



WORLD MENTAL HEALTH DAY 2020

Mental Health for all:
Greater Investment-Greater Access

WORLD FEDERATION FOR MENTAL HEALTH

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HRH Princess Iman Afzan Al-Sultan Abdullah

Patron

WORLD MENTAL HEALTH DAY 2020

The COVID-19 pandemic has brought great disruptions and immense challenges all across the globe. Uncertainty and major changes to the way we live our lives are having a considerable impact on our mental health. Nonetheless I remain optimistic that amidst such adversity, there are silver linings for the mental health community.

With mental health now at the forefront, the pandemic has increased pressure to address both pre-existing and newer issues. There has also been no shortage of coverage on staying mentally healthy - why it is important, how it can be done, and how we can support one another. The simple act of asking a loved one "How are you?" is no longer underestimated. In some ways, COVID-19 has broken barriers and created more awareness on mental health, and we must ensure that these conversations continue in the post-pandemic "new normal".

It is in this context that I feel the theme **Mental Health for All. Greater Investment - Greater Access. Everyone, everywhere...** is most timely for World Mental Health Day 2020.

I am proud to share that sentiments on mental health are changing in Malaysia. I have been humbled time and time again by the efforts of my peers to push for a more holistic, whole-of-society approach to mental health.

As Malaysia transitions out of its own lockdown, we have concluded that communities and society at large could possibly be more fragmented and polarised if mental health reforms are not catalysed



- amongst different income groups, and amongst those newly experiencing mental health issues and those who have pre-existing conditions. I am sure that this is not unique to Malaysia alone.

With efforts to decriminalise suicide underway back home, we are beginning to see some recognition that investments in mental health should also be made by those beyond the mental health community. Such investments need not be economic or financial, groundbreaking or revolutionary. Rather, these investments are of our time, attention, love and compassion, all of which can be done out of our own goodwill.

First, we can learn to have empathy for those suffering as well as their families. We can also improve our mental health literacy as the spectrum is wide, with stark differences between mental health issues and illnesses.

Second, we can uphold the basics of human interaction - emotional connection, face-to-face communication, kindness, understanding and thoughtfulness - to nurture mental resilience for those who need it most.

Third, we can be mindful of the important role that communities play in fostering a sense of care and togetherness. By doing our part as members in society, I am confident we will raise awareness on mental health and break its stigmatisation.

These investments are not purely the government's responsibility, nor should doctors be the only answer for those suffering. These investments are the responsibility of all. More importantly, they indicate that we ourselves are an untapped resource in mental healthcare.

For without greater investment in mental health, we risk losing greater access to mental health.

In the time I have spent highlighting the challenges of mental health, it has become apparent that raising public awareness comes hand in hand with ensuring accessible mental healthcare.

The task at hand is for us all to identify challenges that impede good mental healthcare practices; to educate and train primary care providers and frontline staff with mental health first aid strategies; and to improve the overall mental healthcare system to anticipate future needs such as a pandemic.

While COVID-19 has increased the spotlight on mental health, the stocktaking of how greater access to mental healthcare can be improved must always be a continuous process. We can always do more to strengthen mental health response and support in our communities.

Ultimately, mental health, quality of life and wellbeing should be seen as additional indicators of standards of living. This is the level that we should aspire to as we move towards the “new normal”.

I thank the World Federation for Mental Health for the opportunity to be Patron of World Mental Health Day 2020.

My work thus far has focused on kick-starting a much-needed conversation in Malaysia on how we can shape a more attentive and compassionate society. I am honoured to be working alongside the World Federation for Mental Health and their partners to bring this conversation to greater heights on the global stage.

As the COVID-19 pandemic is forcing the entire world to reset and rebuild for a better tomorrow, it is my hope that we too pause and reflect on what we would like our future to be.

My very best wishes for World Mental Health Day 2020.

SECTION A

Introduction



WFMH President's Foreword

INGRID DANIELS

President WFMH

World Mental Health Day, a programme of the World Federation for Mental Health, annually raises awareness within the global community about the mental health challenges, gaps and priorities through collaborative and unifying voices aimed at taking action, addressing and creating lasting change in a world where we need to restore the dignity of all living with mental health needs.

World Mental Health Day was first observed on 10 October 1992 as an annual activity of the World Federation for Mental Health aimed at promoting mental health advocacy and educating the public on relevant issues. Celebrated on the 10th October, it provides an opportunity to place the spotlight on the mental health challenges experienced in our world today.



The world as we know it has changed dramatically as we experience the unimaginable and unprecedented turmoil caused by the COVID-19 global health pandemic which has impacted on the mental health of millions of people. We could never have imagined that a virus of this nature could wield such devastation across nations. Hard and drastic lockdown measures implemented in many countries to reduce COVID-19 transmissions, infections and deaths saw the enforcement of physical isolations and distancing become a new reality disrupting natural social interactions. Parallel to emotional and health implications large scale socio-economic fallout has been witnessed as markets and economies were destabilised. The overwhelming impact of the virus revealed and exposed the deep inequalities and levels of poverty experienced by many, particularly in lower – and middle income countries, causing further mental distress and vulnerability. Pushed to the foreground was the exposure of many social ills such as; racism, gender-based violence and many others.

The mental health consequences of COVID-19 superseded by an already overburdened mental health landscape in which the number of people living with depression and or anxiety increased by nearly 50% from 416 million to 615 million (WHO, 2016). We know that mental, neurological and substance use disorders exact a high toll on health outcomes, accounting for 13% of the total global burden of disease (WHO, 2012). One person in every four will be affected by a mental disorder at some stage of their lives. The treatment gap remains large with 50% of people with mental disorders in high income countries and 85% of persons in low-and middle income countries having no access to treatment (WHO, 2012). Fragile health systems have not been able to address or cope with the large treatments gaps and need for men-

tal health care. We have observed how delicate health systems are further stretched and challenged by the increase in demand for mental health interventions as a result of the pandemic.

Sadly, the global denial and failure to invest in mental health over many years has resulted in a shameful situation in which access to treatment has limited individuals' rights to wellness and health which has been exacerbated by the COVID-19 crisis. The inadequate response to invest and increase access to mental health has resulted in gross failure to ensure that every global citizen can live fully integrated lives. Mental health continues to be misunderstood, ignored, stigmatised, underfunded and overlooked. COVID-19 has in many respects been an equalizer and has placed at the forefront the critical need for good mental health interventions, responses and support during this time.

Taking our current reality and context into account the theme for World Mental Health Day could not have come at a more appropriate time as a call to action becomes critical.

Mental Health for All Greater Investment – Greater Access

The United Nations (2020) states that, "Good mental health is critical to the functioning of society at the best of times. It must be front and centre of every country's response to and recovery from the COVID-19 pandemic. The mental health and wellbeing of whole societies have been severely impacted by this crisis and are a priority to be addressed urgently" (UN, Policy Brief, 2020).

The World Economic Forum (2018) noted that mental health disorders are on the rise in every country in the world and could cost the global economy up to \$16 trillion between 2010 and 2030 if a collective failure to respond is not addressed. We are faced with an international mental health crisis and have been forewarned over the last two decades of this imminent catastrophe. Yet little movement has been seen in shifting the mental health investment agenda despite the global return on investment analysis and economic benefits. According to WHO's "Mental Health Atlas 2014" survey, governments spend on average 3% of their health budgets on mental health, ranging from less than 1% in low-income countries to 5% in high-income countries. The value of investment needed over the period 2016–30 for scaling up treatment, primarily psychosocial counselling and antidepressant medication, amounted to US\$ 147 billion (Chisholm, et al, 2016).

Yet the returns far outweigh the costs. The WHO (2019) states that for every US\$ 1 put into scaled up treatment for common mental disorders, there is a return of US\$ 4 in improved health and productivity. "Despite hundreds of millions of people around the world living with mental disorders, mental health has remained in the shadows," said Jim Yong Kim, President of the World Bank Group. Despite a growth in mental health awareness and case made mental health investment has been stagnant across the globe. It is clear that greater movement and action needs to be seen within countries to increase access to mental health for all.

World Mental Health Day is simply not a one day event and provides us with the opportunity and advantage to hold the attention of governments, donors, policy-makers and all stakeholders to ensure action for greater investment in mental health.

This year the call to action “greater investment in mental health” has to be headed and cannot be ignored in the current COVID-19 pandemic environment. It is unquestionable that mental health is a human right and thus, *now more than ever*, it’s time for mental health for all. Quality and accessible mental health care is an undeniable right and part of the foundation for universal health coverage. Every nation – every voice needs to move and call for greater investment in mental health. Our key activations over the next few weeks through our coordinated efforts and activities with our collaborating partners will ensure that this year we will have the greatest impact in shifting the investment in mental health agenda.

Our call is a simple one – let us hold hands and unify our voices in moving the mental health investment agenda for increased focus and access to mental health and thereby making mental health a reality for all – *everyone, everywhere*.

The Lancet Commission on Global Mental Health and Sustainable Development (2018) note that the sustainable development goals are not achievable without making significant improvements to treating, preventing and promoting mental health. They identify mental health as a humanitarian and development priority, providing evidence that mental health is indeed at the centre of sustainable development.

We can thus conclude that there can be no sustainable development without mental health. There is still time to limit the worse impact and consequences of inaction by being bold and investing in the mental health of all.

“The ultimate measure of a man is not where he stands in moments of comfort and convenience but where he stands in times of challenge and controversy.”
Martin Luther King Jr.

The time for action is now.

Mental Health for All
Greater Investment – Greater Access

Dr Ingrid Daniels
 President WFMH



Mental health: let's invest

DÉVORA KESTEL

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We now live in a time when the daily lives of people across the world have changed considerably due to the COVID-19 pandemic. Many people are afraid of infection, dying, and losing family members. People have been physically distanced from their support networks and many are grieving the deaths of loved ones. Millions of people face economic turmoil, having lost or being at risk of losing their incomes and livelihoods. Additionally, many specific populations continue to experience particularly challenging circumstances. Frontline health-care workers and first responders are continuously exposed to complex stressors in often unprepared and overwhelmed health systems. People living with mental or physical health conditions experience significant disruptions in their care. In every community, older adults, including those with underlying health conditions or neurological conditions, remain uniquely vulnerable.

Children and adolescents also face disrupted education and ambiguity about their futures. Due to family stress and social isolation, many have been exposed to higher rates of abuse or neglect. The impact of these unprecedented uncertainties, occurring at critical points in their emotional and cognitive development, cannot be understated.

Women are also bearing a heavy burden as a result of the pandemic. Gender-based violence is also increasing as many women and girls endure confinement at home with their abusers while services to support survivors have, in some cases, been disrupted..

Meanwhile, people caught in fragile humanitarian settings risk having their health and mental health needs overlooked entirely. Due to tenuous health and social support systems, individuals in these areas already experience limited access to mental health care and now face even greater adversity during COVID-19.

Even before the COVID-19 pandemic, almost 1 billion people were living with mental disorders and nearly US\$ 1 trillion was lost annually in lost productivity due to depression and anxiety alone. Given past ex-

periences with public health emergencies, it is expected that these numbers will substantially increase and the demand for mental health and psychosocial support will be greater than ever.

Taken together, these factors paint a striking portrait of urgent mental health needs across the world today. Unfortunately, these needs are emphatically underscored by decades of chronic under-investment in the mental health field, particularly in community-based services. On average, countries spend less than 2% of their health budgets on mental health, with 80% of that expenditure going to mental health hospitals. Furthermore, international development assistance for mental health is estimated to be less than 1% of all development assistance for health. This is despite the fact that evidence-based care for depression and anxiety alone brings a US\$ 5 return on investment for every US\$ 1 spent. Meanwhile, the return for evidence-based drug dependence care may be as high as US\$ 6.

Yet, despite these challenges, today we are presented with a historic opportunity to place mental health high on the global agenda. Before COVID-19, mental health was gaining traction among global development priorities encapsulated in the SDGs, in the international humanitarian field, and in the human rights discourse. Then, in June 2020, a group of 95 countries sent a *Joint Statement in support of the Secretary-General's Policy Brief on COVID-19 and the Need for Action on Mental Health* to the 74th President of the United Nations (UN) General Assembly and to the UN Secretary-General. The statement affirmed the need for greater support for mental health and called for strategies to ensure that governments take the actions necessary to mitigate the mental health impacts of COVID-19.

Now more than ever we must harness this momentum to move mental health forward. The UN Secretary-General, in his policy brief on the need for action on mental health, recommended that countries take three actions: 1) apply a whole-of-society approach to promote, protect and care for mental health; 2) ensure widespread availability of emergency mental health and psychosocial support; and 3) support recovery from COVID-19 by building mental health services fit for the future. Fortunately, many of the tools and approaches needed to enact these recommendations have already been outlined in WHO's Comprehensive Mental Health Action Plan. However, to date, investment and implementation have remained limited. This is why we must now take decisive action that shows mental health for all is not merely a notion to tacitly support, but something that requires active engagement, practical commitment and financial investment.

WFMH and Global Mental Health Advocacy

PROFESSOR GABRIEL IVBIJARO MBE JP

Secretary General WFMH

It gives me great pleasure as Secretary General and Chief Executive Officer of the World Federation for Mental Health (WFMH) to thank each of you for your contribution to mental health advocacy, and particularly your support for World Mental Health Day, Saturday 10th October 2020.

