), amongst others. Indeed, in 2009, WHO's mhGAP Guidelines Development Group evaluated the evidence for psychological first aid and psychological debriefing. It concluded that psychological first aid, rather than psychological debriefing, should be offered to people in severe distress after recent exposure to a potentially traumatic event. Caution against the use of individual psychological debriefing after exposure to traumatic events has fuelled the popularity of psychological first aid. Psychological first aid is very different from psychological debriefing in that it does not necessarily

involve a discussion of the event that caused the distress. Support based on the principles of psychological first aid is a form of support that may be delivered by professionals and non-professionals alike after a brief orientation of a less than a day.

In 2011, WHO, together with partners, released its own field manual of psychological first aid, followed by a guide for capacity building. The field manual has been tremendously popular, being among the top 10 most ordered products in the WHO bookstore and with translations in more than 20 languages. Psychological first aid, because of its scalability, is now most likely the most implemented form of mental health support in large humanitarian crises, such as today in Syria, last year during the Ebola epidemic in Guinea, Liberia and Sierra Leone and after the earthquake in Nepal, and currently during the refugee crisis in Europe.

Although psychological first aid should be scaled up widely, psychological first aid should be a component of the overall response to emergencies, but by itself it is an insufficient response for public mental health response. Guidance — such as the WHO mhGAP module on Assessment and Management of Conditions Specifically Related to Stress, the WHO Humanitarian Intervention Guide, and the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Supports in Emergency Settings — include psychological first aid as one of a multitude of complementary mental health and psychosocial supports that should be made available to people exposed to crises. Importantly, these supports also include strengthening community and family supports, management of people with mental disorders, and protection of vulnerable people, including those with severe psychosocial disabilities. Thus, while scale up of psychological first aid is feasible and appropriate during crises, it should be complemented with other essential mental health and psychosocial

activities. A common mistake in current humanitarian responses is to only make psychological first aid available. Yet, an organized mental health response that exists of psychological first aid only is as inappropriate as a physical health response that exists of physical first aid only.

In various countries of the world, psychological first aid has been incorporated into disaster preparedness. Building on this experience, national disaster management authorities may consider having teams ready who could travel to disaster-affected regions to orient local first responders in psychological first aid when disaster strikes. Psychological first aid may also be included in training of workers who meet trauma survivors as part of their daily job such as firemen, police officers, health staff in hospital emergency units and humanitarian aid workers.

The World Federation for Mental Health has been in official relations with the World Health Organization for more than 65 years; WHO is proud to be associated with the Federation in the events related to the World Mental Health Day 2016. We appreciate World Federation for Mental Health's initiative to include psychological first aid in its theme for World Mental Health Day 2016.

MENTAL HEALTH FIRST AID

Betty Kitchener AM.

Co-founder of Mental Health First Aid Program

CEO, Mental Health First Aid International

Adjunct Professor, Deakin University, Australia

Key Messages:

- All members of the public can learn basic skills to help people with mental health problems.
- We need to aim to have large numbers of people trained throughout the world to be able to provide mental health first aid
- Parity is needed with the provision of physical first aid.

Mental health first aid is the help offered to a person developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis. The first aid is given until appropriate professional help is received or until the crisis resolves.¹

The aims of **mental health first aid** are to:

1. **Preserve life** where a person may be at risk of harm
2. **Provide help** to prevent the mental health problem from becoming more serious
3. **Promote recovery** of good mental health
4. **Provide comfort** to a person with a mental health problem.

Mental health first aid will typically be offered by someone who is not a mental health professional, but rather by someone in the person's social network (such as family, friend or work colleague) or someone working in a human service occupation, e.g. teacher, police officer, employment agency worker.

Members of the public may provide mental health first aid, even if they have not had any formal training in how to do so. However, skills can be greatly increased by undertraining a Mental Health First Aid training course, which teaches how to recognise the cluster of symptoms of different illnesses and mental health crises, how to offer and provide initial help, and how to guide a person towards appropriate treatments and other supportive help. Mental Health

First Aid courses do not teach people to provide a diagnosis or therapy, which is the domain of professional training, but rather aim to spread the skills of providing initial support more widely in the community.

Why Mental Health First Aid?

There are many reasons why people can benefit from training in mental health first aid.

Mental health problems are common, especially depression, anxiety and misuse of alcohol or other drugs. According to the WHO World Mental Health Surveys, there is a high lifetime prevalence of mental disorders across the globe.² Throughout the course of a person's life, it is highly likely that an individual will either develop a mental health problem themselves or have close contact with someone who does.

Many people are not well informed about how to recognise mental health problems, how to respond to the person, and what effective treatments are available.³ There are many myths and misunderstandings about mental health problems. Common myths include the idea that people with mental illnesses are dangerous, that it is better to avoid psychiatric treatment, that people can pull themselves out of mental health problems through will-power, and that only people who are weak get mental health problems. Lack of knowledge may result in people avoiding or not responding to someone with a mental health

problem, or avoiding professional help for themselves. With greater community knowledge about mental health problems, people will be able to recognise problems in others and be better prepared to offer support.

Many people with mental health problems do not get adequate treatment or they delay getting treatment. The WHO World Mental Health Surveys found that only a minority of adults with mental illnesses received even minimally adequate treatment in the previous year.⁴ Even when people seek treatment, many wait for years before doing so.⁵ The longer people delay getting help and support, the more difficult their recovery can be.^{6,7} People with mental health problems are more likely to seek help if someone close to them suggests it.^{8,9}

There is stigma and discrimination associated with mental health problems. Stigma involves negative attitudes (prejudice) and discrimination refers to negative behaviour. Stigma may have a number of negative effects. It may lead people to hide their problems from others. People are often ashamed to discuss mental health problems with family, friends, teachers and/or work colleagues. It may also hinder people from seeking help.¹⁰ They may be reluctant to seek treatment and support for mental health problems because of their concerns about what others will think of them. Stigma can lead to the exclusion of people with mental health problems from

employment, housing, social activities and having relationships. People with mental health problems can internalise the stigma so that they begin to believe the negative things that others say about them. Better understanding of the experiences of people with mental health problems can reduce prejudice and discrimination.

People with mental health problems may at times not have insight that they need help, or may be unaware that effective help is available for them. Some mental health problems can cloud a person's thinking and rational decision-making processes, or the person can be in such a severe state of distress that they cannot take effective action to help themselves. In this situation, people close to them can facilitate appropriate help.

Professional help is not always available when a mental health problem first arises. There are professional people and other support services that can help people with mental health problems. When these sources of help are not available, members of the public can offer immediate first aid and assist the person to get appropriate professional help and supports.

Mental Health First Aid has been found to be effective. A number of research studies have shown that training in Mental Health First Aid results in better knowledge, attitudes and help-giving.¹¹

The Global Spread of Mental Health First Aid Training

Mental Health First Aid training began in Australia in 2001 and spread rapidly around the country.¹² Now, more than 2% of the Australian population has done a Mental Health First Aid course. From Australia, it has spread to over 20 other countries, with over 1.2 million persons trained by 2015. It is hoped that the World Federation for Mental Health's adoption of Psychological and Mental Health First Aid as a theme for the 2016 World Mental Health Day will add a further boost to the global spread of mental health first aid skills. A feasible short-term goal is for every country is to match Australia in achieving 2% of adults trained. In the longer-term, the goal must be parity with physical first aid globally, with basic skills in providing assistance being seen as an important aspect of good citizenship.

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WFMH CAMPAIGNING FOR WORLD MENTAL HEALTH DAY

Dr. L. Patt Franciosi, Former President of WFMH

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Key Messages:

- World Mental Health Day is a signature event for WFMH
- WFMH is proud to have given this gift to the world
- It is a focal point for mental health advocacy worldwide

World Mental Health Day, an official project of the World Federation for Mental Health (WFMH), was observed for the first time on 10 October 1992, and 10 October continues to be the official day of commemoration all over the world. WFMH Deputy Secretary General Richard Hunter and Professor Max Abbott of New Zealand, who was WFMH President at the time, originated the event.

Dick Hunter, the creator of the idea, was a man with a dream that mental health concerns would be recognized as an integral part of overall health, and who felt that the mission of WFMH was to seek parity for mental health alongside physical health. He brought passion to the crusade to improve the care of people with mental illnesses, and each year without knowing it the organizers of national and local World Mental Health Day activities carry forward his vision. He would have been very proud to see how wide the reach of the Day is now.

A few years after October 10th was selected as the annual observance day, the WFMH Secretariat developed the concept of an annual theme, with the Federation assembling a packet of information that could be sent to everyone, free of cost, to allow them to follow the theme in their own way, holding local events within their own budgets. It was a practical way to spread mental health advocacy, drawing attention to the needs of people with mental illnesses and to the importance of mental health. Almost immediately some national authorities joined in, organizing large countrywide campaigns for public education. At every level the idea of participating in an international activity had resonance among those who believed that care and concern for those with mental disorders should have higher priority.

The annual themes selected by WFMH have covered a broad range of topics:

1992/93	General Themes
1994	Improving Mental Health Services throughout the World
1995	Mental Health and Youth
1996	Women and Mental Health
1997	Children and Mental Health
1998	Mental Health and Human Rights
1999	Mental Health and Ageing
2000/01	Mental Health and Work
2002	The Effects of Trauma and Violence on Children & Adolescents
2003	Emotional and Behavioural Disorders of Children & Adolescents
2004	The Relationship Between Physical & Mental Health: co-occurring disorders
2005	Mental and Physical Health Across the Life Span
2006	Building Awareness — Reducing Risk: Mental Illness & Suicide
2007	Mental Health in A Changing World: The Impact of Culture and Diversity
2008	Making Mental Health a Global Priority: Scaling up Services through Citizen Advocacy and Action
2009	Mental Health in Primary Care: Enhancing Treatment & Promoting Mental Health
2010	Mental Health and Chronic Physical Illnesses
2011	The Great Push: Investing in Mental Health
2012	Depression: A Global Crisis
2013	Mental Health and Older Adults
2014	Living with Schizophrenia
2015	Dignity in Mental Health
2016	Psychological and Mental Health First Aid

Over the years the United Nations, the World Health Organization, the Pan American Health Organization and hundreds of national and international mental health groups have celebrated World Mental Health Day. Events have been held in countless cities and countries around the globe, the material has been translated into six different languages at various times, and after starting our first World Mental Health Day Facebook page recently we welcomed over 12,000

‘likes’ in only 6 months. Once the Day became the largest project of the WFMH, Deborah Maguire assumed the position of administrative coordinator in 1998. Dr L. Patt Franciosi has chaired the World Mental Health Day Committee for the past sixteen years. World Mental Health Day has grown significantly every year and is considered the world’s most highly recognized global mental health advocacy program, celebrated in many countries worldwide.

Richard Hunter and the WFMH saw that an international World Mental Health Day could be, in his words, “a focal point around which global mental health advocacy could gain maximum public attention”. We will continue to work towards the dream of making mental health a priority for everyone, everywhere, by continuing the tradition of World Mental Health Day as one of our signature programs for years to come.

MESSAGE FROM THE NATIONAL ALLIANCE ON MENTAL ILLNESS

Mary Giliberti

Chief Executive Officer NAMI (National Alliance on Mental Illness)

We are pleased to support the **World Federation for Mental Health** and its efforts to promote World Mental Health Day 2016. As America's largest NGO for mental health, NAMI and our members understand the significant stigma associated with mental illness and fully support WFMH's efforts to eliminate discrimination for those individuals living with mental illness and their families. These issues transcend the boundaries of all countries. We are grateful to the WFMH for nearly 80 years of successful advocacy and its unwavering commitment of protecting the dignity of all persons living with a mental illness.

SECTION II: KEY ELEMENTS OF PSYCHOLOGICAL & MENTAL HEALTH FIRST AID

KEY ELEMENTS OF PSYCHOLOGICAL FIRST AID

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Key Messages:

- Current Psychological First Aid (PFA) models are designed for delivery by anyone in any setting who can offer early assistance to affected people – from health or mental health personnel, disaster response or humanitarian workers in various sectors, to lay volunteers and community members.
- PFA is evidence-informed and consistent with strong professional consensus for social support of persons in the early aftermath of exposure to critical events.
- PFA orientation for staff and volunteers has become standard practice for organizations working in recent humanitarian emergencies, and has been increasingly applied in various crisis contexts – from individual crisis events such as a fire or interpersonal violence, to mass events such as the Ebola Virus Disease outbreak, the Nepal earthquake and the European refugee crisis.

Psychological First Aid: Key Concepts and Global Applications

“Perhaps you are called upon as a staff member or volunteer to help in a major disaster, or you find yourself at the scene of an accident where people are hurt. Perhaps you are a teacher or health worker talking with someone from your community who has just witnessed the violent death of a loved one...” (WHO, 2011)¹

When terrible things happen, Psychological First Aid (PFA) is a set of skills that anyone can use when lending a helping hand to those who are affected. The above excerpt from the Foreword to the *Psychological First Aid: Guide for Field Workers* (WHO, 2011) begins to describe the various kinds of helpers who apply the skills of PFA in their work supporting people in distress. PFA orientation for staff and volunteers has become standard practice for organizations working in recent humanitarian emergencies, and has been increasingly applied in various crisis contexts — from individual crisis events such as a fire or interpersonal violence,

to mass events such as the Ebola Virus Disease outbreak, the Nepal earthquake and the European refugee crisis.

In this brief, we explore the concept of PFA, evidence that informs the approach, how it is applied in diverse contexts and innovations in large-scale capacity building.

The Concept of Psychological First Aid

“Psychological first aid involves humane, supportive and practical help to fellow human beings who have suffered a serious crisis event.” (WHO, 2011)¹

The need for evidence-informed, early psychosocial support following critical events has gained a growing recognition and interest in the last decades. Based on expert consensus, international agencies — including WHO, the Sphere Project, and the Inter-Agency Standing Committee (IASC) — recommend PFA as the frontline approach for helping people who have recently suffered a crisis event.^{2,3,4} But PFA is not a new concept. The term was

originally coined at the end of World War II⁵, and PFA has been written about and applied in various ways for decades as an approach to help affected people.⁶

Although its name may evoke ideas about clinical psychology, PFA is not professional counselling. Current PFA models are designed for delivery by anyone in any setting who can offer early assistance to affected people — from health or mental health personnel, disaster response or humanitarian workers in various sectors, to lay volunteers and community members. In large-scale events, PFA as a psychosocial response may be offered as one component of a multi-sectoral disaster management program.⁷

PFA aims to minimize harm for people who are suffering, and to support them in ways that respect their dignity, culture and abilities. The goals of PFA are pragmatic and constructed around practical areas of action.⁸ While the WHO PFA Guide (2011) is unique in that it has been translated into more than 20 languages, several PFA guides and manuals exist for use in

various international settings.⁶ Although they may vary in certain actions or steps, all contain common elements basic to the provision of PFA.

According to the WHO PFA Guide (2011), the main themes of PFA are:

- Providing practical care and support, which does not intrude;
- Assessing needs and concerns;
- Helping people to address basic needs (e.g. food and water, information);
- Listening to people, but not pressuring them to talk;
- Comforting people and helping them to feel calm;
- Helping people connect to information, services and social supports;
- Protecting people from further harm.

The WHO PFA Guide is built around the following action steps: **Prepare...Look, Listen and Link**. Helpers *Prepare* by learning about the crisis situation, who is affected and what services and resources are available, and safety and security concerns. **Look, Listen and Link** are described in Figure 1 below. (See Annex A for the WHO PFA Pocket Guide.)

Good communication skills — both verbal and non-verbal — are fundamental to PFA. These include active listening, empathy and offering support in ways that are appropriate and respectful to the social and cultural norms of the people being helped. Helpers learning about PFA will often practice communication skills in role plays — such as asking about needs and concerns, being comfortable with silence, helping the person feel calm, not giving false reassurances or false promises, and not judging the affected person for things they did or didn't do during the crisis event.

