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Introduction

Many European countries address mental health concerns and promote mental well-being through specialised programmes and practices which focus on, but are not limited to, community-based and more accessible mental health services. While these programmes and practices may benefit various stakeholders involved in mental healthcare, there is not currently a systematic method of disseminating quality, practical information about good practices in mental health for use by other stakeholders within Europe. The *EU Compass for Action on Mental Health and Well-being* addresses this gap through a variety of means, including this brochure.

The mission of the *EU Compass for Action on Mental Health and Well-being* is to collect, monitor, exchange, analyse, and disseminate information on policy and stakeholder activities in mental health in order to improve mental health and well-being in Europe. It is intended that these activities will offer insight and guidance to other stakeholders in mental healthcare to improve the health, the delivery of healthcare and well-being services, and general well-being of European residents.

Each year, a brochure with examples of good practices is published. The 2018 *EU Compass for Action on Mental Health and Well-being Good Practices Brochure* focuses on *community-based mental health services* and on *more accessible mental health services*. It contains programmatic information about European good practices in mental health and well-being which has been evaluated by experts. A brief summary of each practice, its addressed priority areas, the lessons learned, and recommendations to future adopters can be found within this brochure. As well, further information about each practice can be found on the practice's website. During the yearly Compass Forum on Mental Health and Well-being, representatives from Member States and other stakeholders discuss mental health and well-being priority topics, including Good Practices, lessons' learned from others, and consensus papers that reflect the latest scientific knowledge.

Methods

Data collection tool

An in-depth qualitative survey was developed to gather data about mental health and well-being programmes and practices in Europe. The survey was developed by the EU Good Practices team, including experts from the Trimbos Institute in the Netherlands, the NOVA University of Lisbon, the Finnish Association for Mental Health, EuroHealthNet, DG Sante, and Chafea. The tool was developed to be easily disseminated online, comprehensive, clear, and relevant to mental health and well-being stakeholders. The link to the survey was disseminated through email, through website links, through newsletters, and through presentations. Stakeholders were asked to complete this survey about their practices.

Evaluation criteria

In order to effectively analyse the data submitted by mental health and well-being practice stakeholders, the Good Practice team developed a rigorous evaluation tool and process. The evaluation tool used in this booklet was based on the common set of criteria approved by Member States under the Steering group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases; the EU Compass has developed a tool to collect and assess practices following these criteria and additional relevant criteria for good practices in mental health and wellbeing. The criteria included:

- Information
- Relevance
- Theory-based
- Intervention characteristics
- Participation
- Ethical aspects

- Effectiveness and efficacy
- Sustainability
- Intersectoral collaboration
- Transferability
- Equity

Data collection

Mental health and well-being stakeholders were invited to submit data on their practice until December 31, 2017. The survey contained detailed instructions for completing the survey, including the exclusion criteria. Practices were not eligible for review and inclusion in the Good Practices brochure if they had not been evaluated in some way. Practices were submitted from 10 EU Member States:

Austria, Belgium, Germany, Greece, Italy, Ireland, the Netherlands, United Kingdom, Spain, and Portugal. By December 31, 2017, 26 practices had been submitted. Of the 26 practices submitted, 21 included information on evaluation and were eligible for review by Good Practice evaluators.

Selection and training of evaluators

Submitted practices were evaluated by specialists from a variety of sectors, especially from community-based mental healthcare. Evaluators were selected from many countries: Bulgaria, Romania, Belgium, Finland, Croatia, the Netherlands, Luxembourg, and Portugal. Evaluators were trained one-on-one.

Evaluation

All practices that met the inclusion criteria (having been evaluated in some form) were reviewed thoroughly by two Good Practice evaluators. Good Practice evaluators were encouraged to discuss the practice if there were any questions and come to a final decision on whether or not the practice met the criteria for inclusion in the Good Practices brochure.