WFMH was launched in London, UK in August 1948 at an International Congress on Mental Health. It aimed to promote mental health and citizenship, mutual understanding through co-operation across professional boundaries, the establishment of mental health services in every country of the world and the promotion of education about mental health, with the aim of empowering people who deliver and receive mental health services.

At its inception WFMH recognised the need to highlight excellence by awarding prizes for significant research, scientific publications and outstanding initiative and excellence in mental health services to inspire others and raise standards in mental health.

From the start WFMH pledged to lend their support and encouragement to the United Nations, to lobby for Universities to establish Chairs of Mental Health and regional Institutes of Mental Health for research, training, and public education.

We have seen much improvement in the standards and delivery of mental health care for many citizens of the world since 1948, and the profile of mental health has been raised with the general public, but there is still a long way to go.

This year's coronavirus pandemic has affected everybody and highlighted how poorly prepared many nation states are to address mental health wellbeing during a time of global crisis. The need for WFMH is just as important today as it was in 1948.

This year's World Mental Health Day theme '*Mental health for all: greater investment – greater access*' provides us with an opportunity to re-affirm the founding principles of the World Federation for Mental Health. The WFMH family cannot achieve this alone. Every one of us has to play our part.

We continue to need each other in the same spirit of collaboration, and we need to work across traditional boundaries as we did in 1948, forging alliances that can work together to ensure that we achieve mental health for all. Mental health matters.

I have become Secretary-General and CEO of WFMH at a difficult time and face many challenges, some similar to those faced by citizens in 1948. History tells us that by working together we can overcome our challenges and difficulties and build a better society.

I am grateful to previous Secretary Generals who have gone before including J.R. Rees (1948-1961), Francois Cloutier (1962-1965), Pierre Visseur (1965-1967), G.M. Carstairs (1968-1972), Michael Beau-brun (1972-1974), Tsung-yi Lin (1975-1979), Robert Beiser (1979-1983), Eugene Brody (1983-1999), Preston Garrison (2002-2009) and Vijay Krishna Ganju (2010 -2012).

I am very grateful to the Officers and President of WFMH, and all our individual and institutional members for your continued support.

World Mental Health Day established in 1992 would not have become a reality but for the work of Richard (Dick) Hunter, the Deputy Secretary General of the World Federation for Mental Health. Richard Hunter built on the goodwill of many to ensure that our annual World Mental Health Day celebration on 10th October became a reality. With Richard Leighton a television producer he made a global telecast the central feature of worldwide activities. Subsequently the World Health Organization agreed to become a co-sponsor, and the project was also supported by the Carter Center, when former U.S. First Lady Rosalynn Carter agreed to become Honorary Chair of the event.

World Mental Health Day has helped to improve global mental health literacy. I call on all media outlets and social media to join us to publicise this year's theme '*Mental health for all: greater investment – greater access*,' and I ask citizens, policy makers and those who pay for services to play their part.

No-one is immune from mental distress we all need each other. Mental health matters.

Professor Gabriel Ivbijaro MBE JP

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#mentalhealthmatters

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SECTION B

Greater Investment – Greater Access



Healthy People 2030: The Integration of Mental Health into Well-Being for All

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Healthy People 2030: The Integration of Mental Health into Well-Being for All

Introduction

The stated Healthy People 2030 initiative’s vision is: “A society in which all people can achieve their full potential for health and well-being across the lifespan” (1). This vision together with Healthy People 2030’s mission, foundational principles, and overarching goals, create the framework and roadmap for the fifth decade of the U.S. initiative (Box 1). This framework embraces and emphasizes health *and* well-being, providing a greater opportunity and imperative to enhance and support health, including mental health.

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Healthy People 2030 Framework: Vision, Mission, Foundational Principles and Overarching Principles

Vision

A society in which all people achieve their full potential for health and well-being across the lifespan.

Mission

To promote and evaluate the nation's effort to improve the health and well-being of its people.

Foundational Principles

- Health and well-being of the population and communities are essential to a fully functioning, equitable society.
- Achieving the full potential for health and well-being for all provides valuable benefits to society, including lower health care costs and more prosperous and engaged individuals and communities.
- Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy. 2
- Healthy physical, social and economic environments strengthen the potential to achieve health and well-being.
- Promoting and achieving the nation's health and well-being is a shared responsibility that is distributed among all stakeholders at the national, state, and local levels, including the public, profit, and not-for-profit sectors.
- Working to attain the full potential for health and well-being of the population is a component of decision-making and policy formulation across all sectors.
- Investing to maximize health and well-being for the nation is a critical and efficient use of resources.

Overarching Goals

- Attain healthy, purposeful lives and well-being.
- Attain health literacy, achieve health equity, eliminate disparities, and improve the health and well-being of all populations.
- Create social and physical environments that promote attaining full potential for health and well-being for all.

The framework's foundational principles highlight the physical, mental and social health dimensions that comprise the linked efforts of promoting health and well-being and preventing disease (See Box 1). The focus on achieving health equity and eliminating health disparities is continued to be emphasized and there is added visibility for attaining health literacy. Furthermore, the need for shared responsibility is highlighted by stressing the need for multiple diverse sectors to work together across various settings. Finally, a broad perspective and integrated view of health and well-being considerations is proposed in decision-making and policy formulation.

Health and Well-Being

We believe it is no coincidence that the World Federation of Mental Health (WFMH) was formed the year the World Health Organization (WHO) was established, with the definition of health included into the preamble of its constitution (1948). The WHO definition of health –“the complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity” – continues to inspire the Healthy People initiative. To further stimulate actions to promote health and recognize the importance of addressing the impact of the determinants of health, “well-being” was added to encompass aspects beyond physical and mental conditions. Well-being is comprised of multiple elements, some of which overlap with health, but also includes “emotional, social, financial, occupational, intellectual and spiritual elements.” Health and well-being are defined in Healthy People 2030 as “how people think, feel and function – at a personal and social level – and how they evaluate their lives as a whole” (2). For individuals and communities to achieve their full potential for “health and well-being” the active involvement and collaboration among diverse stakeholders is required. It is through their collective impact that health and well-being can be best addressed.

Health and well-being is regarded as a single term and describes separate but related states, i.e., health influences well-being, and, conversely, well-being affects health. Health is considered to include a person’s physical and mental condition whereas well-being encompasses additional states of being and aspects of life such as security, prosperity, sense of connection, and purpose (3-5). Well-being may be considered both a determinant and outcome of health (6). For many people, well-being is a more unifying and motivating pursuit than health. How people think, feel, and function reflects an integration of body, mind, and spirit and recognizes the interdependency of each state with the others. For instance, how we think influences how we feel, and how we feel influences how we function (7). Additionally, the health and well-being definition operates at more than a single level. Multiple determinants affect health and well-being and, as proposed in the framework, such influences come from within each person as well as from the social, physical, and economic environments and settings in which people are born, live, learn, work, play, worship, and age.

Promotion of “health and well-being” requires an understanding of a society’s values and the pursuit of equitable living conditions. A multisectorial approach across the nation and its communities is needed to achieve health and well-being. The behavioral, psychosocial, socioeconomic, cultural and political circumstances of our populations need to be considered when health and well-being are the desired outcomes. The underlying “causes of the causes” of poor health include mental health considerations and call for an emphasis on psychological and social support and resources in order to make progress. Stress, social exclusion and social gradient, as well as essential elements, such as food, housing, and transportation need prioritization and focused attention.

Mental Health

The Healthy People initiative is a science-based roadmap with specific measurable goals and objectives with targets to guide the action of individuals, communities and stakeholders to improve health. Since its launch in 1980, each iteration of Healthy People, including Healthy People 2000, Healthy People 2010, Healthy People 2020, and Healthy People 2030, has included objectives related to mental health. Each decade the extent and scope of issues relevant to mental health have grown. While the initial 1990 topics did not specifically mention mental health, topics such as the control of stress and violent behavior and misuse of alcohol and drugs were included. A more formal focus on mental health and mental disorders followed in each subsequent decade. In Healthy People 2010 and Healthy People 2020 mental health also was selected as a Leading Health Indicator, one of a small set of high priority objectives. Concurrently topics aligned with mental health also grew in number. In Healthy People 2020, the objectives related to mental health included access to health services, adolescent health, injury and violence prevention, substance abuse, and education and community-based programs. Healthy People 2030 pivots from a focus on “health” by itself to a focus on health and well-being” and includes a topic area dedicated to mental health with fourteen Core Objectives, one Developmental Objective, and two Research Objectives. Table 1 presents the Healthy People 2030 Mental Health and Mental Disorders objectives, their baseline and targets, data sources, and additional contextual information.

Table 1: Healthy People 2030 Mental Health and Social Determinants of Health Objectives

Mental Health and Mental Disorders Objectives (MHMD)

8 Core Objectives; 1 Developmental Objective; 1 Research Objective

Core Objectives

Final ID	Objective Statement	Short Title	Baseline Statement	Target	Target-Setting Method	Data Source
MHMD-01W	Reduce the suicide rate	Reduce the suicide rate	14.2 suicides per 100,000 population occurred in 2018 (age adjusted to the year 2000 standard population)	12.8 per 100,000	Percent improvement	National Vital Statistics System - Mortality (NVSS-M), CDC/NCHS; Population Estimates, Census

Final ID	Objective Statement	Short Title	Baseline Statement	Target	Target-Setting Method	Data Source
MHMD-02	Reduce suicide attempts by adolescents	Reduce suicide attempts by adolescents	2.4 suicide attempts per 100 population of students in grades 9 through 12 occurred in the past 12 months, as reported in 2017	1.8 per 100	Minimal statistical significance	Youth Risk Behavior Surveillance System (YRBSS), CDC/NCHHSTP
MHMD-03	Increase the proportion of children with mental health problems who receive treatment	Increase the proportion of children with mental health problems who get treatment	73.3 percent of children aged 4 to 17 years with mental health problems received treatment in 2018	82.4 percent	Projection	National Health Interview Survey (NHIS), CDC/NCHS
MHMD-04	Increase the proportion of adults with serious mental illness (SMI) who receive treatment	Increase the proportion of adults with serious mental illness who get treatment	64.1 percent of adults aged 18 years and over with SMI received treatment in 2018	68.8 percent	Percentage point improvement	National Survey on Drug Use and Health (NSDUH), SAMHSA
MHMD-05	Increase the proportion of adults with major depressive episodes (MDEs) who receive treatment	Increase the proportion of adults with depression who get treatment	64.8 percent of adults aged 18 years and over with MDEs received treatment in the past 12 months, as reported in 2018	69.5 percent	Percentage point improvement	National Survey on Drug Use and Health (NSDUH), SAMHSA
MHMD-06	Increase the proportion of adolescents with major depressive episodes (MDEs) who receive treatment	Increase the proportion of adolescents with depression who get treatment	41.4 percent of adolescents aged 12 to 17 years with MDEs received treatment in the past 12 months, as reported in 2018	46.4 percent	Percentage point improvement	National Survey on Drug Use and Health (NSDUH), SAMHSA

Final ID	Objective Statement	Short Title	Baseline Statement	Target	Target-Setting Method	Data Source
MHMD-07	Increase the proportion of persons with co-occurring substance use disorders and mental health disorders who receive treatment for both disorders	Increase the proportion of people with substance use and mental health disorders who get treatment for both	3.4 percent of adults aged 18 years and over with co-occurring substance use disorders and mental health disorders received both mental health care and specialty substance use treatment in 2018	8.2 percent	Minimal statistical significance	National Survey on Drug Use and Health (NSDUH), SAMHSA
MHMD-08	Increase the proportion of primary care office visits where adolescents and adults are screened for depression	Increase the proportion of primary care visits where adolescents and adults are screened for depression	8.5 percent of primary care office visits included screening for depression in persons aged 12 years and over in 2016	13.5 percent	Minimal statistical significance	National Ambulatory Medical Care Survey (NAMCS), CDC/NCHS

Developmental Objectives

Final ID	Objective Statement	Short Title
MHMD-D01	Increase the number of youth with serious emotional disturbance (SED) who are identified and receive treatment	Increase the number of children and adolescents with serious emotional disturbance who get treatment

Research Objectives

Final ID	Objective Statement	Short Title
MHMD-R01	Increase the proportion of homeless adults with mental health problems who receive mental health services	Increase the proportion of homeless adults with mental health problems who get mental health services

Social Determinants of Health (SDOH) Objectives

6 Core Objectives; 0 Developmental Objectives; 1 Research Objective

Core Objectives

Final ID	Objective Statement	Short Title	Baseline Statement	Target	Target-Setting Method	Data Source
SDOH-01	Reduce the proportion of persons living in poverty	Reduce the proportion of people living in poverty	11.8 percent of persons were living below the poverty threshold in 2018	8.0 percent	Projection	Current Population Survey Annual Social and Economic Supplement (CPS-ASEC), Census and DOL/BLS
SDOH-02	Increase employment among the working-age population	Increase employment in working-age people	70.6 percent of the working-age population aged 16 to 64 years were employed in 2018	75.0 percent	Percentage point improvement	Current Population Survey Annual Social and Economic Supplement (CPS-ASEC), Census and DOL/BLS
SDOH-03	Increase the proportion of children living with at least 1 parent employed year round, full time	Increase the proportion of children living with at least 1 parent who works full time	77.9 percent of children aged 17 years and under were living with at least 1 parent employed year round, full time in 2017	85.1 percent	Projection	Current Population Survey Annual Social and Economic Supplement (CPS-ASEC), Census and DOL/BLS
SDOH-04	Reduce the proportion of families that spend more than 30 percent of income on housing	Reduce the proportion of families that spend more than 30 percent of income on housing	34.6 percent of families spent more than 30 percent of income on housing in 2017	25.5 percent	Percentage point improvement	American Housing Survey (AHS), HUD & Census
SDOH-05	Reduce the proportion of children who have ever experienced a parent or guardian who has served time in jail	Reduce the proportion of children with a parent or guardian who has served time in jail	7.7 percent of children aged 17 years and under had ever experienced a parent or guardian serving time in jail in 2016-17	5.2 percent	Percentage point improvement	National Survey of Children's Health (NSCH), HRSA/MCHB
SDOH-06	Increase the proportion of high school completers who were enrolled in college the October immediately after completing high school	Increase the proportion of high school graduates in college the October after graduating	69.1 percent of high school completers were enrolled in college the October immediately after completing high school in 2018	73.7 percent	Projection	Current Population Survey (CPS), Census and DOL/BLS

Research Objectives

Final ID	Objective Statement	Short Title
SDOH-R01	Increase the proportion of federal data sources that collect country of birth as a variable	Increase the proportion of federal data sources that include country of birth

The year 2020 marks not only the launch of Healthy People 2030, but also a year during which there has been an unprecedented effect on global health and well-being resulting from the global impact of the COVID-19 pandemic and protests against structural racism and discrimination. These and other challenges only strengthen our resolve of the need to support collective efforts to achieve health and well-being. WFMH is well positioned to provide essential awareness, advocacy and preventive and treatment services for mental health concerns and Healthy People 2030 can be a well-aligned effort to accomplish our shared goals.