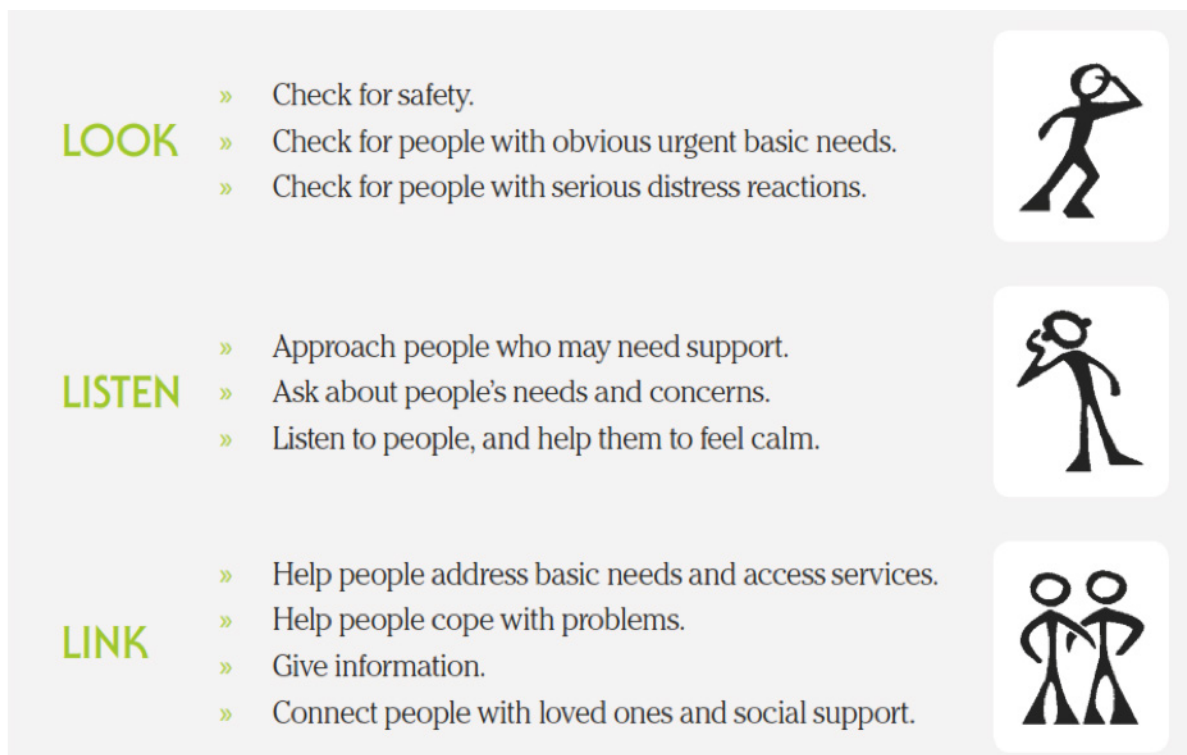
PFA does not involve pressuring people to tell details of the story of what happened to them or their feelings about the event. Sitting quietly with someone in distress or who does not want to talk, or offering some practical comfort such as a glass of water or a blanket, is also a great support. PFA is time-limited assistance; therefore, PFA helpers aim to help affected people to mobilize their own coping resources so they can regain control, and to connect with available services and supports that they may need in the course of their recovery.

Practical support, information and connection with loved ones and services are also basic elements of PFA. People impacted by crisis events may have a range of basic needs — such as food, shelter and health services. Helpers learn about and link affected people with available services and supports, accurate information (about the event, plans, and the welfare and whereabouts of loved ones), help in prioritizing and solving problems and, importantly, their family, friends and other social supports.

Some people in crisis situations likely need special assistance to be safe, to access basic needs and services, and to connect with loved ones and social support. PFA pays particular attention to people who may need special attention in a crisis, including:

1. **Children and adolescents**, especially those separated from their caregivers.
2. **People with health conditions or physical and mental disabilities** (i.e., frail elderly people, pregnant women, people with severe mental disorders, or people with visual or hearing difficulties).
3. **People at risk of discrimination or violence**, such as women or people of certain ethnic groups.

Figure 1. The Action Principles of PFA (WHO, 2011)



PFA helpers must also understand the limits of the help they can provide, and how to refer people who need specialized care to professional health or mental health services. This is not only important for offering the affected person the best care possible, but also for ensuring their own wellbeing and safety. Self and team 'care for caregivers' is another common and essential element in various PFA resources, and acknowledges the unique stresses helpers face in offering assistance to people affected by crisis events.

The Evidence Informing PFA

Behavioral science research in post-disaster settings provides empirical evidence for PFA. This includes research on factors that influence risk and resilience in affected individuals and communities^{3,9,10} and social and behavioral functioning post-disaster.¹¹ PFA is based upon factors described in disaster literature^{2,7} that seem to be most helpful to people's long-term recovery, including:

- Feeling safe, connected to others, calm and hopeful;
- Having access to social, physical and emotional support;
- Feeling able to help themselves, as individuals and communities.

Experts in the field point to the key role that social care responses play in people's resilience in the face of crisis events, such as access of survivors to social, physical and psychological support.¹² PFA articulates these key social care responses into actions that can be easily taught to and provided by lay persons, as recommended in humanitarian guidelines.⁴

In sum, PFA is evidence-informed and consistent with strong professional consensus for social support of persons in the early aftermath of exposure to critical events. Although PFA is universally accepted as an early intervention for crisis-affected people, empirical evidence is still needed to better understand how best to provide orientation to lay people and professionals¹³ and how capacity building in PFA influences disaster preparedness systems. Emerging reflective studies from the field shed light on qualitative methods to capture the impact of PFA on individuals, families and communities.¹⁴

PFA around the World

Crisis events — whether small or large in scale — are profound moments in people's lives. They may challenge people's perceptions of the safety and predictability of the world, faith in humankind or in spiritual or religious beliefs. Crisis events may change the landscape of people's lives, damaging physical infrastructure and potentially displacing people from their homes, communities or countries. They may impact social networks — the fabric of support, companionship, protection, belonging and identity — and people's resources for coping, adapting and rebuilding life in new physical, social and cultural realities.

The injury and profound loss that often accompany crisis events are uniquely personal experiences. Many factors can influence the way crisis events are experienced, including personal history, available social support, the economic and political situation and the stability and availability of services in the place where the crisis event happens. In addition, the way people express distress, seek help and give help — what is customary to say and do and NOT to say and do — are rooted in personal and cultural histories.

Although people in crisis situations may have many shared feelings and challenges, culturally inappropriate approaches can cause further harm and add to suffering. PFA emphasizes the importance of helping responsibly, and reducing potential harm to those affected. The foundations of PFA include humanitarian principles, good psychosocial practice for supporting people affected by critical life events, and attention to the socio-cultural, political and economic context in which crisis events occur.

PFA is designed to be flexible and adaptable to a variety of settings and needs. As PFA has been increasingly implemented in countries and crisis contexts around the world^{15,16,17}, it has been tailored to the particular context, culture and social situation. *The Psychological First Aid: Guide for Field Workers* (WHO, 2011)¹⁸ was developed together with 60 international peer reviewers, and endorsed by 24 humanitarian organizations. This process ensured the guide could be easily translated and adapted to diverse contexts. It is currently available in more than 20 languages, adapted to ensure locally appropriate, acceptable and responsive psychosocial programming.



Japan

“Since the Great Hanshin earthquake in 1985, a lot of ideas on MHPSS support from abroad have been brought to Japan. Many of these ideas and techniques are not suitable for Japanese culture. Especially forcing people to speak about their problems is not appropriate. For example, when you attend a funeral you do not force the relatives and close ones of the deceased to talk. You provide silent support, just by being there.” — *Personal communication, Dr. Yoshiharu Kim, Japan National Information Center for Disaster Mental Health*



comfort and emotional care. The guide *Psychological first aid during Ebola virus disease outbreaks*¹⁹ therefore included an opening chapter to educate users about Ebola disease, safety precautions, and messages they could give to families and community members in stopping the spread of disease. Examples were given of novel ways family members could have contact with their loved ones in isolation at treatment centres (e.g. by mobile phone), linking grieving people with social support through extended family and community networks and developing alternative burial rituals to reduce further risk of infection for mourners. Facilitation materials were adapted with creative communication role plays for offering compassionate, respectful support that did not involve touching the affected person.

Innovations in PFA Capacity Building

As PFA is more widely applied and utilized in crisis contexts around the world, various innovations have emerged for capacity building and connecting helpers for support and information sharing. A sample of the range of innovations and initiatives to build PFA capacity is described below:²⁰

MHPSS.net PFA Training and Adaptation Group

The PFA training and adaptation group on the Mental Health and Psychosocial Support (MHPSS) Network online site provides a forum for sharing PFA resources, training and field experience, queries and expertise among a global network of PFA providers. To date, the forum has 188 members and 43 resources available for download. Four subgroups (Sri Lanka, Japan, Taiwan and Saudi Arabia) facilitate networking and language-specific resource sharing among their members. <http://mhps.net/groups/training/pfa-training-adaptation/resources/>

Videoconference Webinars

World Bank TDLC, a partnership project of Japan and the World Bank, facilitates knowledge exchange and sharing within the development community in the Asia-Pacific region and beyond. World Bank TDLC offers videoconference-based, distance learning in PFA to build regional PFA capacity. A total of 126 participants from China, Nepal, Thailand,

Indonesia, Sri Lanka, Vietnam, Mongolia, Japan, Philippines and Indonesia have participated in interactive, practice-based webinars, building regional linkages and networks. <https://www.jointokyo.org/en/programs/category/C211/>

A five-minute informational PFA video is also available: <https://www.jointokyo.org/en/programs/catalogue/PFA>

National and Regional Capacity Building

Various groups have undertaken capacity building in PFA at scale, including the United Nations (UN) and NGO humanitarian organizations (including International Organization for Migration, International Medical Corps, Handicap International, World Vision International), other UN entities and governments.

The Japan National Center for Disaster Mental Health (NCDMH) implemented a Training of Trainers program to bring PFA capacity to all regions of Japan through various organizations, including Ministries of Health, Labor and Welfare; Foreign Affairs; Police and the Self Defense Force; various NGOs; universities and disaster-affected local prefectures. Currently there are 90 trainers and more than 1,200 people trained in PFA. PFA was also incorporated into an official training course for disaster mental health by the Ministry of Health, Labor and Welfare. See NCDMH: <http://saigai-kokoro.ncnp.go.jp/>

The Pan American Health Organization (PAHO) and WHO provided PFA training to first responders, including mental health professionals, health personnel, police, firefighters and community members in a large capacity building effort in Latin America and the Caribbean. Over 600 first responders were trained in PFA in Antigua and Barbuda, Bahamas, Belize, British Virgin Islands, Jamaica, Suriname, Trinidad and Tobago. PFA training was requested by National Disaster Organizations in many of these countries, as part of their preparedness exercises before entering the hurricane season.

www.paho.org/hq/index.php?option=com_content&view=category&layout=blog&id=1167&Itemid=353

One particular adaptation was designed for the Ebola Virus Disease Outbreak in West Africa in 2014. The outbreak was among the largest in history and devastated families and communities in Sierra Leone, Liberia and Guinea. Fear, stigma, grief and loss characterized the outbreak with severe impacts on the economy, health care infrastructure and human resources and security in the region. In response to an urgent appeal, the WHO PFA Guide and facilitation materials were adapted to the unique situation.

Adapting the guidance for the Ebola outbreak required attention to several challenges:

- Safety precautions to prevent the spread of Ebola (e.g. no touching);
- Combatting stigma, fear and violence through accurate information;
- Balancing people's rights with responsibilities to follow limitations imposed by the authorities to contain the outbreak

For example, safety precautions precluded touching a person sick with Ebola, their bodily fluids, soiled clothing or linen and anything else they had touched. People in a position to offer PFA — such as contact tracers, health workers and community volunteers — needed to understand Ebola virus disease and how to keep themselves and others safe from infection, and how to adapt the ways they normally provide

E-learning for PFA and PFA during Ebola outbreaks: Plan Learning Academy

PFA e-learning courses were developed by Plan Learning Academy. Freely available for Plan International staff as well as individuals and organizations requesting access, the PFA (english) and PFA during Ebola outbreaks (english and french) courses are self-paced modules utilizing interactive learning techniques and connecting participants in a forum for discussion and experience sharing. <http://www.plan-academy.org/course/search.php?search=psychological+first+aid&lang=en>

Conclusion

Psychological First Aid has articulated the elements of effective, frontline psychosocial support for people affected by crisis events in a way that is accessible for a wide audience of people in a position to offer support. It has enhanced the capacity of helpers and responders in various sectors, lay people, community members and professionals to support survivors of crisis events with empathy, humanity and dignity. This simple and practical guidance has shown the potential to expand mental health and psychosocial support for people in distress, and to transform emergency response in ways that minimize harm to people who are suffering, and promote their recovery.

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KEY ELEMENTS OF MENTAL HEALTH FIRST AID

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Key Messages:

- Extensive research underpins the development of mental health first aid guidelines
- The whole of the community can play a role in supporting people with mental health problems by learning mental health first aid skills.
- The basic skills of mental health first aid are summarized by the ALGEE Action Plan.

Mental health first aid is the help offered to a person developing a mental health problem, experiencing the worsening of an existing mental health problem or in a mental health crisis. There are basic mental health first aid skills that can be learned by anyone in the community and should be seen as part of the responsibility of every person to care for others in their community.

How do we know what to do?

Every person in the world has close contact with people with mental health problems, whether among their family, friends, workplace or neighbourhood. How they behave towards those people may have an important role in their recovery. But how do we know what actions to take that will be supportive and not make the problem worse?

To find out, extensive research has been carried out to develop international best-practice mental health first aid guidelines.¹⁻⁷ These are based on the consensus of international panels of experts. The experts are people who either work as mental health professionals or have lived experience of mental illness themselves or as a family carer. These guidelines have now been developed for a wide range of developing mental

illnesses (depression, psychosis, substance misuse, eating disorders, gambling problems, confusion and dementia) and for mental health crises (such as helping a person who is suicidal, self-injuring, having a panic attack or having had a traumatic experience).

Copies of these guidelines are available for free download from the Mental Health First Aid International website (www.mhfa.com.au). Research has found that people who download the guidelines do actually find them helpful and can use them to improve the support they provide to someone with a mental health problem.⁸

The ALGEE Action Plan

Across all of the different guidelines, some key elements come through consistently. These have been summarized as a Mental Health First Aid Action Plan, with the acronym ALGEE.⁹ Some people may not find 'ALGEE' easy to remember, so Mental Health First Aid international has created a koala mascot called Algee to make it more memorable. The five actions in the plan are below.



Mental Health First Aid ACTION PLAN

Mental Health First Aid is the help offered to a person developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis. The first aid is given until appropriate professional help is received or until the crisis resolves.

- Approach, assess and assist with any crisis**
 - If you are worried about someone and want to talk to them about it, carefully consider the time and place that you will **APPROACH** them about it.
 - **ASSESS** for signs of crisis, and **ASSIST** the person if they are in crisis.
- Listen non-judgementally**
 - A person experiencing a mental health problem needs to be able to talk without feeling judged.
 - **LISTEN** non-judgementally & show the person that you care.
- Give support and information**
 - Give the person whatever **SUPPORT** you are able to, whether emotional or practical.
 - Give the person **INFORMATION** that can help them understand what they are experiencing. Good websites and factsheets are available.
- Encourage appropriate professional help**
 - Mental health problems can be effectively treated with both medical and psychological therapies.
 - **ENCOURAGE** the person to speak to their doctor or a mental health professional about what they have been experiencing.
- Encourage other supports**
 - **ENCOURAGE** the person to use self-help strategies and to avoid using alcohol or other drugs to cope.
 - **ENCOURAGE** the person to seek the support of family, friends and others.

VISIT: www.mhfainternational.org



A free app with the Action Plan is available for both iPhone and Android from <https://mhfa.com.au/resources/mental-health-first-aid-downloads>.

Action 1: Approach the person, assess and assist with any crisis

The first task is to approach the person, look out for any crises and assist the person in dealing with them. The key points are to:

- Approach the person about your concerns
- Find a suitable time and space where you both feel comfortable
- If the person does not initiate a conversation with you about how they are feeling, you should say something to them
- Respect the person's privacy and confidentiality.

In a situation involving a person with a mental health problem, the possible crises are that:

- The person may harm themselves, e.g. by attempting suicide, by using substances to become intoxicated or by engaging in non-suicidal self-injury;
- The person experiences extreme distress, e.g. a panic attack, a traumatic event or a severe psychotic state;
- The person's behaviour is very disturbing to others, e.g. they become aggressive or lose touch with reality.

If the first aider has no concerns that the person is in crisis, they can ask the person about how they are feeling and how long they have been feeling that way and move on to Action 2.

Action 2: Listen non-judgmentally

Listening to the person is a very important action. When listening, it is important to set aside any judgments made about the person or their situation, and avoid expressing those judgments. Most people who are experiencing distressing emotions and thoughts want to be listened to empathetically before being offered options and resources that may help them. When listening non-judgmentally, the first aider needs to adopt certain attitudes and use verbal and non-verbal listening skills that:

- Allow the listener to really hear and understand what is being said to them, and
- Make it easier for the other person to feel they can talk freely about their problems without being judged.

It is important to listen non-judgmentally at all times when providing mental health first aid.

Action 3: Give support and information

Once a person with a mental health problem has felt listened to, it can be easier for the first aider to offer support and information. The support to offer at the time includes emotional support, such as empathising with how they feel and giving them the hope of recovery, and practical help with tasks that may seem overwhelming at the moment. Also, the first aider can ask the person whether they would like some information about mental health problems.

Action 4: Encourage the person to get appropriate professional help

The first aider can also tell a person about any options available to them for help and support. A person with mental health problems will generally have a better recovery with appropriate professional help. However, they may not know about the various options that are available to them, such as medication, counselling or psychological therapy, support for family members, assistance with vocational and educational goals, and assistance with income and accommodation.

Action 5: Encourage other supports

Encourage the person to use self-help strategies and to seek the support of family, friends and others. Other people who have experienced mental health problems can also provide valuable help in the person's recovery.

Learning more through a Mental Health First Aid training course

While everyone can apply basic mental health first aid strategies from reading the action plan and downloading the guidelines, the best way to improve skills is through doing a Mental Health First Aid training course. These courses are now available in many countries. Research shows that Mental Health First Aid training improves trainees' knowledge, reduces stigma and increases helping behaviours.¹⁰

Conclusion

Mental health problems are very common in communities across the world. Inevitably, everyone will either develop one themselves or have close contact with someone who does. Every member of the community can play a useful role in assisting the recovery of people with mental health problems by learning basic mental health first aid skills.