Limitations

While steps have been taken to ensure a fair, ethical, comprehensive, and transparent data collection, evaluation, and documentation process, there remain limitations. A selection is outlined below:

- While the instructions clearly highlighted the need for comprehensive information, many submissions did not provide enough information to be effectively evaluated. This may have resulted in some good practices being excluded due to incomplete information.
- The time investment in completing the survey may have been a burden for some practices. However, stakeholders were encouraged to review and use information from existing reports, websites, articles, and protocols.
- Data on the Good Practices presented in this brochure has been directly taken from the information submitted by the practices. Only a selection of the submitted information can be presented in this brochure due to space limitations.

For further information on methodological issues, please visit the website of the EU Compass for Action for Mental Health and Well-being: <u>https://ec.europa.eu/health/mental_health/eu_compass_en</u>



Community-based Mental Health Services

Practice 1. First European Art Festival for Mental Health (NEFELE FESTIVAL)

Location: Greece

Summary

The NEFELE FESTIVAL began October 2016; it was initiated by the health, social, and cultural sectors. The event is a European project and is part of the Creative Europe-Culture programme. The practice focuses on stigma related to mental health disorders.

The practice notes that the importance of the use of art in mental health rehabilitation procedures is scientifically documented and has an important role in therapeutic approaches. This movement has created professional specialisations in both mental health and the arts. It is therefore rational to connect art to mental health in the context of defending the rights of mental health patients. In addition, the role of artistic creation and employment for establishing/maintaining a good mental state shows that the dimension of prevention emerges as a decisive factor in the field of social welfare and health economics.

As stated by the practice, a festival is an excellent form of combining art and mental health. Organising a European festival had much to offer in the fields of reinforcing existing initiatives, encouraging development, transferring expertise and good practices to reduce costs, widening the war against stigma, and contributing to the development of powerful and united European policies for connecting the fields of art and mental health.

Selected objectives of the NEFELE FESTIVAL are:

- Fighting stigma;
- Connecting art and mental health through the establishment of festivals;
- The internationalisation and dissemination of works of professional artists and mentally ill people, as well as of the organisations involved;
- Increasing public awareness and accessibility of new groups; and
- Offering welfare and business opportunities to mentally ill people who have special talents.

Website: http://www.nefeleproject.eu/

Anti-stigma

Prevention of depression and promotion of resilience Provision of more accessible mental health services Provision of community-based mental health services Suicide prevention

Lessons learned

What worked well & facilitators to implementation

- Involving a wide variety of groups which could lend their strengths to the project. This helped to raise our profile.
- The public's interaction with the variety of events was extremely strong and it was evident that the arts are an appealing and appropriate vehicle to employ in order to create conversations around mental health.
- Sixty-three volunteers played a huge role in implementing this practice.

What did not work & barriers to implementation

- Funding Funds are needed for the team to lead the project, to produce events, and to promote events. The host organisation contributed 40% so it was a pretty big amount to cover for such a big event.
- Profile This was the first edition of the European festival. It required creating an entirely new brand and promoting it throughout Europe, which is difficult since funding is needed for the different tasks within the project.

Recommendations for future adopters of this practice

- Mapping potential groups to involve in events is recommended. This may open access to help, resources, and financial support which may have not been identified yet.
- Media plays an important role in communicating your message and promoting the event. Creating partnerships and developing a campaign plan is recommended.
- Join the NEFELE Network for support, advice, and tips. Talking to people who have been in your position already can be advantageous.
- Documenting your project is recommended; having a video and photos of your event and its impact could help secure future funding.

Level of implementation: *More than one European nation but not Europe-wide* **Responsible organisations:** *EDRA (ART4MORE)*

Practice 2. GET.ON - Online Health Trainings for Improving Mental Health

Location: Germany

Summary

The GET.ON Institute is an online mental health service provider that focuses on improving public mental health in the general population through the use of internet- and mobile-based psychological interventions for a variety of mental health problems as a means to prevent psychological disorders such as depression, anxiety, insomnia, alcohol misuse, and chronic pain. Furthermore, interventions that target important risk factors for depression are provided. The GET.ON Online Health Trainings have been developed and extensively evaluated in clinical trials within a large EU-funded Project at the Leuphana University in Lueneburg, Germany and have since been implemented by the GET.ON Institute.