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Improving access to psychological therapies – needed now more than ever.

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Introduction

COVID-19 and associated economic and social unrest pose an ongoing global challenge to mental health. Early evidence from many countries suggests increased rates of mental distress both directly as a result of COVID-19 anxiety and trauma and from the indirect impact of economic crises^{1 2}. More than ever there is a need to improve access to psychological therapies, given the known evidence of their effectiveness for a range of mental health problems and distress³.

Despite the pressure on health services and the trauma to individuals, the current crisis has also demonstrated opportunities to introduce innovation and enhance existing ways of accessing mental health care.

The quarantine and lockdown which has been a feature of COVID-19 has produced an increased interest in providing remote and virtual access to health care in many different countries and contexts including mental health⁴.

Now, more than ever there is a need to increase access to psychological therapies and consider how innovations can enhance their reach and effectiveness.

In many countries the last decade has seen a strengthening of psychological therapy services. In the UK for example the Improving Access to Psychological Therapies (IAPT) service⁵ led to a significant increase in the use of psychological therapists and evidence of both clinical and economic benefits⁶. The

1- Wang C, Pan R, Wan X, et al. Immediate psychological responses and associated factors during the initial stage of the 2019 coronavirus disease (COVID-19) epidemic among the general population in China. *International journal of environmental research and public health* 2020;17(5):1729.

2- Nicola M, Alsaifi Z, Sohrabi C, et al. The socio-economic implications of the coronavirus and COVID-19 pandemic: a review. *International Journal of Surgery* 2020

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5- Clark DM. Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International review of psychiatry* 2011;23(4):318-27.

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UK has also developed a Child and Youth model of IAPT (CYP- IAPT to address the needs of younger people⁷.

A case study of improving access to psychological therapies for young people in New Zealand.

In 2019 the Ministry of Health commissioned a pilot service delivery initiative designed to increase the access of young people aged 18-25 years to a range of integrated psychological therapies and supports within an existing stepped care model in primary care⁸. The initiative was named 'Piki ', an indigenous Māori word meaning both to support or aid, and to climb or ascend.

Piki was designed with the following innovations:

- Co-design with service users and between multiple partners engaged in the project.
- The introduction of 'peer to peer' interactions and therapeutic engagement.
- The use of a digital platform and App, which is used for data collection, but also as a therapy option for the project.
- An evaluation methodology that would allow feedback at multiple time points during the project timeframe and enable 'course corrections' to the project.
- A major focus on equity of access to services especially for hard to reach communities, and emphasis on self-management skills and resilience.

Co-design

An important innovation of Piki is the use of co-design principles in the development, implementation and evaluation of the project⁹. Co-design with both service users and the multiple partners in the project was used in developing measurement requirements for clinical practice and evaluation, marketing and ongoing modification of service user pathways.

of Clinical Psychology 2018;14

7- Fonagy P, Clark DM. Update on the Improving Access to Psychological Therapies programme in England: Commentary on... Children and Young People's Improving Access to Psychological Therapies. *BJPsych bulletin* 2015;39(5):248-51.

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9- Slay J, Stephens L. Co-production in mental health: A literature review. *London: new economics foundation* 2013.

The evaluation team is utilising a co-produced approach to the evaluation with an equal number of the team being service user academics, and support from the youth service user advisory group¹⁰.

Input from youth and service users was via two routes. A service user reference group was created to support the co-design process, with a specific focus on evaluation. Its members are youth with lived experience of mental distress and experience of primary care services as a result. A Youth Reference Group provides more general advice in terms of youth culture, environment, communication, accessibility and marketing.

The spirit of co-design has remained strong but there is recognition of tension between delivering a project from a platform of existing services and a set menu of innovation, compared with adopting new directions and priorities identified through the co-design process.

In a project dedicated to improving service to young people it has been important to listen to the voice of the youth reference groups when they have felt they were not heard, and when it was felt that fundamental aspects of the model of care had already been decided.

An integrated project with a focus on digital technology innovation

Piki has been integrated with general practice, Youth One Stop Shops, and tertiary institutions to allow onsite service delivery, immediate booking and short waiting times.

The project operates around a digital platform consists of an App and a website. The App includes direct access to the clinical assessment and outcome measures as well as psychological therapy session outcomes. It also provides resources, including tracking tools, a mood diary, an online community, and a facility for therapists and clients to message each other.

Prioritising those most in need

Due to concerns about young indigenous Māori and Pacific populations, and vulnerable groups, the project prioritised those groups in the initial launch, in website marketing, and promotion of Māori and Pacific workforce development.

10- Gordon S, Dowell T, Fedchuk D, et al. Reflections on allyship in the context of a co-produced evaluation of a youth-integrated therapies mental health intervention. *Qualitative Research in Psychology* 2020:1-15.

As with many projects there can be a tension in prioritising between different groups; in this case initially managing the high volume demand from a large student population in the project catchment area. Specific text and social media marketing to Māori and Pacific together with local appointment of additional Māori and Pacific workforce has helped redress the balance.

A peer-to-peer support programme

Peer supporters are non clinical workers with their own experiences of mental distress and adversity who walk beside a person to navigate services and support their personal and social goals on a journey to wellness and recovery¹¹.

Early in project development a peer to peer organisation worked with the service users group, and with Māori and Pasifika groups to co-design the peer-to-peer service developing a programme designed to see clients for an average of six to ten weeks.

Successful peer support development involved negotiating a number of issues including procedures for safety nets for self-harm or suicide ideation and how peer supporters

Piki and COVID-19

The COVID-19 pandemic disrupted many of the processes in Piki, but there were potentially positive benefits to some of the changes. Within two weeks, Piki was able to support changes to complete virtual and remote working using phone and digital platforms. Many health workers and service users were appreciative of this way of providing and receiving therapy. It is also instructive that having managed to introduce new ways of working there is also a wish for many service users to return to face to face ways of receiving therapy, and it is important to further explore the reasons for this.

Conclusion

This youth mental health project contains a number of innovations and ambitious service integration objectives, which make it a case study with potential useful learning for both local national and international scenarios.

11- Asad S, Chreim S. Peer support providers' role experiences on interprofessional mental health care teams: A qualitative study. *Community mental health journal* 2016;52(7):767-74.

Piki has demonstrated it is possible to successfully initiate new innovation from a platform of business as usual services in a relatively short time frame, and to use principles of co-design, and acknowledgement of complexity and appreciative inquiry¹² to negotiate tensions and challenges. Acknowledgement of that complexity provides further learning for scale up of such initiatives since particularly in a post COVID-19 world unexpected issues will arrive and while some of these are likely to be identifiable at an early planning stage, many others will be 'predictably unpredictable'.

A major contributor to the success of Piki so far has been the willingness of many different partners to work with service users and to continue to cooperate on a project with many strands of complexity. This has been achieved by trying to have core values of kindness and compassion at the heart of all activity.

Piki Evaluation Team. Tony Dowell, Maria Stubbe, Sarah Gordon Fiona Mathieson, Dasha Fedchuk , Tracey Gardiner, Sue Garrett, Jo Hilder & Rachel Tester

Access to Piki <https://piki.org.nz/>

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Investing in psychological therapies – the UK model

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The UK National Health Service (NHS) programme to improve access to psychological therapies (IAPT) has created talking therapy services in every locality in England. People can refer themselves directly to their local service and receive evidence-based psychological treatment for their common mental health condition and over half recover from their condition.

The necessary investment to achieve this working age population wide intervention delivers a substantial return on investment. In addition to improved quality of life and income, a government saving of £13,382 per person returning to work at 2020 prices (Baah, 2017) at an average 2020 adjusted treatment cost of £1,011 per person (Radhakrishnan et al., 2013). With similar benefits for those retaining employment and improving productivity.

IAPT Services provide access to evidence-based psychological interventions for common mental health conditions, specifically depression and anxiety disorders. This is centrally funded on the basis that this is cost-effective for the government (Bell et al., 2006). Interventions range in intensity from low intensity (consisting mainly a guided self-help and computerised CBT) to standard high-intensity psychological interventions (mainly formal one-to-one structured psychological interventions). Most interventions come from cognitive behavioural therapy (this formulates mental ill-health as a disorder of behaviour and thinking patterns and seeks to enable the person to become self-sufficient in identifying and altering these). They also include dynamic interpersonal therapy, counselling for depression, and couple therapy for depression.

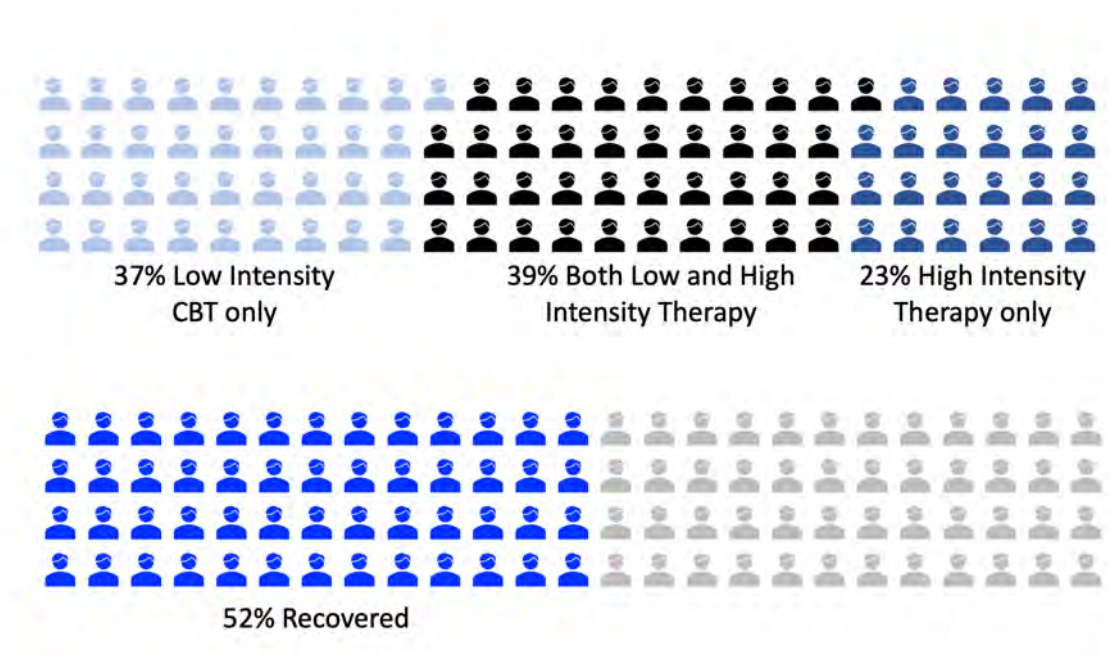
This paper sets out

1. A summary of what IAPT services deliver at a National level.
2. The National and Local factors that support delivery.
3. Some of the challenges of delivering an IAPT Service and how these can be addressed.