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SECTION III: TAKING ACTION

KEY ROLES IN PSYCHOLOGICAL AND MENTAL HEALTH FIRST AID

1. *The Role of Lay Workers*

Vikram Patel

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Key Messages:

- Design interventions based on global evidence of effectiveness and local evidence of cultural acceptability
- Involve diverse stakeholders, in particular people affected by the target mental health problems, in shaping the content and delivery of the intervention
- Task-sharing of mental healthcare with lay people has enormous potential for expanding the workforce

SUNDAR: mental health for all by all

(BJPSYCH International Volume 12 Number 1 February 2015)

The rationale

Even by the most conservative prevalence estimates, about 50 million people are affected by mental health problems in India. In contrast to this high burden, the country has only approximately 5,000 mental health professionals. It is obvious then that the strategies to address mental healthcare need to rely on alternative human resources if the country is to meet more than a tiny fraction of the needs of people affected by mental health problems. It is in this context that Sangath (www.sangath.com), an Indian non-governmental organisation (NGO) headquartered in the state of Goa and now working in several states around the country, began shaping its approach to using lay people to deliver evidence-based psychosocial interventions for mental health problems. Inspired by similar approaches to 'task-sharing' interventions with lay and community-based workers

in other areas of healthcare in India (for example, India's National Rural Health Mission contracts nearly a million such workers to deliver a range of maternal and child health interventions), Sangath adopted an approach which has now been replicated for use across a diverse range of mental health conditions.

The SUNDAR approach

Sangath's approach is characterised by several principles:

- **Designing interventions based on global evidence of effectiveness** and local evidence of cultural acceptability
- **Systematically testing intervention delivery** to ensure the feasibility of its use by lay health workers (who are referred to as 'counsellors') and its acceptability by patients and families
- **Involving diverse stakeholders**, in particular people affected by the target mental health problems, in shaping the content and delivery of the intervention

- **Embedding the intervention in established healthcare platforms**, most commonly those run by the government but also the private sector, which is widely utilised in India, to ensure scalability
- **Evaluating the effectiveness and cost-effectiveness of the intervention** in randomised controlled trials in partnership with leading research institutions, notably the Centre for Global Mental Health in London (<http://www.centreforglobalmentalhealth.org>)
- **Disseminating the findings in a variety of ways**, ranging from scientific papers to audio-video media (see for example <http://youtube/HYGk-gh4IXio> or <https://vimeo.com/67216615>)
- **Working closely with federal and state ministries** of health to scale up the innovations.

Several lessons have emerged from these experiences, which have been coined with the acronym SUNDAR (which means 'attractive' in the Hindi language):

- First, we should **Simplify** the messages we use to convey mental health issues, for example replacing psychiatric labels which can cause shame or misunderstanding with those which are contextually appropriate and widely understood.
- Second, we should **Unpack** our interventions into components which are easier to deliver and incorporate culturally sensitive strategies.
- Third, these unpacked interventions should be **Delivered** as close as possible to people's homes, typically their actual homes or the nearest primary healthcare centre or community facility.
- Fourth, we should recruit and train **Available** human resources from the local communities to deliver these interventions. This often refers to lay counsellors, but could also include parents and teachers in the case of childhood disorders.
- And finally, we should judiciously **Re-allocate** the scarce and expensive resource of mental health professionals to design and oversee mental healthcare programmes, and train, supervise and support community health agents.

This approach is built around a collaborative care framework, the most evidence-based delivery model for integrating mental health into routine healthcare platforms¹, with four key human resources: the front-line lay counsellor; the person with a mental health problem and the family; the primary or general healthcare physician; and the mental health professional. SUNDAR is attractive not only because it enhances access to care using available human resources in an efficient way, but also because it empowers ordinary people to provide mental healthcare for others and, in so doing, promotes their own well-being².

The evidence

Based on this approach, Sangath has completed research involving the systematic development of interventions and subsequent randomised controlled trials of interventions for three mental health problems — dementia, schizophrenia and common mental disorders — all of which have shown significant benefits in terms of clinical or social outcomes. The dementia trial (the Home Care Trial)³ was the first such study from a low-income country and won Alzheimer Disease International's international prize for psychosocial interventions in 2010. The common mental disorders trial (the MANAS Trial) was the largest trial in psychiatry in low and middle-income countries and the first to demonstrate the cost-effectiveness of task-sharing for mental healthcare.^{4,5} The schizophrenia trial demonstrated modest benefits in reducing disability levels in people with chronic illness.⁶

Six projects following the SUNDAR approach are currently in progress, for: the treatment of alcohol use disorders in primary care; the treatment of severe depression in primary care; the treatment of maternal depression in community settings by peers (i.e. other mothers); parent-mediated interventions for autism; school mental health promotion for young people; and the prevention of depression in late life.

The impact

This evidence has been used to scale up mental healthcare in rural communities in one of the poorest regions of the country through VISHRAM (Vidarbha Stress and Health Program), a partnership between Sangath, social development NGOs, the Ministry of Health and psychiatrists. Promisingly, the new National Mental Health Programme of the Ministry of Health (government of India), which finances the country's District Mental Health Programme, citing this evidence, has mandated the establishment of a new cadre of community mental health worker attached to primary healthcare centres throughout this vast country. This evidence, consistent with similar evidence from other low- and middle-income countries on the effectiveness of psychosocial interventions delivered by lay health workers⁷, has led to this approach

being one of the key recommendations of the World Innovation Summit in Health, in its report on mental health.⁸ Examples of such innovations can be found on the recently launched Mental Health Innovations Network (<http://mhinnovation.net/innovations>).

However, this research also points to some of the limits of this approach. For example, the evidence is restricted to a few mental health conditions, has not been evaluated for the critically important procedure of diagnosis and has not yet been scaled up significantly in any country. Thus, it is reassuring that these gaps in knowledge have led to a revolution in the field of global mental health research, with task-sharing among the leading research priorities in the Grand Challenges for Global Mental Health⁹, which has leveraged more than US\$50 million in the past 2 years to support more research and capacity building in this area.

There are a number of NGOs working in low-income countries to build skills among community-based workers to deliver psychosocial treatments for mental health problems, but few that are using robust, peer-reviewed scientific methods to evaluate the effect of these approaches and working closely with ministries of health to scale up these innovations. Sangath stands out as a rare example of an innovator committed to community empowerment, science and scaling up in low-resource settings. The impact of this evidence on the recognition of Sangath as one of India's leading mental health research institutions has been significant and a range of professionals from around the world participate in its annual two-week Leadership in Mental Health course, held in November in Goa, to learn about these models of care.

The relevance for global mental health

The SUNDAR innovation of task-sharing of mental healthcare with lay people has enormous potential for low- and middle-income countries. While it would come as no surprise to learn that there are astonishingly large gaps in access to evidence-based care in these countries, the real puzzle is that large proportions of people do not access such care even in high-income countries. There are many explanations for this observation. At the heart of them all is the remoteness of mental healthcare from the communities it serves: the interventions are heavily medicalised; they do not engage sufficiently with harnessing personal and community resources; they are delivered in highly specialised and expensive settings; and they use language and concepts which alienate ordinary people. In all these respects, the SUNDAR approach may be instructive to rethinking mental healthcare globally.

At the core of this innovation is revisiting the questions of what constitutes mental healthcare, who provides mental healthcare and where mental healthcare is provided. SUNDAR uses appropriately trained and supervised lay workers, working in settings and at times convenient to patients (even in their homes and outside regular working hours). It offers a range of contextually appropriate interventions tailored to the needs of the individual and using familiar labels and concepts. SUNDAR is an approach with relevance to rethinking mental healthcare in all countries. By acting on the axiom that mental health is too important to be left to mental health professionals alone, SUNDAR seeks to achieve a paradigm shift by reframing so-called 'under-resourced' communities as 'richly resourced', for there is surely no community on earth which is not richly endowed with human beings who are capable of caring for those with mental health problems.

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2. The Role of Society

Ritka Karila-Hietala and Johannes Parkkonen, Finnish Association for Mental Health

Key Messages:

- Mental health promotion also promotes resilience by strengthening protective factors and reducing risk factors throughout an individual's life.
- Many important individual, familial and societal determinants of mental health often lie in non-health policy domains, and mental health promotion should also champion policy interventions addressing these.
- A core objective is to promote population mental health literacy, including socio-emotional skills, coping skills and stress management skills, starting during pregnancy and the first years of life.

Mental health is a necessary prerequisite for societies to flourish, and it could be argued that as our societies move into the information society era, the population's mental capital (i.e. cognitive, emotional, and social skills resources required for role functioning) is more crucial today than it has ever been. At the same time this transition can make our mental health more vulnerable, due to the many stressors in information-driven economies and growing inequalities between and within countries. Mental health promotion can play an important role in strengthening the resilience of our communities and make people more prepared to face future challenges.

The quality of emotional, social and community relationships as well as cognitive factors are influential in forming resilient individuals and communities. Resilience is a function of the interaction between an individual and the social environment and therefore dependent on the social context and availability of social support. A supportive environment promotes protective factors and increases resilience. Mental health promotion also promotes resilience by strengthening protective factors and reducing risk factors throughout an individual's life. Increased resilience and a reduction of risk factors associated with common mental

health problems will not only help to prevent them but will simultaneously be of universal benefit for society at large. A core objective is to promote population mental health literacy, including socio-emotional skills, coping skills and stress management skills.

The foundations of mental health are laid down during pregnancy and the first years of life. Therefore, mental health literacy can be strengthened in childhood by good parenting and mental health promotion in child-care, pre-school and school settings. Providing access to good quality affordable childcare centres available for all protects against internalising problems associated with intra-family socio-economic disadvantage.

The relationship between work and mental health promotion is especially complex. On the one hand, work is a source of personal satisfaction and accomplishment, interpersonal contacts, social capital and financial security, which are prerequisites for good mental health. Good workplace social capital (i.e. trusting relationships) has been shown to also protect against depression. On the other hand, there is evidence indicating that a high workload, job insecurity, lack of control, high emotional demand, and workplace bullying and violence, are associated with stress and mental disorder. Effective interventions exist to

promote mental wellbeing and reduce stress at work as well as to facilitate early recognition of mental disorder which also result in economic savings to the workplace, even in the short term.

Many important determinants of mental health are structural, such as:

- Poverty,
- Deprived neighbourhoods,
- Gender inequality,
- Lack of freedom,
- Limited access to services,
- War, and
- Discrimination arising from stigma and prejudice.

Individual, familial and societal determinants of mental health therefore often lie in non-health policy domains such as social policy, taxation, education, employment, and urban planning. Hence, mental health promotion should also champion policy interventions addressing structural determinants that operate within and increasingly across all countries. These are particularly important as socioeconomic deprivation often has long-reaching consequences over generations and intergenerational transmission of mental ill health is well documented. Due to the differences between countries, there is no single model to follow.

Although usually the health sector needs to take the key role in mental health promotion, here sectors outside the health sector also have a fundamental capacity to influence mental health outcomes — for example:

- The **social sector** in ensuring affordable and high-quality day-care centres for children;
- The **educational sector** in promoting socio-emotional learning and wellbeing and in preventing mental stress;
- The **employment sector** in developing good management and efficient return-to-work practices;
- The **housing and urban planning sector** in providing good quality and reasonably priced housing and access to public parks and play areas; and
- **Many sectors** in offering people in later life opportunities for continuing and discovering meaningful life styles, including participation in their communities.

Lessons learned from the promotion of physical health indicate that the road to improved mental health among populations lies less in the investment in late-coming mental health services, but more in a co-ordinated public mental health programme to implement large-scale promotion and prevention activities. There is also a need to develop data collection and reporting to make it possible to monitor people's mental health, including positive mental health indicators, and to assess the impact of decisions in all policy sectors on mental health. In addition, tools for mental health impact assessment and for involvement of the civic society need to be available and applied systematically at different levels of governance.

PHYSICAL, PSYCHOLOGICAL AND MENTAL HEALTH FIRST AID

1. Making the Case for Service Users and Carers

Yoram Cohen

President of GAMIAN-Europe (Global Alliance of Mental Illness Advocacy Networks -Europe)

Key Messages:

- Mental health is a matter of increasing importance to all of us
- Patients and carers should be at the center of all aspects of healthcare provision and work to improve the availability, accessibility and quality of treatment for all mental health problems
- All of us share the same fundamental goal to maximize our well-being

Mental health is a matter of increasing importance to all of us. Everybody knows somebody that has some form of mental health problem. Some of us cope with the ups and downs of life well, while on the other hand, some develop a mental illness. This can happen to any of us; mental health concerns us all.

We want to ensure that patients are at the center of all aspects of healthcare provision and work to improve the availability, accessibility and quality of treatment for all mental health problems. We believe that there is no health without mental health.

All of us share the same fundamental goal which is to maximize the well-being of patients and to generate the best treatment outcomes possible. The main difference is that in the patient's eyes, the quality of the treatment he or she receives is, by far, the most important consideration – more so than the economic cost of that treatment to the state. Service users view their care in a personal and subjective manner, whereas the establishment is primarily concerned with measurable and empirical findings regarding treatments outcomes.

The personal perspective of patients, as a group and as individuals, is that their values must be taken into account.

Patients' needs, beliefs and goals should be considered as the most important element of treatment.

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is the first comprehensive human rights treaty of the 21st century. It represents a crucial step in the shift from viewing persons with disabilities as "objects" requiring medical treatment and social protection to viewing them as "subjects" with fundamental human rights. States which have signed the UNCRPD have an obligation to respect, protect and fulfil it. However, there is still a significant gap between the ideals and the reality of how governments and societies treat people with mental health disabilities.

Within the rights of all mental health patients is the right of every individual to be part of the society and in order for inclusion to take place, certain key areas have to be addressed. In order for patients to achieve inclusion, societal attitudes must change, damaging stigmas must be combatted and individuals dealing with mental illnesses must be treated with the priori respect that they are entitled to. Even in terms of mental-health care personnel, awareness of patients' fundamental abilities and rights

is often lacking. Living conditions in certain psychiatry hospitals or social care institutions are inadequate.

We still have a long way to go before we fully realize the ideals proclaimed in the UNCRPD. Improvements and developments need to continue to spread across the globe in an atmosphere of cooperation and collaboration. While it seems that in many areas we are on the right track, there are locations and areas in which many improvements remain to be made. The fight against stigma needs to be embraced on all fronts and in laws and national resources also. The empowerment approach needs to be further developed, expanded upon and financially supported in order to give patients the best possible opportunities to live a meaningful life.

The psychological and mental health first aid will be welcomed by mental health patients and their families. Patients themselves will feel more connected to the society and will get first aid when necessary, exactly the same as any other citizen get first aid. Psychological first aid is more human and takes into consideration the individual's needs. The treatment which they will receive when in need will not be forced upon them but will be more considerate, enabling them to get out of crisis more smoothly.

2. Making the Case for Equity

Professor Dinesh Bhugra CBE

President, World Psychiatric Association

Key Messages:

- People with mental illness have the same equitable rights as other members of society.
- The challenge for clinicians and policy makers is to look at the possibilities of eliminating discrimination against people with mental illness.
- A well-argued and well-settled principle in international human rights is that the elimination of discrimination against vulnerable groups deserves immediate response and action.

This year's World Mental Health Day is about making psychological and mental health first aid available worldwide in the way that physical health first aid is available. One of the reasons for the disparity may be the lack of social justice for people with mental health problems.

People can experience discrimination in a number of ways on a daily basis. This can be related to race, ethnicity, religion, gender or sexual orientation. However, individuals with mental illness appear to face higher levels of prejudice. Stigma means negative attitudes and behaviour related to negative perceptions or feeling threatened. The French philosopher Roland Barthes argued that the creation of 'the other' is important in confirming one's identity. Thus it can be argued that stigma plays a major role in maintaining one's identity vis-a-vis 'the other' who has mental illness. Educational programmes which help to reduce stigma have been shown to change attitudes but often not the behaviour. The challenge for clinicians and policy makers is to look at the possibilities of eliminating discrimination against people with mental illness. Discrimination, its type and levels, can be recorded and measured directly, which means that it will be possible to eliminate it.

Discrimination is defined as the distinction between people on the basis of disability or gender, sexual orientation, age, religion etc., especially if such a distinction leads to creating levels of inequality which impair social functioning of individuals. Several forms of discrimination against people with mental illness can be identified. These include social, economic, personal or

political discrimination. It can be argued that historically all civic movements for empowering vulnerable groups (by virtue of their age, race, religion, ethnicity, sexual orientation) have brought about equality by demanding and pushing for elimination of discrimination rather than by relying on the reduction of negative attitudes and resulting behaviours.

Non-discrimination is at the heart of international human rights law and is enshrined in all human rights conventions. A well-argued and well-settled principle in international human rights is that the elimination of discrimination against vulnerable groups deserves immediate response and action, irrespective of lack of resources, be they financial or human. Social justice carries embedded within it concepts of human rights. Social justice focuses on strengthening and supporting institutions which can then eliminate social discrimination, especially against individuals with mental illness.

Discrimination can be reduced through legal legislative frameworks and appropriate policy initiatives. Governments in general and occasionally individuals can use the legal framework to challenge discriminatory practices and take suitable appropriate action. The laws which foster discrimination – such as lack of rights to inherit property or to adopt children – communicate to the larger community that such blatant discriminatory practices also contribute to a level of inequity in funding for services as well as for research into mental illness.

People with mental illness have the same equitable rights as other members of

society. Other discriminatory practices — for example, lack of housing, employment and educational opportunities — need to be challenged.

Mental health professionals have a moral duty to advocate for principles of non-discrimination and to convince policy makers of their urgent obligation to repeal any laws which foster discrimination against individuals with mental illness.