Through the PROMIND project offered by the GET.ON Institute, immediate access to psychological help is provided to individuals with mild to moderate depressive symptoms or stress levels, individuals who have no local or timely access to psychotherapy or preventive services, or those who do not want to access such services for personal reasons such as fear of stigma.

GET.ON Stress is, to the best of our knowledge, the best-evaluated stress management training world-wide and the only one in Germany. The online training GET.ON Mood Enhancer is the first online training worldwide for which the prevention of depression has been confirmed in a randomised controlled trial. The cost-benefit analyses of GET.ON Stress and GET.ON Mood Enhancer indicated high net-savings on average per participant.

Selected objectives of GET.ON are:

- Overcoming existing barriers to mental health prevention and treatment.
- Increasing the utilisation of evidence-based psychological interventions; using a public mental health approach; and
- Improving the care situation of those affected with symptoms of stress or depression to strengthen the self-competence of the participants in dealing with mental health problems.

Website: https://geton-institut.de

Mental health in the workplace Prevention of depression and promotion of resilience Provision of more accessible mental health services Provision of community-based mental health services

Lessons learned

What worked well & facilitators to implementation

- Cooperating with health insurance companies worked well. As the majority
 of the German population is insured through statutory health insurance
 companies, this presents an excellent way of reaching people with lowthreshold interventions outside of the traditional prevention and treatment
 pathways that represent major barriers for many affected individuals.
- Giving presentations and informing the public and policymakers enhances the visibility of internet-based interventions were facilitators; this also facilitates the implementation and acceptance of the intervention.

What did not work & barriers to implementation

- General accounting models with health insurance companies are lacking. Therefore, different health insurance companies reimburse selected internet-based interventions.
- Due to the lack of quality standards of online interventions, it is difficult for stakeholders to discern between high-quality and untrustworthy offers.

Recommendations for future adopters of this practice

- Internet-based mental health trainings are an innovative way to help people with high levels of stress or mental health problems. However, there are significant differences in effectiveness between internet-based interventions. Consequently, effectiveness cannot be generally assumed and every internet-based intervention should be carefully evaluated.
- It is recommended to establish collaborations with stakeholders, such as health insurance companies, in early stages as the process to implement the interventions into practice can take up a considerable amount of time.

Level of implementation: More than one European nation but not Europe-wide Responsible organisations: BARMER and SLVFG insurance companies

Practice 3. Individual Placement and Support in Italy

Location: Italy

Summary

Since 2003, Individual Placement and Support (IPS) has been practiced in Rimini and about 300 users have benefited from it in this period. About 45% of users were working at any one time, replicating the average results of the large network established by Dartmouth Psychiatric Rehabilitation Centre which now collects data from 14 US States and from some programmes abroad.

In 2008 the Emilia-Romagna Region, on the evidence of the Rimini pilot site, put IPS in its policy and financed a programme to promote IPS. Currently thirty-two out of forty-one clinical mental health counsellors in the region have started offering IPS to their users. Seven hundred sixty-eight users received IPS and 468 of them reached competitive employment in 2016. About 50% of all clients were working at any point in time. Currently, the IPS regional team has been actively engaged in training for eight more regions (Lombardy, Veneto, Lazio, Friuli Venezia Giulia, Marche, Liguria Toscana, and Sicily) that recently started offering IPS in pilot centres. The same team is also trying to build up a European network of IPS centres.

Individual Placement and Support is highly committed to equity and empowerment of mental health services users. Their work is based on the eight principles of objective competitive work, integrated support for the treatment of mental illness, zero exclusion, attention to client preferences, information on economic opportunities, quick job search, systematic work of professional development, and unlimited time support.

Selected objectives of Individual Placement and Support in Italy are:

- Helping people with serious mental disorders to obtain and maintaining a work position in the competitive labour market, avoiding long trainings and sheltered environments;
- That users can obtain a job within three to six months of entering the programme; and
- Offering support in planning and implementing a satisfactory working life according to the users' personal aspirations, education, and goals.