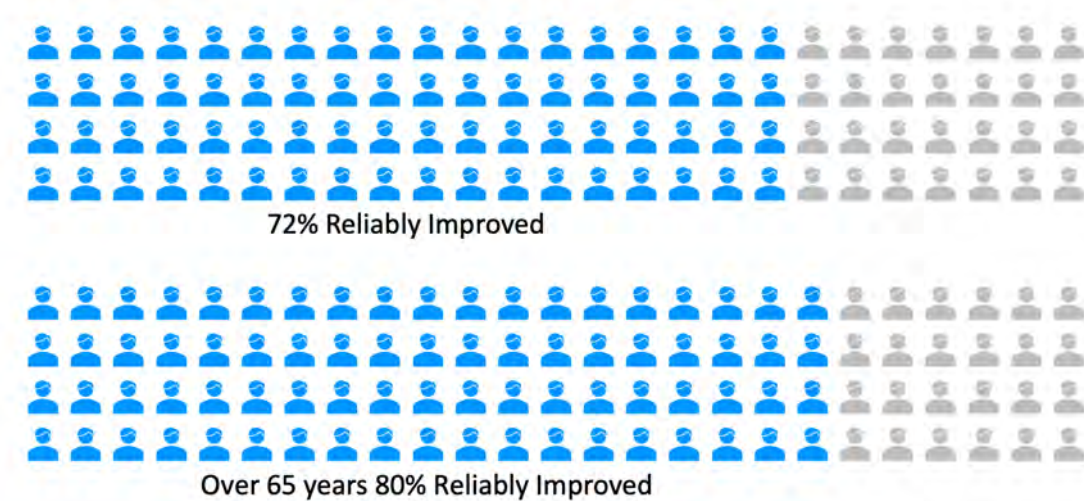
The National Picture

Data on IAPT is publicly available¹:

- IAPT Services received over 1.5 million referrals each year aiming to reach 1.9 by 2023/24.
- IAPT currently delivers access to 20% of the English population with depression or an anxiety disorder.
- Patients received on average seven sessions of therapy
- The did not attend rate for appointments was 10-11%.
- Over 99% complete outcome measures.
- About one third received low-intensity therapy.
- About one quarter received high-intensity therapy.
- About 2/5ths received both low and high-intensity therapy.
- Over 70% showed a “reliable improvement” on their outcome measures.
- Using first and last observation carried forward, the proportion that no longer exceeded cut-off on both the measure of depression and an anxiety measure began at around 45% in 2013 and gradually increased reaching 52% in 2019 (recovery rate).
- The average wait for assessment is around 20 days with over 87% of people waiting less than 6 weeks.



1- <https://fingertips.phe.org.uk/search/IAPT>

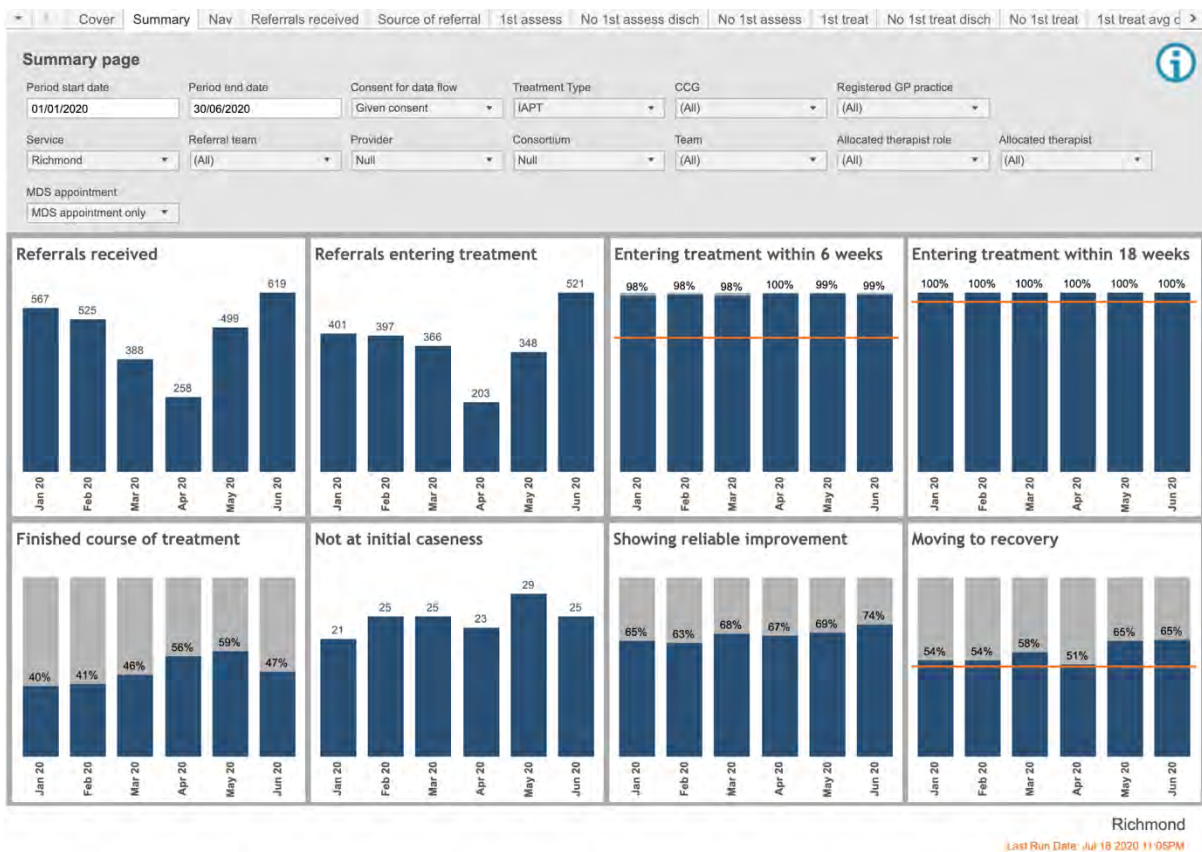


Factors that support delivery

Technology, Staff and resources are three key elements supporting the development of the programme.

Successful Demonstration sites (Clark et al., 2009) created the final clinical model, and subsequent refinement was captured in an IAPT manual² enabling services to configure consistently and effectively. Commercially developed electronic health records (IAPTus and PCMIS) were critical in enabling large volume provision with routine data collection. A centrally agreed and mandated data collection framework minimised the digital overhead and ensured directly comparable outcome measures which must be submitted by every service each month through a central digital portal. Managing these complex systems is supported by real time data reports built into the clinical systems. The image below is a realtime performance dashboard from IAPTus provided by Mayden Health Ltd.

² <https://www.england.nhs.uk/wp-content/uploads/2020/05/iapt-manual-v4.pdf>



The workforce workstream supporting IAPT has been a substantial undertraining. Central funding supported the provision of paid-for courses with fixed-term employment for trainees in services where many subsequently work. In July 2017 there were 5,200 clinicians and 2600 non-clinical staff support services³. A substantial proportion of the clinicians were trained by the programme. Staff continue to receive expert supervision and ongoing professional development to create an effective workforce, this underpins both the capability and capacity of the programme.

IAPT Services are funded locally with an allocation from the centre. Each service is locally commissioned, usually through a competitive tender, for a fixed term (usually a three year) renewable contract. Contracts are open to statutory, commercial or charitable providers working alone or in collaboration. Failing services can expect to lose their contract as can successful services if they are insufficiently competitive. While creating a rigorous, highly competitive marketplace, it also suppressed collaboration and rarely encouraged bad actors to play the system to the detriment of patient care.

3- <https://www.hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%20202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf>

Challenges in delivering an IAPT Service

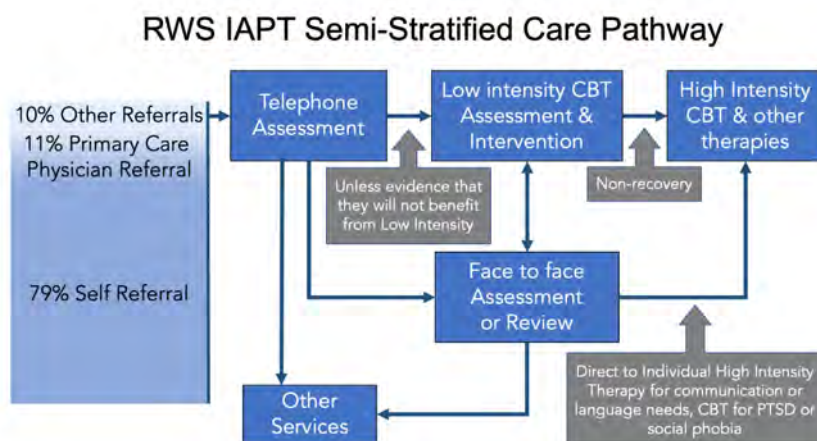
The author leads a service in an affluent borough in London (RWS). In the last six months, 317 (11%) of referrals were directly from primary care physicians (GPs), 2302 (79%) self-referrals, of these 1716 (59%) are via our website.

Engagement

Nationally about 30% of referrals do not progress to an appointment and about 38% complete a course of treatment. Ensuring engagement is critical because early drop out is strongly associated with non-recovery. Speed is key (Clark et al., 2018), during the working week RWS contacts patients on the day of referral and offers a telephone assessment within 4 days this reduces disengagement to 20%.

Capacity

In addition to managing high volume flow, the demand to provide a longer duration of treatment, due to complexity or needs arising from social isolation, often exceeds capacity. While post-traumatic stress disorder, social phobia and body dysmorphic disorder currently require direct high-intensity CBT. For other conditions, RWS asks people to attend educational seminars to teach core knowledge about their condition and initiate self-treatment. Non-responders proceed to intensive CBT groups and if necessary, to formal individual treatment. This approach enables the same resource to provide a maximum of 40 hours of treatment over 6 months rather than a more usual 12 hours over 3 months and waiting times for treatment of weeks rather than months. Over 90% of people completing this programme achieve full recovery. The RWS high level care pathway flow is shown below.



Staff Wellbeing

The low-intensity provision was originally intended to be delivered by emotionally intelligent laypeople following a training course (Richards, David & Suckling, 2008), is now seen as an entry-level position for psychology graduates and career progression creates high staff turnover. IAPT staff in general experience high pressure from large volumes and an expectation that they will deliver evidence-based treatments that conform closely to the original research. A clear expectation of 20 hours minimum of direct clinical contact each week (37.5 hours) helps maintain the balance of ever-increasing institutional demands with professional wellbeing.

Complexity and boundaries

While we can be confident that CBT has long term effectiveness (Wiles et al., 2016), openly accessible IAPT services frequently respond to needs from recurrent (often non-responding) and complex patients who need specialist care or are treatment refractory. Specialist services are often structurally inaccessible and organised around low volume provision. RWS has managed these frequent interface problems by calling a virtual interface meeting with clinical representatives from other providers to address both individual patient's needs and inter-organisational issues.

Summary

Delivering IAPT has been a herculean undertaking that every year delivers access to evidence-based psychological therapy to nearly 3% of the English population. Over 50% of those treated make a recovery giving a substantial return on investment with benefits to the individual and society. At 2020 prices IAPT costs £1,011 per person and each person returning to work delivers a government saving of £13,382 with similar benefits for those retaining work and recovering productivity.

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Investing in mental health literacy

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Introduction

In this paper we offer a framework for systematic thinking about health literacy and discuss important issues in relation to mental health.

When considering mental health, the World Health Organisation's definition is a useful starting point for considering literacy in this health field:

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.¹

However, caution is needed here. This definition has been lauded for moving away from the conceptualization of mental health as a state of absence of mental illness but also criticised for potential misunderstandings when it identifies positive feelings and positive functioning as key factors for mental health since “regarding well-being as a key aspect of mental health is difficult to reconcile with the many challenging life situations”².

1- <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>

2- Galderisi S, Heinz A, Kastrup M, Beezhold J, Sartorius N. Toward a new definition of mental health. World Psychiatry 2015; 14(2): 231-3.

Health literacy, according to Don Nutbeam: is *“the capacity to obtain, interpret and understand health information and services in ways that are health enhancing. It involves the cognitive and social skills which determine the motivation and ability of individuals to gain access, to understand and use information, in ways which promote and maintain good health”*³.

For the National Library of Medicine, health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.⁴

The theme “investing in mental health literacy” can be seen from various perspectives. “Literacy” describes a state which follows a process. The process is formal or informal learning of the learner or formal or informal education. Formal education needs to be organised and delivered (implemented) and thus can be seen as an “investment” of man-power, brain-power, resources and money. Who is investing in mental health literacy? Are patients doing it? Are health professionals? Or are other key players taking part in that role, such as educators or health policy makers? Wouldn’t that be the responsibility of health authorities or politicians? What is the role of the whole community in its vision towards mental health literacy?

Issues for mental health literacy

On the individual level, mental health literacy can contribute to an understanding of one’s own personality as well as the personality of others. Resulting from it, the individual might be empowered to better understand the actions and motivations of the immediate “other” and might thus be strengthened in its mental resilience. Depending of the cultural, the social and the spiritual environment individuals (lay-persons) should acquire or be empowered to attain a general understanding (“education”) of how persons with mental disturbances might feel and what help they might need. Restrictions apply particularly with regard to the persons intellectual capacities and the danger of being over-occupied with psychic issues.

Health services have an obligation to be literate about the needs of the patients they seek to serve. Moreover, health practitioners have to take account of how a population itself considers mental health as a continuous state from normality to an illness state, and how mental wellbeing can be promoted from primary care and community services.

Health literacy is in part related to educational and motivational attainment, since it is not only related with the ability of individuals to gain access to the health information but to understand and use it. In addition, and importantly, it is about the stigma associated with seeking help for mental health problems. Health literacy is critical for patients’ confidence in themselves and the services they seek (or often do

3- Nutbeam D. Health promotion glossary. Health Promot Int 1998; 13(4): 349-364.