The WPA (World Psychiatric Association) Policy Statement on Social Justice (http://www.wpanet.org/uploads/Position_Statement/WPA%20Social%20Justice_FINAL%20Sep%202015.pdf, accessed 26 November 2015) calls for the urgent elimination of discrimination and discriminatory practices against people with mental illness.

Social responsibility should be seen at four levels: individual, community, national or regional and international. At an individual level, social justice needs advocacy, clear identification of prejudices and education in order to change attitudes and, hopefully, subsequent changes in behaviour. At the community or familial or kinship level, social justice is about ensuring that individuals and their immediate environment have the power to ensure that the group has the capability to be healthy and to understand what is missing.

At a national level, social justice means strengthening and empowering institutions, be they schools, the judiciary, ministries or other stakeholders. At the international or global level, institutions such as the United Nations have a major social responsibility to deliver social justice and eliminate social discrimination.

3. Making it Happen in the Workplace — The Employee Perspective

David Kinder

Deputy Director, Workforce, Pay and Pensions, Her Majesty's Treasury, British Government, London

Key Messages:

- Using a staff network, run and managed by people with actual lived experience of poor mental wellbeing, can be an incredibly powerful way of providing support in the workplace.
- Get the buy-in from people right at the top of the organisation. That is crucial for delivering real cultural change.
- Make it fun, make it innovative. There is so much stigma and reluctance about speaking about mental health issues that you need to be creative and find ways to reach as wide an audience as possible.

My name is David Kinder, and I'm a senior manager at Her Majesty's Treasury, the United Kingdom's Finance Ministry. My article may well be unlike others in this publication. I have no qualification or medical experience in the field of mental health. It does not form any formal part of my work objectives or professional career. I do not have a set of tables and figures to present.

But what I do have is a personal story about having suffered with depression and anxiety. And a story about how I've used that experience and worked with other people with similar backgrounds to deliver change in a workplace setting. Here at the Treasury we've set up and led an ambitious and dynamic programme of change to reduce the stigma surrounding mental illness which I believe has had a transformational impact on the way that people with psychological and mental health problems are treated and supported.

My own personal struggles with depression and anxiety in a workplace setting began in 2006. I had just joined the Treasury as a keen and ambitious new graduate. I wanted to do well. From the beginning I found it difficult. And not necessarily because people were telling me things were going wrong. But I looked around me at very capable and intelligent

people, doing what seemed to me like brilliant jobs. And I thought to myself "I'm never going to be able to do that", or sometimes "I'm not good enough to work here".

And then I did what I now know is the worst thing to do in those circumstances when you are doubting yourself and you need support. I didn't tell anyone. I thought maybe if I worked harder and with longer hours, or took on more tasks, that maybe I could prove myself. To whom, I'm now not quite sure. Probably to myself. Over a period of about 9 months, I steadily got worse and worse, until I had a breakdown. Fortunately, I had the sense to go and see my doctor, I was prescribed time off work, I took anti-anxiety medication and slowly but surely, things started to get better. Six weeks later, I went back to work. I mistakenly thought everything was fine, went straight back into old habits, and 12 months later I had a similar episode.

That became the start of a very different way of managing myself, my mental health, and how I work. I counted myself as lucky. I got great support from my managers, my family and my friends. I learned how to do things differently. And I haven't had another episode for around 10 years now.

But I kept seeing other people in my organisation suffering from similar things. Because I recognised the signs, I could often spot them. And so I began to talk openly about my own experiences, even though I was, at first, worried about the impact that might have on my career. But then I started to get an increasingly positive reaction. Each time after I spoke, people would say how much they identified with the problems I'd been speaking about – and had either suffered in a similar way themselves or knew someone who had. The UK Treasury, like, I imagine, many other Finance Ministries across the world, is a busy, fast-paced and often very stressful place to work.

And so two years ago, with the support of our Human Resources team in the Treasury, we decided to launch an employee-led "Mental Wellbeing Network" to reduce discrimination and help promote peer-to-peer support for all staff going through problems with their mental health. We've also had expert help from a national charity in the UK, Time to Change, which has provided us with hints and tips to make sure we're following best practice all the way.

We've had great success. We decided to launch our network with a bang and had a big sign up event with the Chancellor of the Exchequer, George Osborne, and all of our organisation's senior leadership team. We managed to attract 200 people – or 1 in 5 of all people who work in the Treasury. It was a fantastic launch pad.

And from then on we've gone from strength to strength. Two years later and we have over 60 members, all of whom are staff volunteers, who take time out of their day job to help promote better policies to support mental health.

We organise one event every month, which is advertised across the whole organisation, to make sure that we have a regular presence in everyone's minds. Sometimes they are small events – for example we might invite an academic expert into the building to talk about mental health. Sometimes we organise flash mobs to distribute handouts and flyers in our canteen at lunchtime. One of our most successful events was getting 250 people to listen to three of the most senior people in the UK Government talk about "my biggest failures" – exposing their vulnerabilities in a way that doesn't often happen, and showing junior staff that it's ok to make a mistake.

We have designed and run employee-led sessions for staff and managers struggling either with their own mental health and wellbeing or trying to support and manage people who are. We've taken the best guidance and practice for supporting people from national charities and organisations in mental health and rewritten them to be relevant for the people who work in our building. Working with our Human Resources team, we've trained people to become Mental Health First Aiders.

We've put in place systems that aim to support the wellbeing of every member of staff. We think that's important so that managing your mental health becomes something that everyone can identify with. So we've set up weekly "wellbeing walks" run by the network so staff can

meet up with new people. We've offered staff help to practice mindfulness and meditation. And we've designed a toolkit to help every team monitor their own mental wellbeing.

And finally, we've tried to benchmark what we've done and show the results to our senior management team. Once a year, we brief our Executive Management Board on the progress that the network has made. We take a pulse check of the mental health of the building. We highlight places where stress and anxiety and sickness absence are greater. And we get a commitment right from the top that the Treasury values its staff and backs our plans to support their mental health.

Our network is now in year three. We're excited about what we are achieving. The big events and meetings get great feedback. But sometime it's the small things. The people who arrive here and say "I've never worked anywhere that does so much on mental health". Or the person who has been struggling for months and finally has the courage to have that one conversation with their line manager that begins to turn things around.

Now we're maturing as a network, and we've begun to deliver a real change in culture in our workplace, we're thinking about how to push ourselves further and harder. But we don't want to forget the core thing that brought us all together – anyone, at any time, can suffer from poor mental wellbeing, and we want our organisation to be as supportive as it possibly can be to help people get better. And that people who have suffered in the past can become the organisational leaders who help others in the future.

4. Making it Happen in the Workplace — The Employer Perspective

Nigel Jones

Partner, Linklaters and Board Member, City Mental Health Alliance

Key Messages:

- Consider how investing in people's health and wellbeing fits with your organisation's culture, values and people strategy, in addition to commercial business drivers of maintaining a healthy workforce, and the risks of not investing in the health and wellbeing of your people.
- Get buy-in from senior leaders to invest in developing the skills of line managers to deal effectively with physical and mental health issues in their teams.
- Find people who are willing and able (and sufficiently brave) to tell their personal stories of dealing with illness (whether physical or mental), especially those at a senior level – clearly one of the most effective ways of changing the culture around the importance of good health and wellbeing.

It is self-evident that in a leading global law firm like Linklaters our people are our greatest asset. Their talent, hard work and commitment to quality are what make our firm stand out and make it a privilege for me to lead the firm's wellbeing agenda. Across the firm globally we place strong emphasis on the health and wellbeing of our people. This forms an important part of 'Our Deal', the mutual support offered by the firm and by each of us to our colleagues.

We now measure how well we support health and wellbeing in our global engagement survey. From the results we know that we don't get everything right all the time; acknowledging this is part of the journey and a valuable step in the right direction. Given our commitment to providing an outstanding service to our clients, this can often mean hard work and long hours. The pace of work can, at times, be pressurised. We know that, in some cases, pressure can lead to stress if it is not managed effectively and if we don't provide the right support. For this reason, we have had a global stress management policy in place since 2010. We have recently added more emphasis around resilience as we understand the

importance of supporting people in a fast-paced environment such as ours. Achieving a healthy work-life balance is not always easy and that's why we have actively promoted a range of measures, including working at home, to ease these pressures and offer greater flexibility to our people. Moreover, over the last few years we have, as part of our commitment to the aims of the City Mental Health Alliance, tried to be more open about mental health, trying to displace the taboo that has existed for too long around the topic.

Our approach isn't prescriptive. We recognise and appreciate that everyone's needs are different. We encourage our people to learn how best to promote and manage their own physical health and mental wellbeing and to adopt healthy behaviour. In the United Kingdom, we have a comprehensive health and wellbeing programme on offer to all our people which includes activities and information about nutrition, physical exercise, sleep, building resilience and mental health, as well as the provision of excellent benefits such as our Employee Assistance Programme. In addition, we

offer support and training to our people managers and human resources teams so they are better equipped to deal with health and wellbeing issues in the workplace. This has included piloting Mental Health First Aid (MHFA) training and sessions on managing members of their team who are being treated for cancer or are carers for those with cancer. Feedback on the sessions has been really positive, with many now saying they are trying to adopt a more healthy way of life.

Underpinning all of this has been our contribution to the creation and operation of the City Mental Health Alliance (CMHA). The CMHA aims to foster open dialogue and facilitate the sharing of good practice amongst financial and professional services firms in the City of London. I had the privilege of being one of the co-founders, supported by our firm's most senior leaders, and to continue to be an active member of its leadership team. We have learned a great deal from dialogue between members, and the collaborative approach all have taken. It is clear that mental health problems can affect everyone. They do not discriminate between banks, law firms, other professional service firms or corporates. They affect us all. They also affect everyone working in any organisation — junior and senior staff,

our lawyers, our other professional staff and secretaries. I have heard the powerful and personal stories of some senior City leaders, including partners of my firm, who have suffered from mental health problems. Their stories all had a common theme — their mental health deteriorated slowly over a long period of time and they papered over the cracks, carrying on as if everything was 'normal', unwilling and unable to ask for help until things reached a crisis point. Fortunately, they received the clinical help and organisational support they needed to recover and return to work. These stories are one approach that we hope will reduce the current situation — with one in four people in the UK experiencing a mental health problem each year and many not getting the help they need because of the fear and stigma associated with such problems.

As senior business leaders, we have a responsibility to create a culture in our organisations which encourages our people to take responsibility for keeping themselves well, and to ask for support and talk openly about their physical and mental health without judgement. Everyone has mental health in the same way that they have physical health, but culturally it's still much easier to talk about our physical health and to take time off work because of a physical illness, than to talk about suffering from stress, anxiety or depression. It's time to change this.

At Linklaters, we have taken the opportunity globally to mark World Mental Health Day in October each year and to stress the importance of good mental health to all our people. A number of our offices have organised events to raise awareness and in the UK, we've had a specific 'mental health week' for the last two years featuring practical sessions to build resilience, maintain energy and effectiveness, as well as offering massage and mindfulness sessions. In addition, over 300 of our global Partners have attended sessions with Dr Bill Mitchell, a leading clinical psychologist, who has focused on building personal resilience and the role of leaders in supporting the mental wellbeing of their teams. This is part of our strategy to guide our Partners and leaders to recognise and address the signs of ill health (mental and physical)

at an earlier stage, and refer people for help and support in good time before problems escalate.

If your organisation is at the start of its health and wellbeing journey, my top tips to you are:

- Make sure you have the full support of your senior leaders.
- Review the business case for investment in by looking at relevant metrics (further information on what they are is available to CMHA members), as well as gathering employee feedback. Consider the risk perspective of not making an investment in the health and wellbeing of your people.
- In addition to commercial business drivers, consider how looking after people's health and wellbeing fits with your organisation's culture, values and people strategy — including its commitment to being a good corporate citizen.
- Invest in developing the skills of line managers to deal effectively with the physical and mental health issues in their teams — using a train the trainers approach to cascade good practice.
- Find people who are willing and able (and sufficiently brave) to tell their personal stories of dealing with illness (whether physical or mental), especially those at a senior level — clearly one of the most effective ways of changing the culture around the importance of good health and wellbeing.

I am committed to pushing forward this agenda and I urge other senior business leaders to do likewise. Supporting our people to get the best out of themselves is the right thing to do, from whichever perspective you view it.

5. Making it Happen in the Armed Forces

Neil Greenburg

Professor of Defence Mental Health, King's College London; Military and Veterans' Health Lead, Royal College of Psychiatrists

Key Messages:

- Military personnel from all nations routinely face challenging situations in the course of their duty
- The majority will deal with challenging situations with little or no consequences and the minority will require additional support
- Whilst there is a role for mental healthcare professionals in providing care to those who have formally been identified as being ill, the majority of psychological first aid is provided within a person's unit

Military personnel from all nations routinely face challenging situations in the course of their duty. Most deal with them effectively and indeed many find that successfully dealing with a challenge allows them to be better able to deal with such challenges in the future. However, it is inevitable that a minority will become distressed and a smaller proportion still will become unwell. Military forces have long been aware that success on the battlefield depends not just on superiority in terms of personnel numbers and firepower etc. but on the capability and will of service personnel to continue to fight when their enemy's will and motivation have waned.

In the main, the maintenance of psychological hardiness is not a medical issue but a leadership issue. Put another way 'the psychological welfare of troops is primarily a leadership responsibility'. High quality leadership, and indeed comradeship have been repeatedly shown to be important determinants of morale and highly protective in terms of military personnel's mental health.¹ Whilst there is a role for mental healthcare professionals in providing care to those who have formally been identified as being ill, the majority of psychological first aid is provided within a person's unit. Studies have shown that the rates of mental health disorders within teams who perceive their immediate leader as being caring (e.g. 'not taking on extra

duties to make themselves look good at the expense of their team' or 'treating all team members fairly') may be up to a 1/10th of the rate found within units who perceive the opposite.¹ Similarly impressive benefits have been found from high levels of camaraderie which is sometimes known as unit cohesion. Support from line managers and colleagues is equally as important off the battlefield too. For instance, studies have shown that troops who do not feel well connected to their peers after return from deployment are much more prone to develop mental health problems.²

Recognising the importance of peer and junior leader support, the United Kingdom Armed Forces developed a psychological first aid package called TRiM or Trauma Risk Management.³ TRiM is a peer support programme which originated in the Royal Marines in the late 1990s. TRiM practitioners are soldiers, sailors or airmen who have completed a 2 to 2.5 day training course which equips them with the skills to be able to carry out a semi-formal structured conversation with a colleague who has been exposed to traumatic events in order to identify how they are coping. TRiM practitioners are not medically trained; they are infanters, cooks, pilots, snipers, divers etc. Their TRiM training enables them to carry out

a structured interview, with a trauma-exposed colleague, a few days after a traumatic incident and again after about a month. If they find their colleague appears not to be coping well at the initial interview TRiM practitioners assist them to access appropriate support ideally from colleagues, line managers or other similarly non-medical sources for the first month or so after a traumatic event. If when they re-interview them, a month or so later, their colleague is still not showing signs of making a good recovery, the TRiM practitioner facilitates them speaking with a healthcare professional who is able to carry out a more detailed needs assessment and arrange formal treatment if it is required.³ The TRiM process thus aims to foster social support and monitor personnel exposed to traumatic incidents to ensure that those who need professional assistance get it. This is important because, as with the civilian society, the majority of military personnel with mental health difficulties do not seek help at all either because they fail to recognise they have a mental health problem or because of the stigma associated with seeking help. It is perhaps noteworthy that the TRiM system has now been widely used, in the UK at least, by a number of non-military organisations suggesting it has wide applicability in trauma-prone organisations.

Many armed forces also aim to support the mental health of troops by providing specific opportunities for troops to talk to colleagues informally to each other in a safe location after deployment before they return home; this is often referred to as decompression. Decompression provides an opportunity to begin to make sense of what happened on deployment by informally speaking to colleagues. Speaking to peers they have deployed with has been shown to be the preferred way that troops discuss their deployment experiences.⁴ Evidence shows that troops who are provided with an opportunity to decompress before returning home report better mental health than those who do not.⁵ Decompression also provides an opportunity for healthcare professionals to brief troops about the potential for experiencing mental health problems after deployment and similarly focused psychoeducational briefings are often provided to troops before, and at times during, deployment. The evidence of the impact of psychoeducational briefings on mental health is relatively weak although there are some suggestions that it may be beneficial for troops whilst they are deployed but is unlikely to bolster their psychological resilience in the longer term.⁶

In the main most military personnel remain resilient even when called upon to undertake the most arduous of duties. The mental hardiness of armed forces personnel mostly is in the main a result of the close knit teams they form with each other and their immediate leadership. In essence, within most military units, resilience does not tend to lie within individuals instead it lies between individuals. Thus, just as is found in the rest of society, the forging and maintenance of close social ties to people that you can trust and who trust you in return is highly protective of a good state of mental health.

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6. Making it Happen in the Armed Forces — Case Study

Dennis Koire

Psychologist, General Military Hospital, Bombo, Uganda

Key Messages:

- Early intervention before total mental break down helps soldiers to get help before their condition worsens.
- Battle buddies become more open to talk about mental health issues.
- Mental Health First Aid reduces stigma related to mental health problems and mental ill health, and increases soldiers' confidence in helping others with mental health problems.