Provision of community-based mental health services Mental health in the workplace

Lessons learned

What worked well & facilitators to implementation

- Implementation of this practice within Italian Community Mental Health Centres was easier than other psychosocial interventions (social skills training, psychoeducation). The practice has been welcomed and supported by users. Clinicians rapidly adapted to the innovative technique.
- Stakeholders support, commitment by regional and local administration, and financing of the start-up were facilitators.

Recommendations for future adopters of this practice

• It is important to plan enough time for advocacy and information activities.

Level of implementation: Regional / Provincial Responsible organisations: Emilia-Romagna Region; Dartmouth University (USA)

Practice 4. Multisystemic Therapy (MTS)

Location: The Netherlands

Summary

Multisystemic Therapy (MST) is an intensive family- and community-based treatment programme that focuses on addressing all environmental systems that impact chronic and violent juvenile offenders — their homes and families, schools and teachers, neighbourhoods and friends. Multisystemic Therapy recognises that each system plays a critical role in a youth's world and each system requires attention when effective change is needed to improve the quality of life for youth and their families. MST works with the toughest offenders ages 12 through 17 who have a very long history of arrests. MST clinicians go to where the child is and are on call 24 hours a day, seven days a week. They work intensively with parents and caregivers. The therapist works with the caregivers to keep the adolescent focused on school and gaining job skills.

Multisystemic Therapy is an evidence-based approach which has been proven to produce positive results in troubled youth. It blends the best clinical treatments— cognitive behavioural therapy, behaviour management training, family therapies, and community psychology— to reach this population.

After 30 years of research and 18 studies, MST has repeatedly been shown to achieve its objectives. These objectives are to:

- Keep kids in their home and reduce out-of-home placements;
- Keep kids in school;
- Keep kids out of trouble and reduce re-arrest rates;
- Improve family relations and functioning;
- Decrease adolescent psychiatric symptoms; and
- Decrease adolescent drug and alcohol use.

Website: www.mstservices.com

Provision of community-based mental health services Prevention of out of home placement of youth

Lessons learned

What worked well & facilitators to implementation

- The programme is really well described; plenty of materials and research are also available.
- The local organisation (MST Netherlands/Belgium) combined with the knowledge of the local system and contacts were facilitators.

Recommendations for future adopters of this practice

• Starting MST in your community/country if it is not yet available is recommended.

Level of implementation: More than one European nation Responsible organisations: MST-Netherlands/Belgium; Municipalities; Justice Department

Practice 5. Mental health care delivery system reform in Belgium

Location: Belgium

Summary

Until 2010, Belgian mental health care strongly remained a hospital-based system. Although the late eighties and nineties gave rise to new housing initiatives nationwide, such as sheltered living and psychiatric nursing homes, this was only a first step in a further evolution towards a community-based approach. A transformation of supply-driven residential mental healthcare towards a more differentiated demand-driven care was needed. The Joint Declaration of all ministers responsible for public health in 2002 on the future mental health policy stated that future acute and chronic care had to be organised through collaborating networks and circuits for three target groups (children and adolescents, adults and the elderly), bringing mental healthcare as close as possible to the needs and demands of people with mental health problems. In May 2010, public health authorities launched the 'Guide towards a better mental health care', thereby setting in motion the reform for adults. The Guide described a programme and an organisational network model. A network coordinator was financed for each pilot project to facilitate the creation of the intersectoral networks, which had to establish five predefined functions:

- prevention and promotion of mental health care, early detection, screening and diagnostic activities;
- ambulatory teams offering intensive treatment;
- rehabilitation team focusing on recovery and social inclusion;
- residential intensive treatment; and
- specific housing facilities for both acute and chronic mental health problems.

Belgian mental healthcare has undergone profound changes in an ongoing transformation process towards a community-based mental health care. Interorganisational networks and a recovery-oriented practice can be considered key aspects therein. The aim now is to broaden and deepen the reform over the next years for all regions and target groups. The professional sector, the authorities, the patient, and family federations have undertaken this journey side by side.