4- <https://www.ncbi.nlm.nih.gov/mesh/?term=health+literacy>

not seek) to access. Evidence also suggests that vulnerable and disadvantaged people are usually at risk of limited health literacy.^{5,6}

For health professionals and health system managers, it is necessary to consider a wide range of issues. It is common for health professionals to have some ideas about factors affecting patient help-seeking behaviours⁷, including the significance of individual personality and their sense of resilience. Many of us may also be able to apply principles of health promotion to enhance patient mental health literacy. But we need to do much more than this. Individuals with mental health disorders use several sources to gain information about their health and illness, including that of internet in order to make appropriate health decisions, known as *eHealth literacy*. Evidence suggests the eHealth literacy is low in several settings, and recommendations to improve it and access suitable information have been reported^{8,9}.

In addition to awareness of stigma in the perceptions of patients and carers¹⁰ and also (far too commonly) in the minds of health professionals themselves¹¹, health care providers need to appreciate the multitude of different ways in which health, disease and mental illness are understood across ethnicities and cultures. We need to be aware of patient beliefs and concepts about health and illness, including their religious and spiritual beliefs, and the idioms they may use in expressing their distress¹², and ask them to what extent they have understood, critically appraised and use the information they have found; and whether they are capable of using this information to make appropriate decisions to maintain or improve their health. We need also to reflect on our own views about the aetiology of mental illness, most often a combination of biological, psychological and social factors, and consider how these may agree with or differ from our patients' perspective on the determinants of mental illness¹³. This communication and motivation process is anticipated to improve the doctor-patient relationship and enhance the therapeutic effect of the consultation.

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12- Nichter M. Idioms of distress revisited. *Cult Med Psychiatry*. 2010;34:401-16.

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Awareness of mental health stigma is part of the work needed to address mental health literacy as broadly as possible. This includes not only primary health care services, but also other population-based services that can develop positive messages towards mental health including mass-media¹⁴. It is important to consider the role of health professionals in education at different society levels, including school or institutes¹⁵. Existing evidence has shown this positively impacts on population views towards mental health¹⁶.

We also need to be aware of the impact of the health systems within which health care providers are operating. These are radically different in high- and low-resource settings, or in fee-for-service versus open-access systems. Therefore, the health literacy required of both health professionals and patients in successful navigating these systems will also be radically different, depending on the setting.

Case studies

Experiences in high-income settings

Conducted in north-west England, the *AMP programme* was designed to enhance mutual health literacy between health providers and service users in four disadvantaged localities, with a focus on the mental health needs of older people and minority ethnic populations. This involved a multi-faceted model with three elements: community engagement, primary care quality and tailored psychosocial interventions. Community engagement involved information gathering, community champions and focus groups and a community working group. Primary Care teams were offered an interactive training package including knowledge transfer, systems review and active linking. A culturally sensitive wellbeing intervention was tested for feasibility and acceptability for ethnic minority and older people¹⁷. The combined effects of the model included enhanced awareness of the psychosocial intervention amongst community organisations, and increased referral by GPs. Primary care practitioners valued community information gathering and access to the AMP psychosocial interventions¹⁸.

Two *experiences from Catalonia* are presented here, as example of coordination from different services to achieve a better knowledge of mental health literacy and avoiding stigma.

14- Rubio-Valera M, Fernandez A, Evans-Lacko S, Luciano J V., Thornicroft G, Aznar-Lou I, Serrano-Blanco A: Impact of the mass-media OBERTAMENT campaign on the levels of stigma among the Catalan population, Spain. 2015.

15- Casañas, R., Arfuch, V., Castellví, P. et al. "EspaiJove.net"- a school-based intervention programme to promote mental health and eradicate stigma in the adolescent population: study protocol for a cluster randomised controlled trial. *BMC Public Health* 18, 939 (2018). <https://doi.org/10.1186/s12889-018-5855-1>

16- Aznar-Lou et al. *BMC Public Health* (2016) 16:127 DOI 10.1186/s12889-016-2815-5

17- Lovell K, Lamb J, Gask L, et al. Development and evaluation of culturally sensitive psychosocial interventions for under-served people in primary care. *BMC Psychiatry*. 2014;14:217. Published 2014 Aug 1. doi:10.1186/s12888-014-0217-8

18- Dowrick C, Bower P, Chew-Graham C, et al. Evaluating a complex model designed to increase access to high quality primary mental health care for under-served groups: a multi-method study. *BMC Health Serv Res*. 2016;16:58. Published 2016 Feb 17. doi:10.1186/s12913-016-1298-5

- *OBERTAMENT.org* (Openly): A mass-media campaign in Barcelona to reduce mental health stigma, organised from a mental health population-based institution. It has different supports from education and health organisations. It has proved effective in reducing stigma among the general population¹⁹.
- *Espaijove.net* (Young Space): a web and on-site initiative based in Barcelona, with different sources available for adolescents and young people, with the main aim to increase literacy about mental health and avoid stigma²⁰. The initiative integrates education on schools and institutes with collaboration of health professionals, including validated questionnaires for this specific population²¹.

Experience in non-western cultures

In the *Republic of South Sudan*, particularly in rural areas, people often have a very different understanding of mental health. A person presenting psychopathology would rather be regarded as being a victim of “juju”, a kind of voodoo, than exposing a psychiatric disorder. They would tend to turn to a juju-healer, usually addressed as “doctor” there. A physician, rarely available for village dwellers, would have to be in such high esteem that patients would expect him to be “more powerful” than the magician.

However, the question arises to which extent western trained health personnel, organisations, sponsors and governments are entitled to impose a western understanding of mental health and psychiatry there. As a rule, in these rural areas there are either no health services at all or only non-physician health workers. If endeavours for investing in mental health literacy are undertaken at all, they must be undertaken with great respect, empathy and wisdom, since the health worker will not stay in the village but the patient and the healer will.

Conclusions

Health literacy can be improved, with the awareness and involvement of different key stakeholders in the community, from policy makers to educational services.

Investing in mental health literacy is essential, but – as we have explained here – it is also a complicated process that requires not only a family doctor with high communication and motivation skills, but also awareness of the skills that mentally-ill people need to acquire for its supervision and empowerment. It

19- Rubio-Valera M, Fernandez A, Evans-Lacko S, Luciano J V., Thornicroft G, Aznar-Lou I, Serrano-Blanco A: Impact of the mass-media OBERTAMENT campaign on the levels of stigma among the Catalan population, Spain. 2015.

20- Casañas, R., Arfuch, V., Castellví, P. et al. “EspaiJove.net”- a school-based intervention programme to promote mental health and eradicate stigma in the adolescent population: study protocol for a cluster randomised controlled trial. *BMC Public Health* 18, 939 (2018). <https://doi.org/10.1186/s12889-018-5855-1>

21- Castellvi, P.; Casañas, R.; Arfuch, V.-M.; Gil Moreno, J.J.; Torres Torres, M.; García-Forero, C.; Ruiz-Castañeda, D.; Alonso, J.; Lalucat-Jo, L. Development and Validation of the EspaiJove.net Mental Health Literacy (EMHL) Test for Spanish Adolescents. *Int. J. Environ. Res. Public Health* 2020, 17, 72.

is not simply a matter of ‘educating’ patients to see their problems the same way that doctors do. It is necessary to consider the perspectives and the knowledge capacity of patients, as well as the views of health care providers, and we also need to understand the impact of health systems.

Investing in mental health literacy in non-western cultures needs to be handled with respect for local belief-systems, particularly in the face of lack of scientific knowledge and weak theories of western medicine regarding functional disorders.

To take this forward, we recommend adopting a methodological approach from the viewpoint of implementation science. Normalization Process Theory (NPT), which some of us have co-developed and used extensively, is a valuable framework within which to develop and assess the implementation process of initiatives for investing in mental health literacy. The four principal constructs or areas of work of NPT are: coherence (sense-making work), cognitive participation (engagement work), collective action (enacting work), and reflexive monitoring (appraisal work)²².

This type of framework will allow researchers, clinicians, policy makers and – most importantly – people with lived experience of mental distress, to work together to establish how we can invest most effectively in mental health literacy.

22- <http://www.normalizationprocess.org/>

Tackling Stigma and Social Isolation to Promote Access to Mental Health Care and Better Mental Health for All

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Key messages

- By 2030, policy measures need to reverse the trend that predicts increasing disability due to mental illness
- Although effective treatment and prevention is available, most people do not receive it, partly due to prejudice and discrimination. A new approach to anti-stigma campaigns and psychological first aid skills is needed.
- Loneliness and social isolation are becoming increasingly important issues. Investment in connecting people is needed.

Introduction

World Mental Health Day 2020's goal, 'Mental Health for All: Greater Investment – Greater Access', cannot be achieved unless we address the discrimination and social isolation faced by people with mental

illness. Public attitudes towards mental illness are ill-informed and mainly negative. This includes blaming the person for the illness and expecting that an affected person cannot fulfil responsibilities at home or work. These negative attitudes, or stigma, may be experienced as beliefs about the attitudes of others (perceived stigma), or as a person's own thoughts and beliefs about mental illness (personal stigma). These beliefs can easily result in discrimination, such as an unwillingness to work with persons with mental illness, or opposition to someone with mental illness marrying into the family. Stigma can also result in shame. A person or their family may be unwilling to ask for help, even when gaining access to treatment and care can make a big difference to the outcome.

Mental health stigma

The majority of people are living to an older age, and this is one of humanity's major achievements. There are many initiatives to ensure that we all are having a healthier life that is fulfilling and enriching. But this dramatic increase in average life expectancy in the 20th Century is not shared by people who suffer from serious mental health illness.

According to the 2006 Global Burden of Disease estimates, by 2030, the three leading causes of burden of disease will be HIV/AIDS; mental illness, particularly unipolar depressive disorder; and ischaemic heart disease. Unipolar depressive disorder was ranked 4th as a leading cause of disability in 2002 and will rise to the 2nd most common cause of disability by 2030. Epidemiologists also projected that self-inflicted injury will rise as a disease burden from a rank of 17 in 2002 to 14 in 2030. This burden of mental health disability needs to be addressed and the burden arrested or reversed. We need to urgently invest in mental illness prevention and mental health promotion.

Most excess mortality in people with mental ill health is attributed to preventable conditions such as metabolic syndrome including obesity, hyperlipidaemia, hypertension, diabetes mellitus and high-risk behaviours such as tobacco smoking, physical inactivity and risky sexual behaviours. Perhaps if the people concerned were not experiencing a stigmatising mental health condition, the outcome would be different

The evidence tells us that people with a mental illness do not benefit from the improved technology, global wealth and advances in medical science partly because of the labelling of the mental health condition, resulting in prejudice and exclusion. Many people globally, irrespective of country, receive little or no treatment for their mental disorder, the so called 'treatment gap'. The treatment gap is approximately 70% in low and middle income countries, and can be as high as 90%. Even in high income countries the gap ranges from 52% to 74%. Mental health stigma and discrimination make a significant contribution to this global treatment gap.

Although there are effective treatments for mental disorders such as anxiety, depression, bipolar disorder and schizophrenia, many people who have mental illness do not receive evidence based treatment because of stigma, dissatisfaction with previous services, and a lack of awareness of the benefits of treatment. Active engagement with citizens and the community to tackle these factors is required. Services need to be re-designed with stigma reduction in mind. Mental health workforce training should actively encourage stigma reduction practices. The population from childhood onwards should have access to mental health literacy.

Government needs to play a role. Public policies and public health systems need to be organised so they can effectively tackle mental health issues by ensuring that regulations and policy align with expected standards of good practice in mental health promotion and mental illness prevention and treatment. The poor practice and funding across a range of systems designed to address mental health could be improved by the routine employment of mental health advocates by mental health service providers. This role is likely to be filled most effectively by recruiting people with lived experience of mental illness. We therefore need a new approach of embedding anti-stigma campaigns into day to day life and clinical practice.

First aid for physical health emergencies is available to the many. Defibrillators are available in many public places and all employers have protocols to follow to deliver physical health first aid. This is not the case for psychological first aid, even though training is freely available with evidence that shows it works and can reduce both the effects of mental illness and stigma.

We are calling on governments and policy makers to invest in providing psychological first aid skills to their population. We are calling on citizens to demand access to psychological first aid as a priority to decrease the effects of and the stigma associated with mental ill health.

Social isolation and loneliness

The current coronavirus pandemic has highlighted the need to address loneliness and social isolation, not only for the well-being of the elderly and the general population but also for those who have a mental illness.

There are many definitions of loneliness. Simply put, it is a subjective negative feeling of being alone. Social isolation is defined by the number of interactions a person has with others. It may or may not be accompanied by loneliness.

Nearly one third of older adults experience loneliness and social isolation. This is associated with physical and mental health problems including high blood pressure, decreased levels of exercise, poor quality sleep and insomnia, poor vision, feeling low, describing poor quality of life, increased rates of smoking

and alcohol use, poor diet, narrowing of social networks, increased thoughts of suicide, worsening cognitive abilities, and poor compliance with medication. Loneliness is not usually explicitly addressed by support services, even in those for older adults living in nursing homes.