Mental Health First Aid for The Armed Forces in Peace Keeping Operations: A Case Study of an African Mission in Somalia by a Ugandan People's Defence Force Officer

My name is Lieutenant Dennis Koire and I work as a psychologist in the Ugandan People's Defence Force (UPDF). In November 2013, developing an armed forces community trained in Mental Health First Aid (MHFA) was identified as part of an overall mental health strategy to reduce suffering, raise mental health literacy and reduce stigma in the UPDF community. Prior to this there had been several serious mental ill-health incidents within the UPDF that clearly demonstrated the need for a more strategic approach to improving mental health.

In January 2014 a team from MHFA England provided Mental Health First Aid Armed Forces (MHFAAF) training to the lead commanding officers in Battle Group 13 (BG 13) at the Ugandan Peace Support Operations Training Center in Singo, Uganda. The group comprised members of the UPDF mental health team, section commanders, platoon sergeants, platoon commanders, officers in charge of companies, and the two battalion

commanders and deputy commander of BG 13. All of these members were to be deployed to Somalia as part of a foreign peacekeeping mission. My role in this deployment was to lead the mental health team and support the mental health of the troops in BG 13 whilst in Somalia.

Before the training in MHFAAF, I had been trained in physical first aid in preparation for tactical combat casualty care, and had gained significant knowledge on pre and post-deployment psychological training. I had never realized that such a simple and impressive mental health training program existed, the concept of mental health first aid was completely new to me and I have to say that, in a way, I underestimated its usefulness. I quickly realized that this simple mental health training tool could be the key to challenging stigma and effectively educating my troops in mental health. I valued my training as a Mental Health First Aider so much that I then went on to undertake MHFAAF instructor training, becoming qualified to train the MHFAAF course to others.

Best Practice

To maximize the limited resources available to train members, maximize the effect of the MHFAAF training, and minimize the number of referrals from the mission area due to mental ill health, the following principles were put in place:

- a. Train key leaders in all military unit formations,
- b. Offer guidance to medics on how they should work better when faced with cases of mental breakdown, and
- c. Encourage a peer help mechanism to reach every soldier, by having leaders of all unit formations sensitized and given first aid skills to assist anyone with evident mental health problems in need of help.

What was the impact of MHFAAF training on me and my fellow Mental Health First Aiders?

The MHFAAF training was a life changing experience for me and for all of those who undertook the training. MHFAAF training is a simple and effective tool to educate anyone to confidently understand mental health, spot the signs of mental distress and give individuals the strategies to carefully intervene in an operational environment.

On a personal level

Before the MHFAAF training, the following had largely shaped my understanding of mental health in the armed forces:

- a. Undergraduate training in Psychology
- b. Postgraduate training in Narrative Exposure Therapy for post traumatic stress disorder
- c. Certificate in Trauma Counselling
- d. Postgraduate Training in Clinical Psychology (Master of Science in Clinical Psychology student writing my thesis).

I have deliberately shared my previous qualifications to emphasize what helped educate me and shape my mindset as a UPDF Psychologist. My team of psychiatric clinical officers, psychiatric nurses and medical clinical officers had anchored our approaches in solely a medical and curative interventional approach. As an experienced mental health team we were prepared to help treat, cure and refer back to Uganda those with mental ill health using only a reactive pharmacological approach. My mental health team and I were curious to know exactly how a public health education approach like MHFAAF could compare to a curative approach in a combat (or combat-like) situation.

Impact After Training in MHFA

The MHFAAF training genuinely challenged and changed our understanding of mental health and wellbeing in the UPDF. We learnt much more about mental health and understood more specific facts about stigma, empathy, and how we can help anyone with a mental health problem without overly relying on a psycho/pharmaco-therapeutic mindset. This significantly shaped the way we provide support to our troops and their families to this day.

After the MHFAAF training, the whole group of around 60 troops instantly developed a genuine concern for and understanding of mental health and wellbeing. The MHFAAF training gave us the awareness, knowledge and confidence in mental health, and even young UPDF privates discussed the subject of mental health with real empathy and understanding. The awareness and understanding of mental health had spread so effectively in Battle Group 13 that the senior commanders were supportive of the role the mental health team was playing in the field, building on the peer helpers trained in MHFAAF. It felt like the MHFAAF training had reminded the UPDF soldiers that we are just as human as any one and also need to be helped and supported as we support and help others. The BG 13 UPDF troops trained in MHFAAF (Mental Health First Aiders) would routinely contact me and consult whenever they felt that their battle buddies needed some kind of mental health support. I would help support them to care for their troops and this reduced the likelihood of them being transferred to our mental health unit and potentially flown home to Uganda.

The medics who trained with me as Mental Health First Aiders also helped so much in intervening early with mental distress. MHFAAF training taught us to easily identify the early warning signs of mental distress so that we could confidently approach the person and guide them towards our mental health unit. We learnt to normalize experiences of mental ill-health and with early intervention would usually be able to support the person therapeutically with less costly medicine so they would be more efficiently deployed back to their units for duty.

My end of year report for the mental health team at the Level 2 field hospital clearly evidenced that Battle Group 13 had recorded the least number of referrals for mental health related issues compared to those that had not been trained in MHFAAF. I believe we effectively started to change the culture of Battle Group 13 to be more understanding and empathic to

comrades with mental health issues. We witnessed this shift in understanding and awareness because discussions among troops about mental health related subjects became such common place, even in the officers' mess. This to me was the real evidence of the powerful impact of something as simple as MHFAAF.

Extracts of a video interview with a senior commander who was trained as a Mental Health First Aider

QN: Have you had chance to use what you learnt on the MHFAAF course?

ANS: "I learnt how to understand a person who has a mental health problem. Such that I don't aggravate the problem/situation but instead make effort to understand him or her without rubbishing and rushing to conclusion. I have had chance to identify, handle and understand soldiers with mental health problems."

Recommendation

As witnessed first-hand by a senior commander, the mental health team and other soldiers, the need to sensitize soldiers on issues about MHFAAF can't be underestimated. Being a soldier is a calling which has strict and rigid routines. This noble profession calls for utmost psychological resilience, especially during combat filled deployments. In times of combat, conventional means of treatment and psychotherapy may not easily be applied and the norm is to repatriate home. By providing early mental health and wellbeing to soldiers, they are able to detect symptoms in themselves or others, be sensitized on how to respond, educated on what symptoms may mean and informed about the referral pathway in place once symptoms persist. This means mental health problems can be dealt with as they emerge, reducing occurrences of severe debilitating mental break down which requires complex and lengthy treatment approaches.

Armies need to have in place a peer/ buddy anchored approach in dealing with mental health problems. This can go a long way towards reducing stigma associated with mental ill health. Simple and clear information like that provided during MHFAAF training educates soldiers about mental health and demystifies the falsehoods that block good mental health practices in the armed forces community.

Since MHFAAF informs soldiers about the large armed forces community, I suggest that armed forces leaders encourage their units to spread the training further, to help families of soldiers live happier and with better mental health. This will come about through families having a better understanding of mental health, and more empathy with their family members serving in the armed forces. Soldiers will also be sensitive and mindful of their own mental health and how it may impact others in the larger community.

Conclusion

MHFAAF is about knowing the symptoms, intervening early, helping appropriately and referring properly.

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IMPLEMENTING PSYCHOLOGICAL AND MENTAL HEALTH FIRST AID – LESSONS LEARNT

1. *Lessons Learnt in Pakistan*

Dr Saadia Quraishy, CEO AMAN Health Care Services, Pakistan

Key Messages:

- MHFA is a beacon of hope in an otherwise bleak mental health landscape in Pakistan, especially in a population with poor levels of literacy and poor access to quality healthcare
- Delays in access to mental health are detrimental to the individual and society
- Psychological and mental health first aid is an innovative way to start to tackle this

Mental Health First Aid (MHFA) was introduced in Pakistan by MASHAL, an initiative of the AMAN Foundation (a local, not-for-profit trust, based and operating in Pakistan) which aims to promote mental health literacy at grass root levels to dispel the misconceptions and stigma surrounding mental health issues. MASHAL, which means torch in the Urdu Language, also stands for 'Mental and Social Health Advocacy and Literacy'.

MASHAL is led by its CEO, Dr Saadia Quraishy, a consultant psychiatrist from the United Kingdom who first attended the MHFA course in England and decided to bring it to Pakistan in 2014. Through its training workshops MASHAL imparts awareness about mental health, the associated illnesses, and recognition of emerging symptoms of mental illness or mental health crisis so that help can be sought as early as possible. MASHAL has also focused on embedding mental health within primary care, setting up community mental health teams working in close collaboration with primary care providers to provide holistic care in the community as well as advocacy for promoting and safeguarding the rights of vulnerable individuals with mental health disability.

MHFA is envisaged to be a beacon of hope in an otherwise bleak mental health landscape in Pakistan. There is a general lack of recognition of common mental illnesses and a stigma attached to severe mental disorders. The general population, with poor literacy levels and serious dearth of accessible quality health care, attributes the cause of mental illnesses to quasi-religious and cultural beliefs and seeks traditional spiritual healing which can be harmful and delay recovery. This is understandable in an environment where there is an acute shortage of mental health professionals, a proper medical service infrastructure and a dearth of appropriate information on the identification and management of mental illnesses. MHFA seeks to fill this gap by disseminating basic information enabling people to approach, recognize and act as first responders to mental health issues or crises.

Dr Quraishy invited the MHFA Australia CEO, Ms Betty Kitchener, to visit Pakistan and an agreement was signed between the two organizations to set up Mental Health First Aid (MHFA) Pakistan in April 2014. A training workshop was conducted by Ms Kitchener at the premises of the Aman Foundation in Karachi, attended by 28 staff members

of the Aman Foundation. The eclectic group of people was sourced from various business functions across the foundation and provided the first set of 12 trainers for the program. The MHFA Pakistan team then assumed the responsibility of customizing the Australian course material and teaching aids to make it relevant and impactful for local audiences.

The MHFA manual, the s-MHFA course presentation and pre and post-test forms were all localized for the Pakistan context. In addition, all visual aids and clips used during the training sessions were produced anew, casting local actors, conversing in the Urdu language. These short films play a crucial role in depicting illnesses and their associated effects on the patient, thereby enabling the first aider to utilize the most effective and tailored approach for intervention. Additionally, work was also initiated on the marketing and communications front. The MASHAL website was developed, with a page dedicated to MHFA and with provisions to facilitate the registration of participants for the training sessions. Communications collateral delineating the need, rationale and impact of MHFA was designed and produced to be used in conjunction with the corporate MHFA presentation for most business development activities of the program in Pakistan.

Subsequently, MHFA sessions were conducted for various cohorts of Aman staff members, with a focus on those involved in direct contact with program beneficiaries or those forming the team of first stage responders. These included the paramedics from the Aman Ambulance service and various groups of the Aman Community Health Workers which form the backbone of the Foundation's community health interventions. The programs and activities of MASHAL are guided by an integrative approach whereby mental health indicators are assimilated into other projects such as SUKH, the Aman Foundation's family planning and mother and child health venture. Accordingly, the community workers attached to the SUKH project were encouraged to acquire the MHFA accreditation in order to equip themselves with a better understanding of the major and common mental illnesses and the required corresponding actions.

Training sessions have also been held with the staff and teachers of the Amantech program: Aman Foundation's educational and skills development program for young men and women with a view towards helping them attain gainful employment. Equipped with the requisite training in first aid, these teachers and mentors are in a unique position to identify and act upon any emerging signs of mental illness or a mental health crisis, if and when they occur.

Efforts are now underway to increase the outreach of the program through partnerships with external entities such as corporations, educational institutions and other relevant social sector organisations. The revenue generated from MHFA would be utilized for funding MASHAL's community medical program, focused on the provision of treatment and rehabilitation of patients from impoverished areas of Karachi.

The pre and post test results of all respondents have now been recorded and would be used to produce a research paper to demonstrate the efficacy of s-MHFA trainings for the participants. An initial assessment has been conducted with 128 participants (84 males and 40 females; 4 did not declare gender) who formed the initial group of trained first aiders to measure shifts in behaviour, pre and post training, on the following indicators:

- Knowledge Acquisition
- Stigmatising Attitudes
- Helping Attitude

The responses were collected and analysed using the ANOVA analysis of variance test. The results revealed that MHFA sessions in Pakistan, like elsewhere in the world, do indeed improve scores on all these indicators. The course is effective in improving mental health literacy, decreases social distance from those suffering from mental illness, and increases confidence to help someone suffering from mental illness. All results were statistically significant at a 5% significance level. It was also revealed that most responses on Knowledge Acquisition indicator were close to the 'gold standard' set by health professionals themselves.

In order to ensure scalability of the program, MASHAL plans to integrate the operations of MHFA with the Aman Foundation's Urban Health Institute (UHI), which was initially conceptualized as a department to fulfill the training needs of Aman Health initiatives, but now ventures out to deliver services to other non-government organisations (NGOs) and institutions as well. Additionally, a consortium of 20 mental health organisations was formulated by Dr. Saadia Quraishy, CEO, Aman Health Care Services at the Aman Foundation. This mental health forum seeks to actively engage with each other, other social and development organisations, and the government to propagate and advocate the cause of mental health. The platform also serves the cause of MHFA by normalizing it into the programs of other mental health organisations for effective scaling up of the program.

The MHFA course content also provides guidelines to cope with the psychological after effects of disasters, both natural and man-made. Pakistan is prone to natural disasters like earthquakes and floods, and has seen a spate of terrorist attacks, with 16/12 Peshawar tragedy being the most deadly in terms of the target and lives lost. In addition to being readily prepared to face and deal with such adversities, there is also a pressing need to focus on the psychological trauma faced by victims and survivors, and in doing so prevent any mental illness from arising and facilitate their return to normal life.

Armed with this vision, Aman Health Care Services, in collaboration with Harvard University's South Asia Institute, organized and conducted a conference titled "Mental Health and Disaster Response". As well as Dr. Saadia Quraishy, the speakers included eminent Harvard professor Dr. Jennifer Leaning, Dr. Ruth Barron, Dr. Ayesha Mian from the Aga Khan University Hospital and Ms. Sharmeen Khan. The speakers, equipped with their own experiences in disaster mitigation, shared riveting accounts and frameworks for effective implementation of post disaster programs. The Speaker Series was followed by a Roundtable discussion along the theme of "Sustainable Rapid Response to Disasters in Pakistan", spread over two days. Key practitioners of mental health and disaster response were invited to share their views and generate actionable ideas for a practical and coordinated approach to disaster response. The underlying theme across the three day event was imparting ways and means for disaster pre-emption through prior training and resilience building among communities.

Mental Health First Aid Pakistan is poised to grow and make a lasting impact in the realm of mental health awareness and advocacy, through its active collaborations with other stakeholders and by fostering a culture of sensitivity to mental health issues and through the provision of effective strategies to tackle mental health issues and crises.

To date, MHFA Pakistan has conducted 27 standard sessions, accrediting 500 people through 12 trainers.

2. Lessons Learnt in the USA

Linda Rosenberg, President and CEO at National Council for Behavioral Health

Key Messages:

- One in five American adults experiences a mental illness each year. It is highly likely that any given individual will interact with someone experiencing a mental health concern
- Mental Health First Aid was included in the President’s plan to reduce gun violence and increase access to mental health services.
- Mental health first aid gives you the skills you need to identify — and ultimately help — someone in need.

Why Should Americans Care About Mental Health?

- One in five American adults experiences a mental illness each year. It is highly likely that any given individual will interact with someone experiencing a mental health concern (including depression, anxiety, psychosis, and substance use).
- 75% of mental illnesses appear by the age of 24, yet less than half of children with diagnosable mental illness receive treatment.
- Employers face an estimated \$80 billion to \$100 billion in indirect costs annually due to mental illness and substance use – including lost productivity and absenteeism.

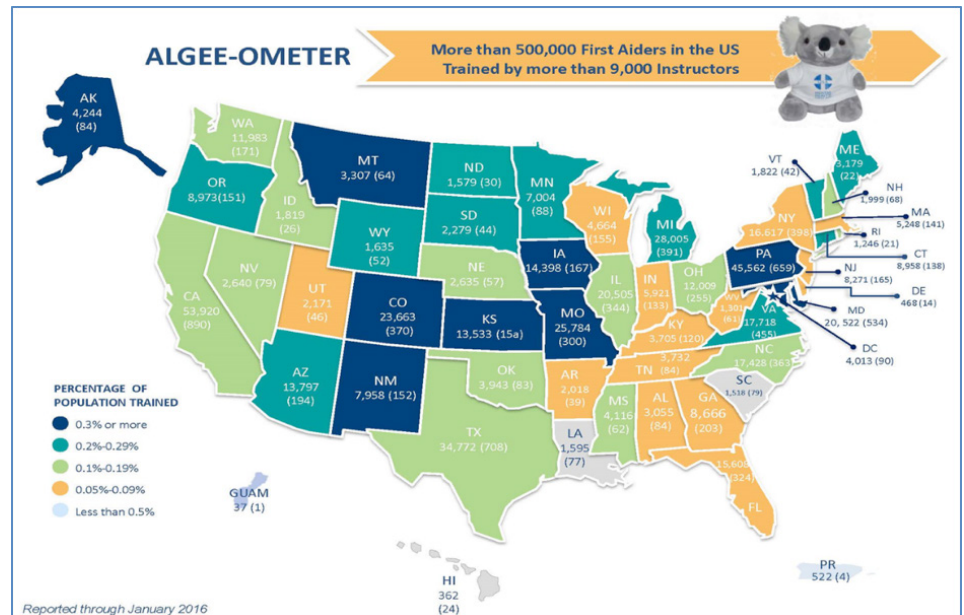
What is Mental Health First Aid?