Website: www.psy107.be

Provision of community-based mental health services Provision of more accessible mental health services Mental health in the workplace Integrated approaches to governance / mental health in all policies

Lessons learned

What worked well & facilitators to implementation

- The local implementation, taking into account the opinion of the actors in the field (bottom-up approach coupled with top-down elements), worked well.
- The development of the model of care based on the concept of Network (a zone of action) on the basis of a global and integrated offer worked well.
- The network coordinator for the coherence of resources and the formalisation of procedures worked well.
- The involvement of users / relatives at all decision levels was a facilitator.
- The model was based on the community approach with a vision oriented towards recovery.
- Interest was shown by the WHO for the reform that our authorities wished to take into consideration by carrying out, in partnership, the manual of innovative practices.

What did not work & barriers to implementation

- The process of substantial change must be considered in the long term.
- Complementary financing from psychiatric hospitals (risk of an overcentralised role of psychiatric hospitals undermining the basic vision of the reform) did not work well.
- It was difficult for some actors in the field to integrate into a new work culture based on network practices and consultation with the user.

Recommendations for future adopters of this practice

- It is helpful to include all relevant authorities, all stakeholders, professionals, users, and relatives in a bottom-up movement.
- It is important to include users and relatives: "Nothing about us without us".
- Having a clear strategic plan is recommended.

Level of implementation: National

Responsible organisations: Federal Ministry of Public Health

Practice 6. Projecto CuiDando – Mobile Unit of Integrated Domiciliary Care in Mental Health

Location: Portugal

Summary

Portugal is restructuring their mental health services, shifting away from institutional treatments to community-based mental healthcare. A Mental Health Care National Network (RNCCI) is being implemented, currently in a pilot mode. This network addresses some of the recommendations of the European Union, World Health Organization, and the European Court of Human Rights, creating more effective and human services, both clinical and recovery wise, to replace traditional care. According to Portugal National Health Service, this network aims to provide a wider range of mental health community-based services, decentralising mental health services to allow better access for all people.

Domiciliary teams are one of the pilot services that are being created in this integrated network, although since February 2017, there are only 3 teams in the field. The lack of services, like domiciliary teams, is a reality replicated over several different countries in Europe. The Barcelos municipality has a strategic plan that also focuses on mental health and states that services must be created, including domiciliary teams team, to provide care to at least 20 patients. House Health St John of God - Barcelos also found, based on their experience with acute hospitalised users, that 47% of the population hospitalised weren't in this situation for the first time. Considering international recommendations and these findings, House Health St John of God - Barcelos decided to create a community-based service – Project CuiDando - with the objective of reducing hospitalisation days and by this contributing to the autonomy and quality of life of these users.

Project Cuidando is a mobile unit of integrated domiciliary care in mental health that ensures home mental healthcare services to people with mental illness who live in Barcelos Municipality (89 parishes). Project CuiDando has a multidisciplinary team and works in close collaboration with other institutions in the community. This Project has a total capacity of 30 users.

Website: http://isjd.pt/cssjd-barcelos/#apoiodomiciliário

Provision of more accessible mental health services Provision of community-based mental health services

Lessons learned

What worked well & facilitators to implementation

- The continuous referral flow of users to the programme, as well as the positive results, helped others to identify Projecto CuiDando as a source for this type of care.
- Being a free service for the client and providing home visitations project facilitated implementation.
- Synergy was created between the House Health St John of God Barcelos and the local social network.

What did not work & barriers to implementation

• Lack of funding for the continuity of services was a barrier.

Recommendations for future adopters of this practice

• It is useful to create synergies with several other institutions in the community that would be able to support users.