Asking about loneliness should be part of routine wellbeing assessments. It is relatively simple and easy to do. There are loneliness scales available and one called ALONE is currently being validated for professional use and covers areas such as: *“Do you think anybody would want to be your friend?”*; *“Are you lonely?”*; *“Are you an outgoing and friendly person?”*; *“Are you feeling upset or sad?”*.

An investment in connecting people will decrease rates of loneliness and improve mental and physical wellbeing. This can be accomplished by increasing the use of technology including robots and through social interventions such as providing opportunities for volunteering, befriending, supporting engagement in adult pursuits. Investment in well-being workers and social prescribers can support individuals to prevent and address loneliness. Providing resources to Community Mental Health Services will enhance the services provided to those people with a diagnosed mental illness to maintain community connectedness.

Investment in mental health should consider the whole system pathway from mental health promotion, prevention and treatment by addressing mental health stigma and social connectedness at its heart in order to improve quality of life and outcomes.

Conclusion

Together, we must resolve to end stigma and discrimination related to mental illness. High resourced countries have much to learn from low resourced countries and vice versa. Prevention is key and together, with combined resources, we can break down the walls of social disconnectedness. As noted above, we must seek to invest in the mental health welfare of all people. World Mental Health Day serves as a reminder that we are all neighbors and part of a larger community.

To this end, let us resolve that by 2030, we will no longer be talking about stigma in mental health because these disorders will be not viewed as different than other medical conditions; that people everywhere will be able to receive evidence-based treatment for mental health conditions, without prejudice or discrimination; and investments now in averting loneliness and protecting at risk individuals will be in place everywhere. This should be our public health mandate going forth.

By 2030, policy measures need to reverse the trend that predicts increasing disability due to mental illness

Although effective treatment and prevention is available, most people do not receive it, partly due to prejudice and discrimination. A new approach to anti-stigma campaigns and psychological first aid skills is needed.

Loneliness and social isolation are becoming increasingly important issues. Investment in connecting people is needed.

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Investing in improving access to child mental healthcare in South Africa

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Key Messages

- Adopt a social justice approach to child mental health that recognises that mental health outcomes are associated with social and economic factors
- Investment in mental health must extend beyond psychosocial programs and incorporate indigenous concepts where necessary
- A collaborative approach is needed – interventions must extend beyond clinics into schools, communities and the economy.
- Intervene early and adopt a lifespan approach
- Create systems to ensure that policy translates into practice

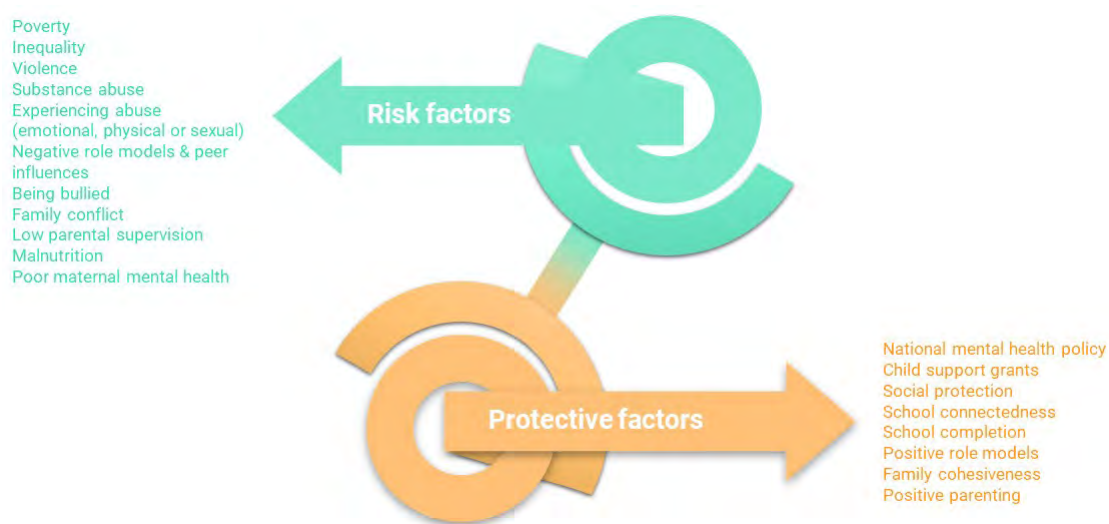
Introduction

Child mental health remains a much neglected area worldwide despite local and international policies promoting the need to focus on child mental health. This is more so in low and middle-income countries like South Africa where 10 – 20% of children and adolescents may experience mental health problems.¹ South African research has demonstrated that social and economic factors – such as poverty, illness and violence – further influence and exacerbate mental health outcomes.² South Africa is amongst the most unequal nations in the world with regards to distribution of wealth and resources. It is also a country with some of the highest rates of violence in the world. This combined with the high rates of poverty and unemployment places many children at risk of domestic violence, substance abuse, sexual abuse and neglect. The prevalence of HIV in the population has led to millions of children being without parents and at further risk in child-headed households. The country is home to many refugees whose children face discrimination and are often denied access to school and healthcare services. Gender-based violence extends to children as well. While young boys are victims of all forms of violence, there are high

1- Kieling C, Baker-Henningham H, Belfer M, Conti G, Ertem I, Omigbodun O, et al. Child and adolescent mental health worldwide: Evidence for action. 2011. *The Lancet*, 378(9801): 1515-1525.

2- Hunt, X., Skeen, S., Honikman, S., Bantjes, J., Mabaso, K.M., Docrat, S. & Tomlinson, M. Maternal, child and adolescent mental health: An ecological life perspective. In Shung-King M, Lake L, Sanders D & Hendricks M (eds). *South African Child Gauge* 2019. 2019. Cape Town: Children's Institute, University of Cape Town.

levels of violence, especially sexual violence including rape, perpetrated against girls and young women. The economic cost of sexual, physical and emotional violence perpetrated against children in SA, and neglect of children – including disability- adjusted life-years lost due to death and ill health, reduced earnings and welfare costs – is estimated as being ZAR196 billion, or 4.9% of SA’s gross domestic product.³ The risk for children is cumulative with functioning (or the lack thereof) in one area impacting on another cascading across the lifespan starting in the antenatal period through to adolescence.² This is best evidenced by the results from the National Youth Risk Behaviour Survey where being older, in higher grades, bullied and binge drinking in the past month, being a gang member and hit by a partner in the past six months, ever been forced to have sex, ever had sex, having had one or more sexual partners in the last three months, ever planned to attempt suicide and having made one or more suicide attempts were significantly associated with feelings of sadness or hopelessness. However a significant number of learners experienced similar stressors but did not report feelings of sadness or hopelessness possibly due to the positive contextual factors experienced by these learners, that is contextual factors related to relationships like family cohesiveness, parental supervision and school connectedness.⁴



Objectives

It is clear that South African children are vulnerable to developing mental health problems if these are not addressed for early on in the lifespan. Research and interventions for child mental health are urgently needed.

3- Richter, L., Mathews, S., Kagura, J., & Nonterah, E. (2018). A longitudinal perspective on violence in the lives of South African children from the Birth to Twenty Plus cohort study in Johannesburg-Soweto. *South African Medical Journal*, 108(3), 181-186. doi:10.7196/SAMJ.2018.v108i3.12661

4- James, S., Reddy, S.P., Ellahebokus, A., Sewpaul, R. & Naidoo, P. The association between adolescent risk behaviours and feelings of sadness or hopelessness: a cross-sectional survey of South African secondary school learners. 2017. *Psychology, Health & Medicine*, 22:7, 778-789, doi: 10.1080/13548506.2017.1300669

South Africa has a National Child and Adolescent Mental Health Policy Framework that was developed in 2003 to provide strategic guidance in this area. It focuses on primary care and intersectoral coordination to build resilience amongst children, adolescents and their families. However this vision has not translated downwards to broad scale interventions.⁵ In fairness, the South African government has for a number of years been providing a Child Support Grant. There are feeding schemes running in thousands of schools and the government seeks to improve access to education, housing and healthcare in policy and practice amongst other social justice interventions. However the issues related to mental health need more attention.

A number of small localized interventions at different stages of the developmental lifespan have/are currently in place that have produced positive impacts on child mental health. Some case studies are highlighted here.



Current approaches to improving mental health for children in South Africa

The Perinatal Mental Health Project (PMHP) has provided a package of integrated mental health services for pregnant and postnatal (perinatal) women in collaboration with the Departments of Health and Social Development and the NGO sector. The services consist of several components that include

5- Mokitimi, S., Schneider, M. & de Vries, P.J. Child and adolescent mental health policy in South Africa: history, current policy development and implementation, and policy analysis. *Int J Ment Health Syst* 12, 36, 2018. <https://doi.org/10.1186/s13033-018-0213-3>

universal health promotion and prevention, and capacity development. The PMHP adopts a universal approach from the first antenatal visit where women are provided with basic education and materials on maternal mental health and are screened for mental health conditions. Supportive counseling is provided where needed. Additionally the mental health needs of frontline workers are also addressed, including mental health literacy, capacity-building and support for the mental health of staff, themselves.⁶

A similar approach is adopted by the Ububele Baby Mat project. This project aims to support mothers by encouraging reflective functioning so that they can focus on their babies, similar to the indigenous practice of Umdlezane. The practitioners meet with the dyads (psychologist + social worker) informally, on a mat in the middle of the clinic and discuss their concerns in full view of other mothers who are waiting to have their babies weighed and immunized. The facilitating of wondering, *mhlawumbe* in isiZulu, encourages deeper thought about the meaning of the presenting problem. If the Baby Mat practitioners identify an attachment difficulty or if the client presents with any at-risk behaviour, a referral is made for Parent-Infant psychotherapy. The Ububele Educational and Psychotherapy centre runs a therapeutic pre-school for children from the Alexandra township and surrounding areas which provides them with a holistic and enriching ECD experience, as well as therapy for those who need it. They provide training courses in psychosocial care and support for those who work directly with children (psychotherapists, social workers, social auxiliary workers, nurses, pre-school teachers, child care workers and lay counselors). Most community-based childcare workers interact with up to 20 children each day, and so training 100 childcare workers reaches 2 000 children more effectively daily (see www.ububele.org).

The Sinovuyo kids in South Africa parenting programme provides sessions to parents of 2-9 year olds over a period of 12 weeks that focusses on building a strong parent–child relationship and equipping parents with positive discipline strategies. The programme uses the analogy of a “rondavel of support” for this: helping parents first build strong walls (i.e. a loving and warm relationship) before constructing a roof (i.e., manage difficult behaviour positively). The programme has been used with the with 296 parents in the Nyanga and Khayelitsha townships (Western Cape, SA) and showed promising results.⁷

The National Association of Child Care Workers has developed the Safe Park model which is currently being replicated across South Africa by over 20 organisations. This initiative aims to provide safe spaces for children to play where they have access to adult supervision. The model can be implemented formally via an organization where land may allocated by local authorities and equipment is provided or informally where resources are scarce. Communities can be proactive about creating these spaces with volunteers. The Safe Parks model offers healing, support and belonging to all children and works to countering the stigma countering the stigma that children and families affected by the HIV/AIDS

6- Honikman S, Van Heyningen T, Field S, Baron E & Tomlinson M. Stepped care for maternal mental health: A case study of the perinatal mental health project in South Africa. 2012. *PLoS medicine*, 9(5): e1001222;

7- Van Niekerk, A. & Mathews, S. Child violence, injury and safety: A challenge for child health. In Shung-King M, Lake L, Sanders D & Hendricks M (eds). 2019. *South African Child Gauge* 201 (pp.21-37). Cape Town: Children’s Institute, University of Cape Town

pandemic experience (see <http://www.naccw.org.za/isibindi/safe-parks>). Similarly a Safe Bus model is used where community members walk children to school.⁷

The South African Depression and Anxiety Support Group (SADAG) was recently recognized for its introduction of speaking books to promote health amongst children. Speaking books are available in English and indigenous languages (65 languages) and educate children on various topics ranging from health education and disease prevention through to mental health and social development (65 topics, see <https://speakingbooks.com/our-library/>). SADAG also provides regular psycho-educational workshops and lectures aimed at promoting mental health amongst adolescents in particular. SADAG has been particularly effective in mitigating suicide amongst adolescents in South Africa (see http://www.sadag.org/index.php?option=com_content&view=category&id=111&Itemid=136).

The Helping Adolescents Thrive (HAT) project is amongst the most recent interventions which aims to aims to promote and improve adolescent mental health by providing psychosocial interventions to enhance adolescents' cognitive, emotional and social capabilities and skills in low resource settings, applicable for use in less resourced settings through different delivery platforms. The HAT intervention is targeted at adolescents (10 – 19-years old). HAT seeks to provide support to governments and other partners to implement the package thereby helping build capacity and monitoring implementation.²

In the Kwazulu-Natal region the Qhawekazi Empowerment Programme has been effective in reducing the HIV and TB incidence and unwanted pregnancies in young women aged 19 to 24 years using a Cash plus Care intervention. In this behavioural change initiative a conditional incentive is provided in the form of cash or vouchers. Part of the condition is to attend health/ empowerment sessions and to take up HCT and TB screening once every 6 months. The care component is inclusive of the monthly health/ empowerment/ life skills session. Additionally care also includes the support given at the health care facility (see <https://www.cindi.org.za/cindi-projects/qhawekazi.html>).