Mental Health First Aid is an 8-hour course which teaches people how to help someone who is developing a mental health or substance use problem or experiencing a mental health crisis. The training helps employees from all levels to identify, understand, and respond to signs of addictions and mental illnesses. Like Cardio Pulmonary Resuscitation, Mental Health First Aid prepares people to interact with a person in crisis and to connect the person with help. Mental Health First Aid participants receive a list of community health care providers, national resources, support groups, and online tools for mental health and addictions treatment and support. All participants receive a program manual to complement the course material.

Who should take Mental Health First Aid?

- Police Officers/Public Safety
- Veterans & Military
- Teachers & School Staff
- Medical Personnel
- First Responders
- Faith Communities
- Parents and Friends
- Neighbors and Colleagues

Who are we reaching?



How has the program evolved?

Since its inception in 2008, Mental Health First Aid has grown to:

- 541,675 first aiders (from 1,305 in 2008!)
- 8,961 instructors
- 400 people trained a day
- 2 programs: Adult and Youth
- 2 languages: English and Spanish
- 5 modules: Veterans, Public Safety, Higher Education, Rural and Older Adults

What Federal Support is there for Mental Health First Aid?

Mental Health First Aid was included in the President's plan to reduce gun violence and increase access to mental health services. In 2014, Congress appropriated \$15 million to the Substance Abuse and Mental Health Services Administration (SAMHSA) to train teachers and school personnel in Youth Mental Health First Aid; in 2015 an additional \$15 million was appropriated to support other community organizations serving youth. The Mental Health First Aid Act of 2015 (S. 711/H.R. 1877) has broad bi-partisan support and would authorize \$20 million annually for training the American public. Fifteen states have made Mental Health First Aid a priority by appropriating state funds, including Texas that has allocated \$5 million.

What are people saying about Mental Health First Aid?

"It really gives you the skills you need to identify — and ultimately help — someone in need."

- First Lady Michelle Obama, on being trained in Mental Health First Aid.

"In July 2015, I had the opportunity to take a Mental Health First Aid course at WestCare Nevada. Little did I know that just a few days later I would be using the information and techniques I had learned in the class in a real life situation."

- Rick Denton, Certified First Aider

How do I find a course?

To find a course or contact an instructor in your area of the United States of America, visit www.MentalHealthFirstAid.org.

Mental Health First Aid USA is coordinated by the National Council for Behavioral Health, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.

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3. A Story of Growth and Lessons Learnt in England

Poppy Jaman (CEO MHFA England) & Eleanor Miller (MHFA England)

Key Messages:

- Since its inception, MHFA training in England has undergone substantial development, with new products launching to meet the demands of the market and existing products being developed to ensure they are up to date and relevant to the intended audiences
- MHFA England has also paid attention to making its products accessible to those who may have a disability such as sight or hearing impairment and is currently working with a leading learning disability charity
- It has also been very beneficial to our Armed Forces

Growth of a Business

In 2006, Mental Health First Aid training came to England, delivered and funded through the Department of Health. Based on the success of this programme and the clear demand for increased delivery of mental health training, in 2009 an application was made to Companies House to form a Community Interest Company, with a core mission to deliver MHFA training within England. Since then, MHFA England has gone from strength to

strength, both financially (Figure 1) but also in terms of meeting its core objective of increasing mental health literacy. In March 2016 MHFA England was entered into the Fortuna 50 list and was ranked ninth in a list of small women led businesses, based on its growth over the past seven years. This ranking was based on information provided by Companies House and is created in consultation with the United Kingdom Prime Minister's office.

Figure 1. Growth of MHFA England



MHFA England now employs 15 people in its central office in London, has a national training team of 18, has recruited over 50 instructors onto its team of workplace and youth associates and oversees the quality assurance and training of more than 1,000 instructors across the regions. The net result of this business growth is that by the end of 2015, around 114,800 people in England have been trained in MHFA skills, across a range of products and sectors (Figure 2).

The continued challenge for the business is developing the infrastructure and people resource to meet an increasing demand for mental health awareness training and maintaining the stringent quality assurance process that is synonymous with MHFA England training products and delivery. The current strategy for growth is based on a regional scale-up plan and further strengthening of the quality assurance process.

Product development

Since its inception, MHFA training in England has undergone substantial development, with new products launching to meet the demands of the market and existing products being developed to ensure they are up to date and relevant to the intended audiences. In line with its social objectives, MHFA England has also paid attention to making its products accessible to those who may have a disability such as sight or hearing impairment and is currently

working with a leading learning disability charity to develop an adapted training course for use within this disadvantaged community. As an overall point, 100% of MHFA England's profits are reinvested into enabling the company to meet its social objective — to increase mental health literacy within the English population — and this includes continuous product development and expansion into different market sectors.

General population

The first product to launch in England in 2006 was the Standard MHFA training course which takes place over two days, is aimed at the adult population and covers four key modules:

- The meaning of mental health;
- Suicide and depression;
- Anxiety, eating disorders, and self-harm; and
- Psychosis.

At the end of the course participants are given a certificate to demonstrate that they have undertaken the training required to become a Mental Health First Aider. The seven-day instructor training programme, which is undertaken by individuals who then go on to deliver the two-day course, is accredited by the Royal Society for Public Health (RSPH).

In 2011, MHFA England launched a three-hour awareness raising course called MHFA Lite, which is suitable for those who might

not have the time or budget to complete the full two-day course or who require an introductory session before deciding to commit to a longer training option. MHFA Lite is not designed to teach people to be Mental Health First Aiders, but is a useful product in terms of raising mental health awareness within the general population.

Young People

With an increased national focus on children's mental health and based on the success of the two-day standard product, in 2010 it was decided that MHFA England would launch the two-day Youth product — an MHFA course which is tailored to those who are working, living or interacting with young people. This was met with interest from the education sector and since then the product has undergone a complete revision and was relaunched in October 2014. In addition to the two-day course, and to meet the needs of the busy school timetable, a one-day Youth MHFA course and three-hour Youth Lite course have also been added to this product portfolio. This continues to be an important focus area for MHFA England and one which ties in with the national agenda for improving children's mental health through education and mental health services. The company is currently recruiting MHFA instructors to join the associate team or to upskill to be able to deliver the youth products and join the associate team.

Figure 2. MHFA England Key Achievements



Armed Forces Community

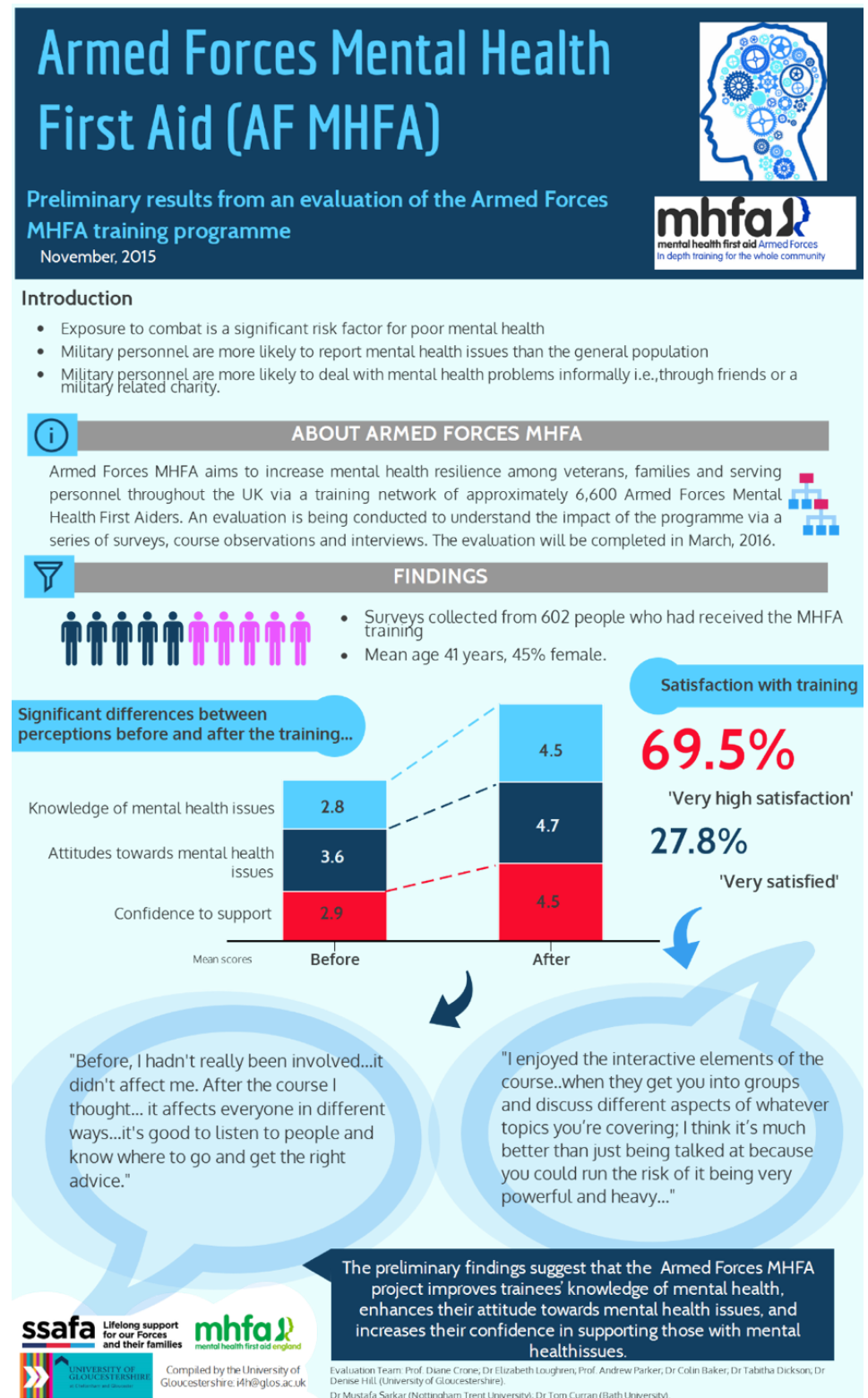
The Armed Forces community, both serving and ex-serving, is a sector of society which has been recognised as having specific mental health issues and, therefore, requirements. Based on the identified need for greater mental health literacy within this community, the government allocated a budget of £600,000 to develop a MHFA training product tailored to this audience. MHFA England, in-conjunction with three of the UK's leading mental health charities, piloted and then went on to launch a two-day Armed Forces MHFA training product which went live in October 2013. Since that time, 6,600 members of this community have been trained as Armed Forces Mental Health First Aiders. Evaluation of the programme is currently being conducted by the University of Gloucestershire, with preliminary findings showing the training to be highly effective at increasing mental health literacy within the Armed Forces community (Figure 3).

Workplace

Since its inception in England, the Standard MHFA course and the subsequent MHFA Lite have been delivered into both public and private sector workplaces across the country by individual MHFA instructors. However, with a growing demand from the corporate and public sector for large-scale role-out of mental health awareness training, MHFA England developed its business offering to suit this audience. Since 2014, MHFA England has run a very successful workplace team, the purpose of which is to facilitate the delivery of a range of training products, including the standard two-day MHFA, a one-day MHFA, a half-day MHFA course and MHFA Lite. The result of this approach is that MHFA England is now working with some of England's biggest employers including the British Broadcasting Corporation (BBC), Unilever, Ernst Young (EY), Lendlease, the Royal Mail and NHS England.

With workplace continuing to be a strong focus area for the business, the challenge for MHFA England is the recruitment of experienced and skilled instructors to join the MHFA Associate team and for these Associates to be located in areas which meet the demand from the corporate and public sector.

Figure 3. MHFA in the Armed Forces



Higher Education

MHFA England has been successfully training staff and students within a Higher Education setting for some time now using the standard two-day training course. However, there has been demand from this sector for a one-day course which is tailored to help address some of the issues which arise in the transition years between childhood and adulthood. As such, MHFA England has worked closely with the Higher Education Network and charity Student Minds, to develop a one-day product which is currently being piloted in several universities. The product is due to be launched at the end of 2016.

Recognising Best Practice

In 2012 MHFA England held its first ever national awards ceremony at the House of Lords. This awards event was designed to recognise and celebrate the work of some 1,000 MHFA instructors delivering training and helping MHFA England to meet its social objective of increasing mental health literacy within the community. Since then, the company has held an annual awards event and 161 awards have been given out to individuals and organisations who have demonstrated examples of best practice around mental health training.

As an organisation, MHFA England has also won a number of awards including; the Kaleidoscope Plus Health and Wellbeing Business of the Year Award, Living Wage Employer, the Greater London Authority Healthy Workplace commitment award and being listed in the Fortuna 50. These awards demonstrate MHFA England's continued commitment to being an employer and training provider of choice and an organisation which values its staff.

Influencing the National Agenda

Over the past few years, MHFA England has significantly raised its profile in the national media, built networks within government, education and business and positioned itself as the leading provider of mental health awareness training. All of this work has allowed MHFA England to contribute to the national debate around mental health and has resulted in some key government recommendations and adoption of best practice by employers.

The organisation's ability to proactively communicate and network at this level has been greatly enhanced by two new executive Board appointments in 2015; that of a Chief Operating Officer and a Marketing and Communications Director.

In February the CEO for MHFA England met with the UK Prime Minister and contributed to a round table discussion on how mental health is addressed in the workplace. On International Women's Day, 8th March 2016, the Finance Director for MHFA England attended a reception at the Prime Minister's Office and highlighted the merits of training school staff in Youth MHFA with the Secretary of State for Education. MHFA England also sits on the National Children's Bureau steering group for mental health in schools and continues to promote the need for evidence-based training for school staff of every level.

Some key outputs from this work include:

- Adopting MHFA training within the workplace is one of two key recommendations made within the 2016 Business in the Community report on workplace mental health (<http://wellbeing.bitc.org.uk/news-opinion/news/press-release-line-managers-key-improving-wellbeing-work>)
- The British Youth Council's Select Committee into Mental Health recommended that mental health training should be a mandatory part of initial teacher training and that the Department of Health should work with a group of young people to develop a trusted app that has NHS branding... including a mental health first aid kit and clear links to mental health services and link to other online resources. (http://byc.org.uk/media/279518/ysc_report_response_cleared.pdf)
- MHFA was recommended as a training provider by the Department of Health (<https://www.gov.uk/government/publications/national-framework-to-improve-mental-health-and-wellbeing>) and by Public Health England (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/410356/Public_Mental_Health_Leadership_and_Workforce_Development_Framework.pdf)

- The government's advisor around young people's mental health has publicly announced her support for Youth MHFA to be introduced into schools and the benefits of doing so (<https://www.tes.com/news/school-news/breaking-views/explosion-anxiety-depression-self-harm-and-eating-disorders-among>)

Lessons Learnt

The transition of MHFA England from a small start up to a sustainable social enterprise has not been without its challenges, and of course as with any growing organisation, there are lessons learnt along the way. However, through strong leadership, a committed central team and a passionate and dedicated community of instructors, MHFA England has gone from strength to strength and continues to make an impact on its core aim of increasing the mental health literacy of the general population. The key learnings from MHFA England include:

- **Articulate the organisation's vision** and remember to stay focused on achieving those aims.
- **Retain the ability to flex capacity to meet the demand for business** because there will always be peaks and troughs along the way.
- **Ensure the Quality Assurance process is robust** because the uptake of training is driven by reputation and compromised quality is a risk factor for the business.
- **Organisations that are commissioning mental health training are usually looking for impact through evaluation.** It is therefore important to capture the data from every course delivered and be ready and able to report that data.
- **When MHFA became part of the public health strategy, with government making clear recommendations for its use, the training became even more relevant.** This endorsement has positioned MHFA training as a worthy component of a preventative approach to mental health.
- Having the opportunity to work directly with employers in the public and private sector has **enabled MHFA England to understand what the workplace needs and then tailor its products to fit.**

ENHANCING PSYCHOLOGICAL AND MENTAL HEALTH FIRST AID

1. *Activating Social Networks*

Shona Sturgeon B. SocSc (SW), Adv. Dip. PSW, MSocSc (ClinSW)
Vice President, South African Federation for Mental Health
Past President, World Federation for Mental Health
World Federation for Mental Health Vice President for Africa

Key Messages:

- Psychological and mental health first aid should be available to all in Africa
- You can set up your own group to promote it
- This WFMH initiative is welcome

Anne's Story

I am a 45 year old woman from Douglas, a small town in the Northern Cape Province of South Africa where unemployment, poverty and stigma and related discrimination towards persons with mental disorders is rife. I was diagnosed with major depression some years ago and I receive follow up treatment at my community clinic.

Recently I participated in an empowerment session hosted by the South African Mental Health Advocacy Movement (SAMHAM), a project of the South African Federation for Mental Health, where I learned about psychosocial and intellectual disabilities and human rights. This sparked a strong determination in me to improve the lives of persons with mental health problems in my community. I decided to take the initiative and started a support and advocacy group, involving mental health care users from the community clinic and their family members. In a short space of time the group has grown to almost 50 members. I have now started to get another group together in a different community.

The role I play in my community is to provide information related to mental disorders, treatment options and available services, and where required to assist individuals to access services. I send potential human rights violations to SAMHAM so that they can intervene or offer advice. The group I have established forms a support structure that adds great value to each of the group members, especially considering the limited services available in the community of Douglas where the psychiatrist visits only once a year and nursing staff are overwhelmed with a high patient load for general health care. Members of the community frequently approach me for support and advice and I have built good relationships with the clinic's nursing staff.