Level of implementation: Municipality Barcelos

Responsible organisations: Portuguese High Commissionaire for Health (ACS); City Council of Barcelos; St. John of God Foundation; the House Health St. John of God – Barcelos

Practice 7. Flexible Assertive Community Treatment (F-ACT)

Location: The Netherlands

Summary

A Dutch version of Assertive Community Treatment (ACT) is the Flexible Assertive Community Treatment (F-ACT). The multidisciplinary F-ACT team works in a defined catchment area for all people with severe mental illness and can operate in two different ways, namely:

- Individual case management by a member of the team, where other disciplines can be involved based upon the needs of the patient; and
- Intensive (ACT) team care, which involves the clients having contact with several team members; these clients are listed on the Community Treatment board and the team discusses them daily to decide which form of care should be provided and by which team members.

The flexible switching of care within a team between levels is the quintessence of F-ACT. For most clients, individual supervision suffices. However, if psychosis recurs (or threatens to recur), if hospitalisation is imminent, or if an individual needs extra care for other reasons, care is stepped up. This is a fluctuating group of 10–20% of the clients in the team's total caseload. For clients requiring more care, the team provides team care according to the ACT principle of 'shared caseload'. This means that all members of the team have been informed about the client and that he or she is monitored and counselled by several care workers in the team. As a result, the client can receive care every day or even several times a day.

To ensure good coordination of the care workers' activities, there are daily meetings to discuss clients who are listed on the Community Treatment board. If individual supervision is not enough, the client's name is listed on the board during the team's meeting. The clients on this board are discussed every day. This group consists of clients with psychotic disorders, usually combined with addiction problems (dual diagnosis). Many of them had been in hospital (sometimes for a long time) and were caught in the 'revolving door' between the hospital and the community.

Website: https://www.f-actnederland.nl/

Provision of community-based mental health services

Lessons learned

What worked well & facilitators to implementation

- The following features worked well:
 - The switching between two modes of care;
 - Integrating medical and social interventions;
 - Working in a well-defined catchment area;
 - Providing care to a larger group of patients with severe mental illness than conventional ACT Daily team meetings;
 - Multidisciplinary collaboration;
 - *Recovery-oriented care;*
 - Integrating community and hospital care; and
 - Making a comprehensive care plan.
- The interdisciplinary way of working, the collaboration with patients and stakeholders, applicability in scarcely populated rural areas, and adaptability to different contexts facilitated implementation.
- The model is attractive to mental health professionals.

What did not work & barriers to implementation

- The mental health services stakeholders from community mental health teams and the psychiatric hospitals belonged to different work and care cultures with different visions.
- In the financial structure of mental health services, there were financial incentives that support hospitalisation. Therefore, the transition of hospital based to community-based mental health care with F-ACT teams was a financial risk for the mental health services involved.

Recommendations for future adopters of this practice

- There is a need to address the 'why'. The F-ACT model has shown to be an effective model to support the recovery and meet the needs of persons with severe mental health problems which can be adapted to different contexts.
- It is important to build the community mental health teams together with patients and caregivers.

Level of implementation: National Responsible organisations: GGZ Noord-Holland-Noord



More Accessible Mental Health Services

Practice 8. Cognitive Behavioural Therapy for substance use disorder in individuals with mild intellectual disability (CBT+)

Location: The Netherlands

Summary

The programme is an 18-sessions Cognitive Behavioural Therapy programme for the treatment of substance use disorder in individuals with mild intellectual disabilities. The programme was developed as individuals with intellectual disabilities often do not benefit from mainstream programmes. The CBT+ programme is available to all Dutch substance use treatment facilities, as well as to other agencies offering treatment to individuals with intellectual disability and substance use disorder. The programme combines individual therapy sessions with a social system-based approach and aims. The CBT+ protocol involves the manual for therapists and a workbook for patients, as well as information sheets for caregivers.

The programme was developed in collaboration with substance use treatment services, intellectual disability services, and their clients. The first draft has been extensively piloted and tested in collaboration with all stakeholders, and has been re-written for the final protocol.