Conclusion and recommendations

The case studies provided represent a few of the many initiatives currently addressing child mental health in South Africa. They were specifically chosen as they represent examples of initiatives which represent the WFMH theme of greater investment, greater access. Several recommendations for South Africa and other low and middle-income countries stem from case studies such as these. It can be noted from the initiatives that advocating for child mental health requires a life span approach that starts from pregnancy through to adolescence.

Figure 1 is taken from the 2019 South African Child Guage Report² and demonstrates the actions necessary in a lifespan approach to improve access to child mental health.



From: Hunt et al., Maternal, child and adolescent mental health: An ecological life perspective. In Shung-King M, Lake L, Sanders D & Hendricks M (eds). *South African Child Gauge* 2019.

Further what is clear from the interventions suggested in Figure 1 is that mental health requires an integrated approach. As mental health is impacted greatly by environmental conditions like poverty, inequality, violence, etc it is necessary to adopt a social justice approach that recognises that mental health outcomes are associated with social and economic factors. Interventions must extend beyond psychosocial programs to all elements of care that includes interventions for structural challenges. A collaborative approach is needed that extends into schools, communities and the economy. Finally it is a good start for a country to have a child mental health policy but it is of even greater importance to create systems to ensure that policy translates into practice. This has been an ongoing message but in the absence of policy or commitment to policy, the theme of greater investment, greater access is still possible through NGO's, community organisations and individuals. The Mental Health Innovation Network - Africa provides an excellent open access platform for the sharing of such initiatives (see <https://www.mhinnovation.net/organisations/mental-health-innovation-network-africa-mhin-africa>).

Activating communities – investing in the mental health of older adults

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The scale of the problem

The world population aged over 60 is estimated to become 2 billion by 2050¹. In the same year, 30% of the population residing in the European Union area will be over 65 years of age and 10% will be over 80 years of age. The growth of the older adults' number will be rapid in middle and low-income countries, with enormous consequences for these vulnerable economies². In the less developed regions, by 2050 older persons are expected to account for a fifth of the population. The high mortality rate of older adults because of COVID-19 will not change this estimation. Many people live a long and happy life without any mental health problems and, despite the widespread image that older people are sad, slow, and forgetful, mental disorders are not an inevitable consequence of aging. Nevertheless, one of the possible negative consequences of the rapid aging of the world population is the increase of the number of older adults with mental disorders, which is likely to overwhelm mental health systems in all countries² as they are now.

At least 20% of people aged 55 and more may suffer from mental health problems. Biological changes can interfere with the functioning of the brain. Social change can lead to personal isolation or devaluation. Somatic diseases are also important factors in breaking an already fragile psychic balance. Mental disorders can exacerbate the symptoms and functional disabilities associated with medical illnesses and increase the overall cost of care³.

Mental health problems can have a significant impact on an older adult's ability to carry out the basic activities of everyday life and to reduce the person's independence, autonomy and quality of life. The first step to reduce these negative consequences is simply by making a proper diagnosis. Unfortunately, mental health problems are not often diagnosed and treated. Many older adults struggle without proper help, or simply without any help at all⁴.

1- United Nations. World Population Ageing 2009. UN, New York, 2009.

2- World Health Organization & Alzheimer's Disease International. Dementia: a health public priority. WHO, Geneva, 2012.

3- American Association for Geriatric Psychiatry. Geriatrics and mental health—the facts (http://www.aagponline.org/prof/facts_mh.asp).

4- United States. Public Health Service. Office of the Surgeon General. Mental Health. A report of the Surgeon General. NIMH, Washington, D.C., 1999. <http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS>. Accessed on 26 may 2013.

There are many prejudices about the meaning of mental illness. Many older adults today still see mental illness as a sign of weakness and are unlikely to admit their difficulties. In addition, symptoms of dementia and depression are too often considered as part of normal aging.

Despite the significant and increasing number of well-prepared professionals, a well-developed body of knowledge, and a large number of caregivers, it is becoming more and more difficult to persuade the authorities to invest in the overall older adults' mental health. This is not consistent with the growing demographic numbers of this age group in the population. The distribution of skilled mental health resources for caring older adults among the different regions of the world and income groups is significantly uneven and, in many countries, they are even scarce.

In this context, the absence of a comprehensive policies and targeted programs for the older adults' mental health is not surprising. Despite the improvement in educational programs, the recruitment of new human resources to work in favor of the older adults' mental health is becoming increasingly difficult. Even in Europe, where services are considered to be better developed, between 2011 and 2014, there was a 3% reduction in the median number of total psychiatrists per 100,000 inhabitants and an increase of only 1% in the median number of nurses per 100,000 inhabitants: and Europe is still the WHO region with the most skilled human resources in mental health, and the region of the world with the highest rate of older adults⁵.

Other health professions working with older adults are also affected. The lack of psychologists specialized in older adults' mental health severely reduces training opportunities for psychologists and is an obstacle to the development of positive attitudes towards the choice of a career with the older adults. The low availability of specialized psychologists also reduces the availability of supervision of non-specialized psychologists providing support to older adults. However, the lack of adequate resources is not the only factor limiting the recruitment of adequate health personnel. Negative prejudices among the general public, decision-makers and health care providers, including doctors, have long contributed to making professions related to the care of older adults less attractive than other specialties.

While in some parts of the world professionals interested in this area of care argue for designing specific services to care older adults, in some countries, there is a movement to close specific mental health services for older adults, considering that this exclusivity reinforces segregation within the health system. This specificity was originally recognized as being necessary to treat patients with multiple co-morbidities and special needs, and for which there was a tendency not to consider them as a priority adult population. Developing services should be closely matched with the resources available, existing health systems and prioritization. While developing specialist services at a national level may be appropriate for some health systems and countries, integration of old age care and old age mental health care into primary health services may be more appropriate in others.

5- World Health Organization. Mental Health Atlas 2014. WHO, Geneva, 2015.

The high mortality rate of older adults because of COVID-19 pandemic certainly may be explained by the high frailty level of these persons as well by the presence of multimorbidity conditions in this specific group. But the present organization of general care – and not only in mental health settings - for older adults has a high responsibility too, besides the huge personal sacrifice and dedication of the all professionals caring these persons. The organization of services for older adults suffering from general and mental disorders needs vast improvement. There has been little attention on the needs of older adults suffering from anxiety and affective disorders, with suicidal ideation or with psychotic disorders, while persons with dementia are also in need of particular care. A successful care system for older adults starts when it can assure access to care for all in need. For this, it will be necessary to improve the perception of the older adults' value for communities. Activating communities maybe the clue for future investments in the mental health care for older adults.

Dignity in mental health care

Dignity in mental health care and social support for older adults – a complex and hard to define concept - is one of the many dimensions of the global human dignity. It is the base for an ethical approach to the promotion of someone's well-being, besides the presence of a mental health problem. When dignity in mental health care is promoted - including the protection against stigma, discrimination, violence and older adults abuse and neglect - the chances of a better clinical outcome are higher. The dignity principle in mental health care sustains the legal and ethical framework to support older adults who may have lost their autonomy and independence as a result of mental health problems and other co-morbidities associated with old age and the ageing process^{6 7 8}.

A Human Rights framework specifically for older people with mental health problems is still missing. This is necessary because of the special vulnerability of this population by virtue of societal ageism, stigmatization, exclusion as well as the disability and dependency which mental illness in old age may confer. The following values should underpin such framework⁹:

- *Independence*: older adults with mental health problems have the right to contribute usefully to society and to make their own decision on matters affecting life and death. However, those who are not able to live independently, have the right to rely on others, for instance on community help.
- *Safety*: older adults with mental health problems have the right to live safely, with adequate food and housing, free of violence, abuse, neglect and exploitation.

6- Saxena S, Hanna F. Dignity- a fundamental principle of mental health care. Indian Journal of Medical Research. 2015; 142(4): 355-358

7- United Nations General Assembly. International Covenant on Economic, Social and Cultural Rights. United Nations Treaty Series. 16 December 1966.933:3

8- World Health Organization. Quality rights tool kit to assess and improve quality and human rights in mental health and social care facilities. Geneva: WHO, 2012

9- World Health Organization. Organization of care in psychiatry of the elderly: a technical consensus statement. WHO/MSA/MNH/MND/97.3. WHO, Geneva, 1997

- *Care and treatment*: older adults with mental health problems should benefit from family and community care and protection and have access to healthcare to maintain or regain their optimum level of function and well-being and prevent or delay deterioration.
- *Confidentiality*: older adults with mental health problems have the right to expect that information about them should be treated confidentially. The degree of any breach of confidentiality must be proportionate as well as necessary. This is culturally sensitive.

Good health and a life of good quality are recognized as fundamental human rights, in the respect of the human dignity. Older adults have the right of access to a range of services that can respond to their health and social needs. These needs should be met appropriately for the cultural setting and in accordance with scientific knowledge and ethical requirements¹⁰. Human dignity can be violated in multiple ways, such humiliation, instrumentalization or objectification, degradation and dehumanization. All these kinds of violations can be present during the clinical activity. Stigma and discrimination against older adults are important factors contributing to reduce the access to care to older adults.

Stigma and discrimination against older adults with mental disorders

All persons with a mental disorder (or who are being treated as such persons) shall be treated humanely and with respect for the inherent dignity of the human person. It therefore follows that the stigmatisation of people with mental disorders must be countered wherever it occurs. Since stigma against old age – independent from that against mental disorder – also occurs in many (although not all) societies, there is therefore a ‘double jeopardy’ for older people with mental disorders, and both issues need to be addressed in anti-stigma strategies for this age group. This stigma is unacceptable and everyone has the right to be protected from it. Counteracting stigma and discrimination is a duty of governments, NGOs, services, patients’ organizations, families, and communities. To be effective, they will need to work in partnership. Actions against stigma and discrimination of older people with mental disorders: - should be a priority of all, to achieve the state of physical, psychological and social well-being as defined by the Constitution of the WHO; it should form part of the promotion of good mental health by professional training and public education, and should be a major component of all levels of a health and social care programme¹¹. These actions will only result if all the community participate to this effort.

10- Katona C, Chiu E, Adelman S, et al. World psychiatric association section of old age psychiatry consensus statement on ethics and capacity in older people with mental disorders. *Int J Geriatr Psychiatry* 2009; 24: 1319-1324

11- WHO/WPA. Reducing stigma and discrimination against older people with mental disorders. WHO/MSD/MBD/02.3. WHO, Geneva, 2002

Dignity and social determinants of health

There is no good mental health in absence of good social, economic and physical environments. Mental well-being is an asset of individuals, communities and populations whose value can change throughout the life course, especially late in life. Someone's mental health is affected by a range of determinants throughout life, such the genetic heritage, personal experiences, and the environment in which the person lives.

Social determinants of health are the conditions in which people are born, grow, live, work and age and which are shaped by the distribution of money, power and resources at global, national and community levels¹². These social determinants are associated with mental disorders by contributing to its onset or course. Social inequalities are associated with increased risk of many common health disorders – including mental health disorders – and even of premature death.

Social determinants may play a role as risk factors for mental health problems (unemployment, poverty, inequalities, stigma and discrimination, poor housing, poor early years' experience, violence, abuse, drug and alcohol abuse, poor general health, caring duties), while others may be protective factors (social protection, resilience, social networks, positive community engagement, positive spiritual life, hope, optimism, good general health, good quality family interactions, positive intergenerational relationships).

By acting on social determinants of health, it is possible to contribute to promote the older adults' dignity and a better subjective mental health and well-being of older people, to build the capacity of communities to manage adversity, and to reduce the burden and consequences of mental health problems. Disadvantages because of mental health problems in old age damage the social cohesion of communities and societies by decreasing interpersonal trust, social participation and civic engagement¹³.

Recommendations

1. Governments at all levels should ensure that:

- social well-being principles are included in their mental health policies and programs and that older adults with mental illness and their families are included in the design and implementation of these policies and programs;
- there is an equitable and universal distribution of power and resources at global, national and local levels in order to satisfy the older population mental health needs;

12- de Mendonça Lima CA. Social determinants of health and promotion of mental health in old age. In: Bährer-Kohler S. Social Determinants and Mental Health. Nova Science Publishers, Inc, New York, 2011. Pp.: 203-213.

13- Searight HR, Gafford J. Cultural diversity at the end of life: issues and guidelines for family physicians. American Family Physician. 2005;71(3):515 – 522

- there is parity of funding to support promotion of mental health and the prevention and management of mental illness. United Nations, WHO and the World Bank should continue their collaboration to ensure parity of funding for mental and physical health;
 - there is specific policies and programs to reduce both stigma and discrimination against older adults with mental disorders in collaboration with other groups and individuals;
2. Local, regional, national and international associations and organizations of social and mental health professionals, service users, families and carers should be able to advocate for the promotion of social determinants of health and to denounce any attempt of the dignity in the care of older persons with mental health disorders;
3. The collaboration between primary care, secondary care, social care, mental health services users and their families, carers & communities, society, governments and NGO's, is the way to accelerate the delivery of the best possible mental health coverage and to improve the older population mental health and social well-being;
4. Institutions involved in education and training of all mental health and social care professionals working with older persons should include in all graduation and post-graduation curricula:
- different issues of prevention, care, treatment and rehabilitation in older adults mental health;
 - the development of skills to manage the global health and social dimension issues in old age;
5. Social isolation is a risk factor for poor mental health, which can affect older adults' self-esteem. Health and social care commissioners should ensure that there are policies, programs and facilities in place to identify and to help older adults at risk of social isolation;
6. Older women often face specific risks which increase their vulnerability both as sufferers of mental health problems and as care givers. Policies to support them and interventions to prevent mental health problems and isolation in older women must be strengthened.