SAMHAM has also recruited me as a leader and supports me remotely with information and advice wherever I need it. My work allows me to bring comfort to the group members and mental health care users, and it has restored my self-worth and self-esteem.

2. Promoting Access to Primary Health Care

Amanda Howe OBE MD MEd FRCGP

President Elect, World Organization of Family Doctors; Professor of Primary Care, University of East Anglia, UK

Key Messages:

- Family doctors are essential to effective mental health care.
- They have opportunities in every consultation to promote mental wellbeing and reduce the trauma of life events and illnesses.
- A therapeutic doctor-patient relationship over time can enable patients to strengthen their own coping mechanisms and resilience in the face of adverse events.

Enhancing the role of psychological and mental health first aid – promoting access to primary health care

The mental health workload of family doctors is significant. As a practising family doctor with an interest in primary mental health, I see several patients in each clinic who are substantially destabilised psychologically. This is usually due to some acute life event (a serious symptom or illness, bereavement, job loss....) or to some exacerbation of a previous problem (relationship problems, financial hardship...), as well as the more 'conventional' diagnoses and treatments of conditions such as depression, psychosis, or addictions.

The core role of family doctors who work with a defined population over many stages of the life cycle can be summarised as:

- **Being open** to the possibilities of doing basic mental health prevention and promotion in every consultation
- **Being knowledgeable** about how to screen for mental health problems, and how to diagnose and treat the problems likely to present to us
- **Having a positive non- stigmatising attitude** to helping people to accept and work with psychological aspects of illness; and
- **Being a good role model** — caring about patients with mental health problems, not avoiding the difficult issues, and being clear that their issues need to be addressed.

As well as what we do as doctors, we also have to provide an effective service over time. Many factors that cause psychological problems are societal, and we have to work at the level of the 'system' as well as with individual patients. This focuses us on the need to:

- **Run a clinic with a whole team** that deals with these problems well
- **Help the community locally** to develop and support resources that will promote and sustain mental health – particularly for elders and the vulnerable, but also young people, mothers...
- **Advocate to government and health agencies** for the right kinds of services and support for mental health at the broadest level; and also
- **Secure the protection of our own mental health.**

To do this challenging work well, we need the following:

- **For good consultations** – the right training; adequate time with the patient to allow exploration of sensitive issues; safe confidential spaces; records access; and some 'down time' for absorbing the impact of individual cases upon us.
- **For a good clinic** – staff who share our motivations; who also have the right attitude, skills and training; safety routines; and who can liaise with relevant services promptly and effectively.

- **For backup** – adequate local referral services, especially for urgent and serious problems; also access to specialists for advice and debriefing – safeguarding of adults and children, advice on safe escalation of specialist medication, and relevant services may all be valuable when trying to decide what to do next with a patient.
- **For support for patients outside the practice** – community and voluntary groups, online advice on cognitive and self-management approaches, and peer support can all be really helpful.
- **Good evidence** – because research is just as important in mental health as other problems, and this needs to reflect primary care and population health perspectives as well as pharmacological and secondary care interventions.

So those are the ideal conditions – but not all patients can access such a service. The opportunity for patients with any kind of mental health problem to see a skilled and trusted clinician relies on a health service that allows people to attend and get suitable, evidence based- treatment, free at point of use with no significant barriers — a plea for universal health coverage which will not deter the poor and needy. And this needs effective advocacy and leadership – because mental health resources often are deemed less important than physical health, and need equity in provision.

However, even providing a really good primary care service which is accessible, acceptable, affordable and effective, will not be enough. While I am happy to see people with psychological issues, what I can achieve in the brief and valuable time we spend together will need to be built on before or after the clinic visit.

Friends, family, community members, schools and employers can all play a positive or negative role. There are particular additional skills and services needed to deal with local disasters and disruptions, such as the aftermath of the tsunami in 2004, or the needs of displaced people as we have seen so recently in the Middle East and Europe.

The theme of psychological and mental health ‘first aid’ perhaps brings together the work of family doctors and this broader challenge posed by the WFMH for WMHD 2016. Our aim in promoting strong primary health care with embedded family medicine is not to create dependency but to offer that effective ‘first aid’ which minimises suffering and reduces later morbidity. Without the type of skills and the availability of the first line of professional advice and support in any mental health trauma, patients are likely to suffer more and cope less well – but these skills can be broadened and used more by others as well.

Although the image of cardiopulmonary resuscitation and its dramatic physicality contrasts strongly with the quiet empathic listening and witness which helps distressed people to unburden and gain insight, the idea that we can train more people into these skills is attractive. Many people have some of these skills, but to show the whole population that they can both learn to help others and increase their own resilience is a goal worth aiming for. So primary care can act as a role model, a source of support, and perhaps also be a resource which enables others to learn how to ‘do it themselves’. A good aim for WMHD2016!

3. Access to Effective Medication

Michelle B. Riba, M.D., M.S., and John M. Oldham, M.D., M.S.

Key Messages:

- There are many potential factors that may impact on suboptimal rates of adherence to taking psychotropic medications including price, availability, side effects, stigma, education about the need for medication
- Models of care such as collaborative care management, seek to provide more wrap-around services, which include trying to improve availability and use of psychotherapy and pharmacotherapy
- Ways to provide acute psychiatric services, such as “first-aid” responses that would include psychopharmacology and stabilization, are increasingly needed

In the United States, about 20 percent or 1 in 5 Americans will suffer from a mental health condition.¹ Mental health conditions often start in childhood or adolescence and continue throughout the life span. In addition, there are many other psychiatric conditions that might occur as patients age, with heart disease, diabetes and cancer having associated mental health conditions.

The need, then, for appropriate and timely evaluation, diagnosis, treatment, and maintenance of psychotherapy and pharmacotherapy, is enormous. Even when patients are prescribed the appropriate medications, adherence may not be optimal due to a variety of factors including:

- Pricing of medication;
- Copayments of visits to clinicians;
- Stigma;
- Side effects;
- Lack of optimal education or communication about the medication and reasons for taking it, etc.

New models are needed to address some of these important access and care issues. One such model that is increasingly being viewed as successful is collaborative care management, which seeks to optimize psychotropic medications, psychotherapy and other supportive care.

Collaborative care management has been increasingly shown to be effective in caring for patients with mental health needs and chronic physical conditions across primary, specialty and behavioral health care settings.² These systems of care include patient self-management, provider decision support, linkage to community resources and clinical information systems. Other models of care include telemedicine systems, and even a new system by the pharmacy chain Walgreen’s which is putting more care providers in stores as well linking to companies to provide tele-health.

As these new models of care emerge and are shown to be effective, the focus increasingly needs to be on prevention – helping people who have had episodes of major as well as minor mental health problems recognize when their symptoms might be flaring, and when either psychotropic medications might be needed and /or psychotherapy such as cognitive behavioral therapy, supportive therapy, interpersonal therapy, etc. At the same time, people with new mental health symptoms might need to have a better way of discerning who might serve as first responders and could evaluate the problem in order to seek a diagnosis and treatment.

The need to determine the best pathways for such acute events and the need for a combination of psychotropic medication and/or psychotherapy is an important focus and some would call this the need for “first-responders”. Since mental health problems are so disabling and contribute to lost work and decreased functioning, it is important to determine prevention, treatment and maintenance models to help people throughout the life cycle. A major component of such strategies would be to provide resources for those who are on a psychotropic medication and are stable psychologically. There are more and more “apps” online where people can self-evaluate using rating scales for mood and anxiety, or wearable devices, such as Fit-Bits that might measure sleep.³ The goal might be to help people self- identify when they might need to increase their medications, see a therapist for psychotherapy, decrease stress, increase sleep, increase exercise, change diet, etc.

A specific example might be patients with cancer and depression. It is now recognized that screening for distress in patients with cancer should be done initially and at regular intervals using validated screening tools such as the National Comprehensive Cancer Center Distress Thermometer.⁴ Once patients are screened, they can be triaged for further evaluation where psychotherapy and pharmacotherapy can be provided and then reevaluated at regular intervals to make sure there is adherence and optimization of the medication, dose, etc. and minimization of side effects. Without such attention to the need for such an organized system of screening, many patients with moderate to significant distress would be missed.

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4. An Integrated Approach

Gabriel Ivbijaro, Lauren Taylor (UK), Lucja Kolkiewicz (UK), Tawfik Khoja (Saudi Arabia), Michael Kidd (Australia), Eliot Sorel (USA), Henk Parmentier (UK)

Key Messages:

- Psychological and mental health first aid is effective and part of mental health promotion
- Lack of availability is discriminatory and a parity issue
- Everybody knows somebody who has experienced mental health difficulties so in reality the number of people having contact with mental health difficulties is one in one, all of us need this skill

World Mental Health Day 2016, highlighting the importance of Psychological and Mental Health First Aid, provides an opportunity for everybody with an interest in mental health to come together and make the case for psychological and mental health first aid skills to be available worldwide.

Psychological and mental health first aid is a skill that we all need to make the world a better place. The current social and political change increasing the number of refugees and migrants fleeing natural and unnatural disasters increases the urgency to ensure that psychological and mental health first aid is a universal skill that we can all learn and use.

According to the 2016 World Bank Group and World Health Organisation (WHO) meeting in Washington USA 'Out of the Shadows: Making Mental Health a Global Development Priority,' despite the enormous social burden, mental disorders continue to be driven into the shadows by stigma, prejudice, fear of disclosing an affliction because a job may be lost, social standing ruined, or simply because health and social support services are not available or are out of reach for the afflicted and their families. Highlighting and teaching psychological and mental health first aid skills to all will make a significant contribution to pulling mental health out of the shadows.¹

Since the introduction of Basic Life Support (BLS) and Cardiopulmonary Resuscitation (CPR) without equipment in the 1960's many people have benefitted from the intervention of a passer-by, and lives have been saved. We need the same for mental health.

At least one in four adults will experience mental health difficulties at one time or the other but many will receive little or no help when they present in an emergency. In contrast the majority of people with physical health difficulties who present in an emergency in a public or hospital setting will be offered physical health first aid. When we think about all our social networks, everybody will know somebody who may have experienced mental health difficulties, so in reality the number of people having contact with mental health difficulties is one in one. So why is it that people do not get the help, or feel ashamed or hide?

There is evidence for the effectiveness of delivering psychological and mental health first aid in an integrated way at all levels of society from the home, schools, the transport network, the work environment, leisure facilities, primary care centres, mental health services and general hospitals. This can be supported by government, other institutions and groups and most importantly by you and I.

Many people like to go to their general practitioners (GPs) and primary care centres when they are in distress, so as a first contact provider primary care needs to do more, just as has been done to promote physical health first aid.

Evidence informing the integration of psychological and mental health first aid approaches into Primary Care

Psychological first aid is defined by the WHO as providing a humane and supportive response to someone who is suffering, for example after a violent event or a natural disaster.² Psychological first aid is currently "evidence-informed",

based on evidence that has led to consensus guidelines³, for example the *National Child Traumatic Stress Network and National Center for PTSD Psychological First Aid Field Operations Guide*, however it requires further evaluation to prove its effectiveness.

A pilot study suggests that psychological first aid is more effective than social support alone.⁴ Psychological first aid involves reassuring the person and supporting them to attend to their basic needs, but not necessarily recounting the event as in psychological debriefing.⁵ Psychological first aid is intended to prevent future occurrences of PTSD (Post Traumatic Stress Disorder) in those who have been victim of, or witness to, a distressing event and was developed following a Cochrane review which demonstrated that psychological debriefing is ineffective, or even worsens the risk of developing PTSD following such an event.⁵

Mental health first aid, in contrast, is designed to equip members of the public with the skills to help and support an individual going through a mental health crisis, for example suicidal behavior, until the crisis resolves or the person receives professional support.⁶

Mental health first aid programmes have been implemented in Australia and 22 other countries⁷, evaluated by meta-analysis⁶ and shown to increase knowledge around mental health, decrease negative attitudes towards people with mental health problems, and increase help-providing behavior. Further evidence is needed to demonstrate an effect on the mental health of the public in general.⁶

Both first aid approaches do not require mental health professionals.

The WHO guidance states that psychological first aid can be provided by people who are not necessarily mental health professionals- for example, volunteers with various disaster relief agencies.² Mental health first aid is designed to be taught to the general public, both to equip lay people to intervene but also to address mental health stigma.⁶

As early as 1976, Giel recognized the vast mental health needs in developing countries, but that in order to address this with limited resources, the majority of healthcare will need to be provided by different kinds of community health workers, who are not specialists but simply trained to deliver specific health interventions.⁸

The SUNDAR approach, piloted in India, is an example of using lay people to deliver psychosocial interventions for mental health conditions, which has been evaluated by peer review⁹, although not yet for psychological first aid.

Given that primary care healthcare workers are often the first healthcare workers to be in contact with a patient, an understanding of how these approaches can be integrated with primary care services is necessary.

Examples of integration

The Inter-Agency Standing Committee (IASC) recognizes that General Practice “is often the first point of contact” for those with mental health problems following an emergency¹⁰ and a review into use of mental health services amongst survivors of disasters found that larger proportions of those reporting mental health symptoms sought help from their primary care physician as opposed to mental health services¹¹ and Psychological First Aid can be applied by professionals, using them to talk to survivors about sources of social support, and encouraging self-efficacy.¹¹

This advice is already being implemented; Cox and Rishoi stated in 2008 that the American Medical Reserves Corps recommends its volunteers are trained in Psychological First Aid.¹³ The emergency mental health services set up in Haiti following the earthquake included

community mental health clinics with a Haitian general practitioner trained in managing patients with psychiatric conditions, running once-weekly mental health clinics in conjunction with psychosocial workers who provided community outreach following the 2007 IASC guidelines on *Mental Health and Psychosocial Support in Emergency Settings*.¹³

Mental Health First Aid has been shown to be effective at reducing stigma and improving knowledge to recognise mental health problems in both healthcare providers and non-health care providers, in line with what was expected from Primary Care Doctors, and training has been recommended for use in both multicultural societies and mainstream US in order to raise awareness.^{14,15}

Suggestions for the role of primary care in emergency situations

In 2009 Sakuye et al focused on disaster preparedness for older adults and recommended that primary care providers should be appointed to disaster planning committees, that access to primary care services should be ensured by disaster agencies, and that primary care providers should screen elderly adults for disaster preparedness.¹⁶ Similar suggestions have been made for improving mental health care in Australian youth including reshaping General Practice to have a greater focus on Mental Health.¹⁷

Following an event, primary care providers can outreach to the most vulnerable patients¹⁶ and in *The Community Psychiatrist of the Future* (2006), Alan Rosen suggests that instead of GPs contacting psychiatrists directly, a shift could be made toward primary care doctors interacting directly with a multidisciplinary psychiatric team.¹⁸

Approaches to improve mental health awareness in refugees propose an action plan that includes four main stages described by Nazzal et al:¹⁹

- 1) Advocacy and securing funding,
- 2) Identifying key community partners,
- 3) Developing and implementing a plan for prevention and early intervention, and
- 4) Programme evaluation.

They implemented culturally-appropriate interventions that could cross language barriers, for example dance shows with the aims of decreasing mental health stigma and improving refugees’ uptake of mental health services. Pre- and post-intervention questionnaires demonstrated that negative mental health attitudes were reduced.

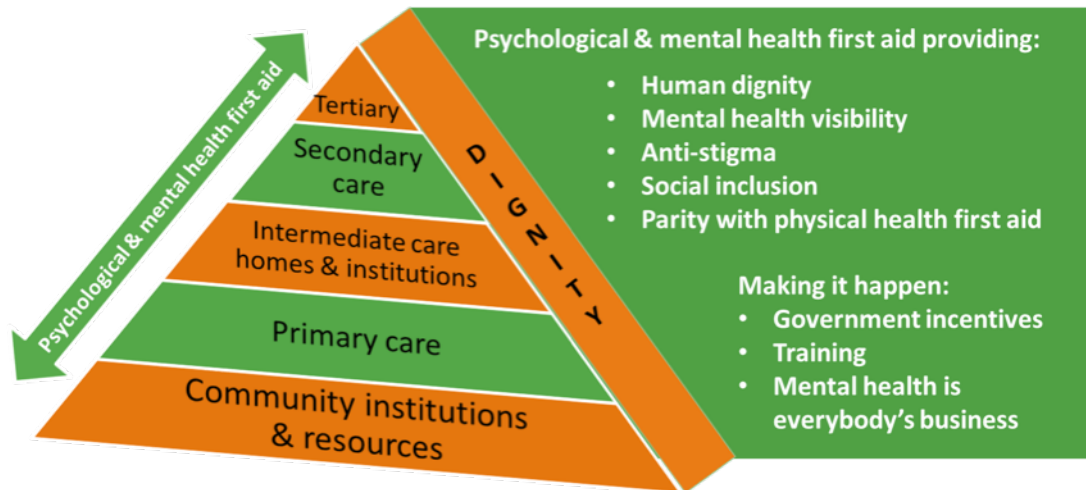
On a theoretical note, discussing preparedness for a theoretical nuclear detonation in America, Dodgen et al²⁰ highlighted the importance of Psychological First Aid in the immediate days following a disaster, and that primary care physicians will need to be vigilant for presentations, such as unexplained physical symptoms or complicated bereavement, that can occur as a result of exposure to a traumatic event.