The CBT+ programme can be implemented by organisations within and outside addiction treatment services, as long as they can provide a multidisciplinary treatment programme. The CBT+ programme can be delivered by trained healthcare professionals. The manual provides detailed information on the content of each session and includes information how to communicate and collaborate with individuals with intellectual disability and substance disorder.

Selected objectives of *CBT+* are to reduce the burden of illness of substance use disorder in individuals with intellectual disabilities by:

- Reducing substance use taking behaviour and promoting healthier alternatives;
- Addressing risk factors underlying substance use taking behaviour; and
- Promoting social support and increasing self-control techniques.

Website: http://www.zorg-perspectief.nl/handleiding-cgt/

Provision of more accessible mental health services Provide therapist with interventions for target group

Lessons learned

What worked well & facilitators to implementation

- The huge need for interventions for this target group was a facilitator.
- Close collaboration between professionals, the national programme 'scoring results', authors, and clients was a facilitator.
- Publishing both the manual and client booklet by a professional publisher was a facilitator.

What did not work & barriers to implementation

 Many professionals still hold the belief that individuals with intellectual disability are not a risk group for substance use disorder and, because it is seen as a rare phenomenon, it is not well-served. Addressing this attitude has been one of the focus areas in the last ten years.

Recommendations for future adopters of this practice

• The pictures and practises are often highly effective and well liked and recommended to be used.

Level of implementation: National

Responsible organisations: National programme 'Scoring Results'; delivery is funded by insurance

Practice 9. Mental Health First Aid (MHFA)

Location: The Netherlands

Summary

Regular first aid courses are recognised for improving the public's skills in giving initial and appropriate help in medical emergencies. However, most first aid courses do not address giving support related to mental health problems. Members of the community can expect to have contact with someone experiencing a mental health problem.

Mental Health First Aid (MHFA) is a standardised, psychoeducational, and skilldevelopment-programme to empower the lay public to approach, support, and refer individuals in distress through improving the participants' knowledge, attitudes, and behaviours related to mental ill-health. The programme covers daily life interactions with persons who have mental health vulnerabilities as well as crisis situations. In the MHFA training programme, trainees learn to recognise signs and symptoms of mental health problems including depression, anxiety disorders, addiction, psychosis, and autism. Many citizens are unable to recognise mental illness and have beliefs about causes and treatment that are not in line with the evidence from research. In the Netherlands, the prevalence of mental disorders is high. Stigmatising attitudes are widespread and hinder recognition and appropriate help-seeking behaviour. Consequently, persons with mental health problems experience difficulties in integration and participation in society. One of the causes for stigma and discrimination is a lack of knowledge and skills in families, friends, colleagues, civil servants (sometimes even professionals), and people in the public. This results in disengagement and isolation, one of the most disastrous social stressors.

MHFA is a first aid course to improve mental health literacy in the general population and provide skills to act appropriately and help people with mental health issues, whether in a crisis or with on-going problems. The content of the training is based on guidelines that were generated by panels including clinicians, mental health consumers and their families.

Website: https://www.mhfa.nl

Mental health in the workplace Mental health in schools

Lessons learned

What worked well & facilitators to implementation

- Using a step by step approach, in cooperation with partners in the country and a high quality standard worked well.
- Subsidies from various governmental departments made the course accessible to a larger number of participants.
- The knowledge from the mother organisation and enthusiasm of employees and co-workers facilitated implementation.

What did not work & barriers to implementation

- Programmes need to start with having 'the right people on the bus'. We used three components in selecting employees: attitude, knowledge, and capabilities.
- Most countries wait long to find initial governmental funding. But with a network organisation, many organisations only have to invest little money. Starting small and thinking big can overcome this barrier.

Recommendations for future adopters of this practice

- The following elements are necessary:
 - A project manager (1 fte)
 - A project coordinator with organising qualities for operational implementation (0.5 fte)
 - A start budget (at least for one year and as money to adopt and adapt)
 - A substantive expert (where MHFA Australia may be useful)
 - An ambassador to get the message across

Level of implementation: More than one European nation but not Europe-wide and National (The Netherlands)

Responsible organisations: MHFA Netherlands