An attempt to integrate mental health care and primary care in India described a plan for integration, how the attempt succeeded, and the challenges faced including that unexplained medical symptoms required a specific focus and general medical staff required encouragement to input into mental health clinics.²¹

Primary care cannot do this alone. We need an integrated approach into all aspects of our lives so that wherever we are we can get the help we need; at home, in the workplace, in our schools and educational institutions, on our transport systems, in our streets and public places, in wars, conflicts and disaster situations so that we can bring human dignity to every situation across all our social and health contacts.

We know that training in psychological and mental health first aid is already being provided by some governments, NGOs, other institutions and individuals but this is not enough. If you have a heart attack in a public place there is likely to be a member of the general public that will know what to do – this is not the case for mental health. If you require physical first aid in any primary care setting in the world somebody will know what to do because there will be a protocol to assist them — this cannot be said for mental health. It is time to act.

Integrating psychological & mental health first aid into our daily lives



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SECTION IV: CALL TO ACTION

CALL TO ACTION: DIGNITY IN MENTAL HEALTH – PSYCHOLOGICAL AND MENTAL HEALTH FIRST AID FOR ALL

The President and Executive Committee of World Foundation for Mental Health (WFMH), WFMH Regional Vice Presidents, the 2016 WFMH World Mental Health Day Working Group and the World Dignity Project call on the world to join us in making psychological and mental health first aid available to all as a global priority.

Many people who experience psychological and emotional distress, personal crises and mental health issues can benefit from receiving psychological and mental health first aid from professionals and the general public.

At least one in four adults will experience mental health difficulties at some time and there is nobody who has not had direct contact with somebody experiencing psychological or mental health difficulties.

Stigma, discrimination and lack of awareness often prevent people from accessing the support they need.

This is an issue of equity and parity

Many people receive little or no help in a psychological or mental health emergency. In contrast the majority of people with physical health difficulties who present in an emergency in a public or hospital setting will be offered physical first aid. If we are to treat mental health and physical health equally we need to address this. This is an issue of equity, parity and discrimination and should not be allowed to continue.

Psychological and mental health first aid works

Psychological and emotional distress can happen to anyone anywhere — in our homes, in our schools, in the workplace, on the transport system, in the supermarket, in public spaces, in the military and in hospital.

Every 40 seconds somebody somewhere in the world dies by suicide, and the young are disproportionately affected. Psychological and mental health first aid is a potentially life-saving skill that we all need to have.

What needs to happen:

- We call on governments to make psychological and mental health first aid a priority to bring it in line with physical first aid
- We all need to learn to provide basic psychological and mental health first aid so that we can provide support to distressed individuals in the same way we do in a physical health crisis
- We should all address the stigma associated with mental ill-health so that dignity is promoted and respected and more people are empowered to take action to promote mental wellbeing

- We should do our bit to spread understanding of the equal importance of mental and physical health and the need for their integration in care and treatment
- The media should educate the general public on the need for psychological and mental health first aid and the importance of fighting mental health stigma and discrimination
- We call on all employers to provide psychological and mental health first aid to their employees just as they do for physical first aid
- We call on all schools and educational institutions to make psychological and mental health first aid available to their staff and students

The World Dignity Project calls on everybody who has been touched by mental illness to start doing their part to raise mental health visibility in the three months before World Mental Health Day (www.worlddignityproject.com).

MHFA England calls on all citizens to join its "thunderclap" on 10th October 2016 to show your solidarity for mental health awareness (www.mhfaengland.org).

Please support WFMH to make psychological and mental health first aid a skill for all citizens so we can make the world a better place. We hope you will consider making a donation, large or small, to help with the costs of the campaign.

Donate at www.wfmh.org we will recognise your contribution on our website with your consent.

\$5 US

\$10 US

**\$ Other
(please state)**

Symptoms are not a barrier to recovery – attitude is.

Gabriel Ivbijaro MBE WFMH President, Chair World Dignity Project

Ingrid Daniels WFMH President Elect

Deborah Wan WFMH Immediate Past President

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Unaiza Niaz WFMH Regional Vice President Eastern Mediterranean

Filipa Palha WFMH Regional Vice President Europe

Hugo Cohen WFMH Regional Vice President Latin America

Abd Malak WFMH Regional Vice President Oceania

Henk Parmentier WFMH & World Dignity Project Ambassador

Claire Brooks World Dignity Project Ambassador

Lucja Kolkiewicz World Dignity Project Ambassador

Anthony Stern World Dignity Project Ambassador

Jean-Luc Roelandt World Dignity Project Ambassador

Pierre Thomas World Dignity Project Ambassador

Claude Ethuin World Dignity Project Ambassador

Renaud Jadri World Dignity Project Ambassador

Lisa Weston World Dignity Project Ambassador

Betty Kitchener MHFA International & Presidential Adviser

Poppy Jaman MHFA England & Presidential Adviser

General Media Release for World Mental Health Day 2016

FOR IMMEDIATE RELEASE

For more information, contact: Deborah Maguire, dmaguire@wfmh.com

The World Federation for Mental Health (WFMH) announces the theme for World Mental Health Day 2016:

Dignity in Mental Health — Psychological & Mental Health First Aid for All

Mental health crises and distress are viewed differently because of ignorance, poor knowledge, stigma and discrimination. This cannot continue to be allowed to happen, especially as we know that there can be no health without mental health.

Psychological and mental health first aid should be available to all, and not just a few. This is the reason why the World Federation for Mental Health (WFMH) has chosen psychological and mental health first aid as its theme for World Mental Health Day 2016.

Since the introduction of Basic Life Support (BLS) and Cardiopulmonary Resuscitation (CPR) without equipment in the 1960's many people have benefitted from the intervention of a passer-by, and lives have been saved.

Our aim is that every member of the general public can:

- Learn how to provide basic psychological and mental health first aid so that they can provide support to distressed individuals in the same way as they do in physical health crises
- Address the stigma associated with mental ill-health so that dignity is promoted and respected
- Empower people to take action to promote mental health
- Spread understanding of the equal importance of mental and physical health and their integration in care and treatment
- Work with individuals and institutions to develop best practice in psychological and mental health first aid
- Provide culturally sensitive learning materials to increase the skills of the general public in administering psychological and mental health first aid.

Please support WFMH to make this a global reality so that we can make the world a better place.

2016 World Mental Health Day Resolution/Proclamation

WHEREAS the World Federation for Mental Health has designated “DIGNITY IN MENTAL HEALTH –PSYCHOLOGICAL & MENTAL HEALTH FIRST AID” as the primary focus of World Mental Health Day 2016; and

WHEREAS psychological and mental health difficulties affect everybody, either directly or indirectly, and

WHEREAS there are many people who receive little or no help when they present in a psychological or mental health emergency, in contrast with the majority of people with physical health difficulties who present in an emergency in a public or hospital setting, and are offered physical health first aid,

NOW, THEREFORE, BE IT RESOLVED that I, _____, encourage all citizens of _____ to join in year-round efforts to:

- Call on governments to make psychological and mental health first aid a priority
- Learn to provide basic psychological and mental health first aid so that we can provide support to distressed individuals in the same way we do in a physical health crisis
- Address the stigma associated with mental ill-health so that dignity is promoted and respected and more people are empowered to take action to promote mental health
- Do our bit to spread understanding of the equal importance of mental and physical health and the need for their integration in care and treatment
- Call on the media to educate the general public on the need for psychological and mental health first aid and the importance of fighting mental health stigma and discrimination
- Call on all employers to provide psychological and mental health first aid to their employees just as they do for physical health first aid
- Call on all schools and educational institutions to make psychological and mental health first aid available to their staff and students

I urge all my fellow citizens to take part in the activities designed for the observance of World Mental Health Day, October 10, 2016.

Signature: _____

Date: _____

World Mental Health Day 2016 Proclamation

DIGNITY IN MENTAL HEALTH – PSYCHOLOGICAL AND MENTAL HEALTH FIRST AID FOR ALL

[SEAL]

WORD OF THANKS

Each year as we begin production of the material, we find ourselves working with amazing professionals who are willing and able to contribute to the campaign — therefore we would like to extend a very genuine thank you to all of the writers involved in producing this year's educational material. We are very grateful to the Honourable Minister Dr P. D. Parirenyatwa at the Ministry of Health and Child Care in Zimbabwe and all the Ambassadors who have agreed to ensure that this year's material is promoted in the countries that they represent. We are also grateful for Shekhar Saxena and his team at the World Health Organization for their contribution; to Betty Kitchener, a global leader in Mental Health First Aid; Poppy Jaman from MHFA England for her contribution and co-ordination; Alistair Campbell for his encouragement and contribution to the educational material; and all the service user and carer organisations who are at the forefront of fighting stigma and making mental health interventions accessible and fighting for dignity and parity in mental health.

We are also grateful to those WFMH staff and volunteers who have contributed so much to ensuring the success of this year's project, particularly Ellen R. Mercer, Elena Berger, Debbie Maguire, Nancy E. Wallace and Myrna Lachenal, and to Claire Brooks for her continuing support for the World Dignity Project.

In addition, the following volunteer UN representatives engaged in advocacy during the year: Bette Levy, Janice Wood Wetzel, Julian Eaton, Ann Lindsay, Kelly S. O'Donnell, Robert van Voren, Yoram Cohen, Poppy S. Jaman, Fionula M Bonnar, and Caroline Morton.

Along with the writers, we would like to acknowledge the professional formatting and design provided by Kyle Reid for this year's educational material and Eric Drabbe for his support with the website promotion and design.

Due to a generous in-kind donation the World Mental Health Day material has been translated into Arabic, thanks to Professor Tawfik Khoja, Saudi Arabia. We hope to have more translations available before October.

We are very grateful to an anonymous donor's foundation in New York that has given generously to WFMH for many years. Your generosity supports the WFMH administration staff and mental health advocacy. We are very grateful for this and salute you.

We would also like to thank Lundbeck for providing an unrestricted grant to support this year's World Mental Health Day campaign. We also wish to thank the following gold, silver and bronze donors who have donated towards the production of this year's material: Larry Cimino, L. Patt Franciosi, Gabriel Ivbijaro and Lucja Kolkiewicz. If you wish to contribute as a gold, silver or bronze donor please let Debbie Maguire know and you will be recognised at this year's Regional WFMH Congress in Cairns, Australia, in October 2016.

SECTION V: SUPPORTING TOOLKITS

PSYCHOLOGICAL FIRST AID: POCKET GUIDE (WHO, 2011)

Psychological first aid: Pocket guide

WHAT IS PFA?

Psychological first aid (PFA) describes a humane, supportive response to a fellow human being who is suffering and who may need support.



Providing PFA responsibly means:

1. Respect safety, dignity and rights.
2. Adapt what you do to take account of the person's culture.
3. Be aware of other emergency response measures.
4. Look after yourself.

PREPARE

- › Learn about the crisis event.
- › Learn about available services and supports.
- › Learn about safety and security concerns.

PFA ACTION PRINCIPLES:

LOOK

- › Check for safety.
- › Check for people with obvious urgent basic needs.
- › Check for people with serious distress reactions.



LISTEN

- › Approach people who may need support.
- › Ask about people's needs and concerns.
- › Listen to people, and help them to feel calm.



LINK

- › Help people address basic needs and access services.
- › Help people cope with problems.
- › Give information.
- › Connect people with loved ones and social support.



ETHICS:

Ethical do's and don'ts are offered as guidance to avoid causing further harm to the person, to provide the best care possible and to act only in their best interest. Offer help in ways that are most appropriate and comfortable to the people you are supporting. Consider what this ethical guidance means in terms of your cultural context.

Do's ✓

- › Be honest and trustworthy.
- › Respect people's right to make their own decisions.
- › Be aware of and set aside your own biases and prejudices.
- › Make it clear to people that even if they refuse help now, they can still access help in the future.
- › Respect privacy and keep the person's story confidential, if this is appropriate.
- › Behave appropriately by considering the person's culture, age and gender.

DON'TS X

- › Don't exploit your relationship as a helper.
- › Don't ask the person for any money or favour for helping them.
- › Don't make false promises or give false information.
- › Don't exaggerate your skills.
- › Don't force help on people, and don't be intrusive or pushy.
- › Don't pressure people to tell you their story.
- › Don't share the person's story with others.
- › Don't judge the person for their actions or feelings.

PEOPLE WHO NEED MORE THAN PFA ALONE:

Some people will need much more than PFA alone. Know your limits and ask for help from others who can provide medical or other assistance to save life.

PEOPLE WHO NEED MORE ADVANCED SUPPORT IMMEDIATELY:

- › People with serious, life-threatening injuries who need emergency medical care.
- › People who are so upset that they cannot care for themselves or their children.
- › People who may hurt themselves.
- › People who may hurt others.

MENTAL HEALTH FIRST AID IN GENERAL SETTINGS

What is mental health first aid?

Mental health first aid (MHFA) is the help offered to a person who is experiencing mental health problems. The person receiving first aid may be in the early stages of developing a mental health issue, have a chronic mental illness or be in the midst of a mental health crisis. In each of these instances, when someone gives mental health first aid they will be offering support, listening non-judgmentally and guiding a person to find appropriate professional help or other support sources.

Why everyone needs to have mental health first aid skills

Mental health problems are common, with one in four people worldwide experiencing mental health problems, but lack of knowledge and the associated stigma may prevent people from seeking appropriate help at an early stage.

Family, friends, neighbours and colleagues can assist by offering help to someone when they notice the signs and symptoms of a mental health problem. Where an issue is identified early on it is more likely that a mental health crisis may be avoided.

Mental health first aid skills can be learned by anyone and should be considered as important as physical first aid because if someone sprains their ankle the chances are you will know what to do. If they have a panic attack, the chances are you won't. However, mental health first aid doesn't teach you to be a psychiatrist or counsellor. A mental health first aider's role is to support and guide a person to seek appropriate professional help.

What are mental health first aid skills?

Mental health first aid skills, just like physical first aid skills, are taught by qualified trainers who use a combination of presentations, practical examples and action learning exercises to educate participants how to engage effectively with someone who is experiencing mental health problems. A skilled mental health first aider is able to have a confident and effective conversation about mental health, with a family member, friend or colleague and encourage them to seek the help they may need.

Extensive research has been carried out to develop international best-practice mental health first aid guidelines, which now cover a wide range of developing mental health problems. Across all the different guidelines, some key elements come out consistently. These have been summarized as a **Mental Health First Aid Action Plan**, with the acronym ALGEE. Below are the 5 actions in the plan:

- **Approach**, assess and assist with any crisis
- **Listen** non-judgmentally
- **Give support** and information
- **Encourage** appropriate **professional help**
- **Encourage other supports**

Copies of these guidelines are available for free download from the Mental Health First Aid International website (<https://mhfa.com.au/resources/mental-health-first-aid-guidelines>).

How do I know if someone is experiencing mental health problems?

- **Only a trained professional can diagnose someone with a mental illness** but those who have attended an MHFA course will be able to spot the signs and symptoms of a range of mental health problems, including anxiety, depression and psychosis.

- If you notice changes in a person's mood, their behaviour, energy, habits or personality, you should **consider a mental health issue as being a possible reason for these changes**.
- **Remain aware** that each individual is different and not everyone experiencing mental health problems will show the typical signs and symptoms but it's important to feel able to open up a conversation if you are concerned about someone's mental health.

How should I approach someone who I think might be experiencing mental health problems?

- **Give the person opportunities to talk**. It can be helpful to let the person choose when to open up. However, if they do not initiate conversation about how they are feeling it is important that you speak openly and honestly about your concerns
- Choose a suitable time to **talk in a space you both feel comfortable** where there will be no interruptions
- **Use 'I' statements** such as 'I have noticed....and feel concerned' rather than 'you' statements
- Let the person know **you are concerned** about them and **are willing to help**
- **Respect** how the person interprets their symptoms
- **If the person doesn't feel comfortable talking to you, encourage them to discuss how they are feeling with someone else.**

How can I be supportive?

- Treat the person with **respect and dignity**
- **Encourage the person to talk** to you
- **Actively listen**, in a non-judgemental way
- **Give the person hope** for recovery
- **Signpost the person to resources or support services** which are appropriate to their situation.

What doesn't help?

- Telling them to 'snap out of it' or 'get over it'
- Trivialising a person's experience by pressuring them to 'cheer up' or 'pull their socks up' etc.,
- Belittling or dismissing the person's feelings by saying things like 'You don't seem that bad to me.'
- Speaking in a patronizing tone of voice
- Trying to cure the person or come up with answers to their problems.

Should I encourage the person to seek professional help?

- **Ask the person if they think they need help** to manage how they are feeling
- If they feel they do need help, **discuss the options they have for seeking help** and encourage them to use those options
- Encouraging them to see their **General Practitioner** is a good place to start
- It is important to **become familiarised with services available locally** and online so you can signpost the person appropriately.

How to find out more about Mental Health First Aid

Mental Health First Aid courses are delivered in 24 countries around the world. Information and links to these MHFA Programs can be found here: <http://www.mhfainternational.org/>

WFMH and the World Dignity Project wishes to thank the WHO for providing the Psychological First Aid Pocket Guide and the members of the Mental Health First Aid Steering Group for developing and providing the factsheet on Mental Health First Aid in General Settings.

We are all capable of providing physical, psychological and mental health first aid in an emergency – don't be a bystander, be a first aider!



**WORLD
DIGNITY
PROJECT**



World Federation for Mental Health

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Designed by

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