How investment in primary care can promote access to mental health in primary care

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Introduction

Integrating mental health services into primary health care is a fundamental health recommendation. In the landmark 2008 report *Integrating Mental Health into Primary Care*, the World Health Organisation (WHO) and World Organisation of Family Doctors (WONCA) explained why investment in primary mental health care is so urgently needed. It improves mental health outcomes for patients by enabling better access to care, increasing detection and effective management of common mental health problems, and providing seamless care for patients with comorbid physical and mental health problems. It also has wider social, moral and political benefits, enabling social integration, reducing stigma and protecting human rights¹.

We can consider collaborative care as a fundamental reference for an efficient model for improving mental health care. Based on primary care, and integrating it with specialised professionals, collaborative care facilitates access, support development of interdisciplinary community interventions and prevent stigmatisation and isolation of people with mental disorders as treatment is offered as part of general health care.

Despite common beliefs, adequate investment in a primary mental health care is not simply a matter of providing relevant training to existing frontline workers. Sustained financing is also needed to enable the creation of a motivated workforce with a variety of relevant skills, ready access to affordable and reliable medicines and psychological interventions, appropriate information systems and a responsive service delivery system. This can only be achieved with high level political commitment to manage often uncomfortable trade-offs and disinvestments in other parts of the health economy.

In this paper, senior members of the WONCA Working Party for Mental Health provide updates on the current status of investment in primary mental health care in seven high-, middle- and low-income settings. We show how progress has been made in the past decade, but are aware that there is still a great deal more to be done.

High-income settings

In the United States, investment in primary care ranges from 5-10% of total health care spending: this includes the entire primary care team, not only family doctors and behavioral health specialists. Major roadblocks in the US health system - including geographic maldistribution and shortage of psychiatric professionals – mean that family doctors are the primary source of mental health care, especially for vulnerable populations and those who need care the most. The COVID pandemic and its devastating effects on communities further highlights the tremendous need for behavioral/mental health services,

¹ World Health Organisation and World Organisation of Family Doctors. *Integrating Mental Health into Primary Care: a Global Perspective*. Geneva, 2008.

and the importance of investment in frontline care². During the past decade, primary care practices have begun to form constellations of care, enhancing their roles of collaborative, integrative care and ensuring better access and equity for populations suffering from health care disparities³. On-going analysis at state levels is examining how legislative and regulatory efforts in certain states can achieve reallocation of resources to primary care.

Primary care consultations for mental health problems in Hong Kong have increased by more than 25% since the turn of the century^{4,5}. This increased access follows the Hong Kong government's investment in family medicine training posts and enhancement of mental health service in public primary care clinics. Training has engaged, enabled and empowered family doctors to diagnose and manage common mental health problems. Multi-disciplinary integrated mental health programmes have been established in primary care clinics throughout the territory. These programmes have enabled patients' easy access to psychological counselling by clinical psychologists or occupational therapists, and psychiatrist consultations in collaboration with family doctors in primary care. Funding for primary care research has also informed family doctors in Hong Kong on how to promote better access to mental health care⁶.

Saudi Arabia has seen sustained investment in primary mental health care. Almost half of all primary care centres now include mental health services. An innovative patient interview approach, the 5-Steps Model, has been validated by expert psychiatrists and family doctors⁷. To date 1200 family doctors and 847 nurses, working in over 1000 primary health centres, have been trained in this approach. Applied not only in Saudi Arabia but also in Egypt, Morocco, and Sudan since 2016, this has empowered staff to provide mental health care in busy clinics.

By contrast, mental health in primary care is rarely mentioned in Japan. Many Japanese suffer from the stigmatisation of mental illness, which is considered untreatable, and end their lives in an institution⁸. Despite having the highest share of people aged 80 and over (8.5% of the population) and the highest prevalence of dementia (25 per 1000 population)⁹, the mental health of caregivers is rarely addressed. Mental health support at work is limited, and the management of mental illness is not standardised. The suicide rate in this group is high. Additionally, under a fee-for-service system, cost-effectiveness is seldom considered, with unnecessary investigations and polypharmacy commonplace.

2- Petterson S, Westfall JM, Miller BF. Projected Deaths of Despair from COVID-19. Well Being Trust and Robert Graham Center. May 8, 2020.

3- <https://www.aafp.org/about/policies/all/mental-services.html>

4- Lee A, Chan K, Wun Y, Ma P, Li L, Siu P. Morbidity Survey in Hong Kong 1994. *HK Pract* 1995; 17: 246-55.

5- Lo Y, Lam CL, Lam T, Lee A, Lee R, Chiu B, Tang J, Chui B, Chao D, Lam A, Chan K. Hong Kong primary care morbidity survey 2007-2008. *HK Pract* 2010; 32: 17-26.

6- Chin WY, Chan K, Lam CL, Lam T, Wan E. Help-seeking intentions and subsequent 12-month mental health service use in Chinese primary care patients with depressive symptoms. *BMJ Open* 2015; 5:e006730

7- Al-Khatami AD. *A guide to Medical Teaching and Learning*. Partridge, Singapore, 2018.

8- Ando S, Yamaguchi S, Aoki Y, Thornicroft G. Review of mental-health-related stigma in Japan. *Psychiatry Clin Neurosci* 2013; 67(7):471-82.

9- OECD, *Health at a Glance 2019: OECD Indicators*, OECD Publishing, Paris, 218-219 and 224-225. <https://doi.org/10.1787/4d-d50c09-en>. 2019

The Japanese government declared mental illness a priority in 2011 and *OECD Reviews of Health Care Quality: Japan* (2015) recommended the establishment of primary care to secure high-quality mental health care¹⁰. However, government leadership and effective policy in this area remains lacking. In 2018, the WONCA Working Party for Mental Health in collaboration with local faculty successfully conducted a ‘Train the Trainers’ course in primary mental health care, exemplified as an investment in high-quality training. Furthermore in 2020, on receiving WONCA’s international accreditation, the Japan Primary Care Association founded a committee prioritising mental health. Although these are small steps, we hope significant strides will emerge.

Middle- and low-income settings

The Brazilian model of *Matrix Support*, where teams of specialized mental health professionals go to community based primary care units to work together with their interdisciplinary teams, is an excellent example of collaborative care in action. Having been implemented as part of two important changes in the Brazilian National Health System (the Family Health Strategy in Primary Care and the Psychiatric Reform in Mental Health), it has helped to develop integrated primary mental health care^{11 12}. But implementation of new public health policies is dependent on clear definition of desired changes and on stability and universality of policy systems. Policy decisions may often be unstable, especially in LMIC countries, and vary from region to region¹³. The Brazilian experience has shown the problems that can arise from variation in provision of adequate means to secure that changes are stable. These include payment, training, inputs and managers’ commitment to public policies. Being such a large country, with the biggest universal public health system in the world, Brazil is an example of how important it is to protect advances in public health, especially during stormy times of political problems.

Around 35% of the population of Nepal suffer from mental disorders. However, the budget allocated for mental health is insufficient: only 0.59 staff work in mental health per 100,000 population, of whom only 0.13 are psychiatrists¹⁴. At the community level, the provision of psychotherapy is negligible. To provide mental health services in primary health care, one should know how to diagnose and treat people with mental disorders; they must have strategies to prevent mental disorders. Primary health care workers must be able to apply key psychosocial and behavioral science skills, for example, interviewing, coun-

10- OECD, *OECD Reviews of Health Care Quality: Japan 2015: Raising Standards*, OECD Publishing, Paris, 38-41. <http://dx.doi.org/10.1787/9789264225817-en>. 2015

11- Athie K., Menezes ALA, Silva AM, Campos M. Delgado PG, Fortes S, Dowrick C. Perceptions of Health Managers and Professionals about Mental Health and Primary Care Integration in Rio de Janeiro: a mixed methods study. *BMC Health Services Research* 2016;16: 532.

12- Macinko J, Harris MJ. Brazil Family Health Strategy: Delivering Community-Based Primary Care in a Universal Health System. *N Eng J Med* 2015;372;23-2177-2181

13- Means AR., Kemp CG. et al. Evaluating and optimizing the Consolidated Framework for Implementation Research for use in low and middle income countries : a systematic review. *Implementation Science* 2020;15:17.

14- Rijal A. Mental Health Situation in Nepal and Priorities for interventions. *Health Prospect: journal of public health*. 2018 Apr 17(special issue):1-3.

selling and interpersonal skills, in their day to day work in order to improve overall health outcomes in primary health care. To implement this a lot of careful planning is needed. We must invest in the training of staff to detect and treat mental disorders, and reduce the overall reluctance of primary health care workers to work with mental disorders. This is especially needed in countries like Nepal, where psychiatrists are not available in remote places. Health care providers working in remote health care centers need training to develop skills to deliver better mental health care¹⁵. Those providers also need motivation in terms of salary, working conditions, updates in their current knowledge in mental health. Extra funds are urgently needed in Nepal to develop the existing structures and human resources to deliver best mental health care.

Mental, neurological and substance use disorders are prevalent in Africa, and most African health systems agree that optimal mental health outcomes are best achieved through integration of mental health services into the general framework of existing primary health care¹⁶. Provision of mental health services in primary care necessitates diagnosing and treating persons with common mental disorders, putting in place strategies to prevent mental disorders, ensuring that primary care workers are trained to apply key psychosocial and behavioural skills, and ensuring prompt referral of those who need specialized care. These activities and skills are dependent on a functional primary care system with adequate investment in workforce, training, pharmacological and psychological interventions and effective information systems. Unfortunately, these basic ingredients are notably missing in most African health systems^{17 18}. These deficiencies need to be urgently addressed. Investment directed at correcting these anomalies in primary health care systems across Africa will ultimately promote access to effective mental health care.

Conclusions

Regardless of setting, there remains an urgent need for sustained investment in primary care in order to achieve genuine improvements in mental health care. Active health policy and strong political will are necessary, but not sufficient. Effective, ongoing training for family doctors and other primary care staff is essential for the translation of policy to practice. So too is investment in the capacity of primary care services to enable longer appointments and continuity of care for patients needing ongoing support. We need effective care pathways between services, and improvements in referral processes, and provision

15- Gupta PP, Jyotsana P, Larrison C, Rodrigues S, Lam C, Dowrick C. Effectiveness of mental health community training on depression and anxiety to the health care profession working in rural centers of eastern Nepal. *J Family Med Prim Care* 2020;9:2416-9.

16- Charlson FJ, Diminic S, Lund C, Degenhardt L, Whiteford HA. Mental and Substance Use Disorders in Sub-Saharan Africa: Predictions of Epidemiological Changes and Mental Health Workforce Requirements for the Next 40 Years. *PLoS ONE* 2014;9(10): e110208. 8.

17- Bresick G, Christians F, Makwero M, Besigye I, Malope S, Dulliel L. Primary health care performance: a scoping review of the current state of measurement in Africa. *BMJ Global Health* 2019;4:e001496.

18- Onokerhoraye AG. Achieving Universal Access to Health Care in Africa: The Role of Primary Health Care. 2016, 20(3):30.

of emotional support for primary care staff themselves. We must enhance the referral process so that family doctors can easily access further support for people who are feeling suicidal.

Bringing mental health care into the fabric of primary care is essential. “This requires vision, alignment with a framework, and a method for holding key stakeholders accountable for person-centered outcomes.”

Access to secondary care needs investment

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Key Points

- Secondary services are needed as an integral part of mental healthcare services for patients with serious mental illnesses to be assessed and treated especially if they cannot be managed in primary care.
- Assessments must be culturally appropriate and sensitive so that those needing them can feel comfortable using them.
- Inpatient services also need to be safe, geographically and emotionally accessible, culturally appropriate so that patients and their families feel comfortable using them. These require adequate resources taking into account geopolitical health determinants.
- Globally the leading cause of disability and lost productivity is due to mental ill health, so reducing the impact by improving access can result in economic gains

Introduction

In healthcare across the world there are generally four levels of care-primary, secondary tertiary and quaternary. A majority of cases will be dealt with in primary or secondary care. Rarely people will need to go to tertiary or quaternary; these two are highly specialised centres. Depending upon the healthcare system available in a particular culture and society, individuals may access secondary care directly by seeing the specialists without recourse to primary care physicians. Secondary care is thus about specialist care and also about admission to psychiatry units whether they are based in acute or district general hospitals or separate psychiatric institutions. Secondary care is needed for many individuals even when community mental healthcare is well-running and well provided. In order to ensure that those who need it get the best and most appropriate care when they need it is vital.

Definition of secondary care

For the purposes of this article, secondary care is defined as medical care provided by specialist who may be trained in a particular specialty, organ, disease or a mixture of these. In many countries access to secondary care is controlled by primary care physicians. This is most likely to be provided in hospitals and will include accident and emergency, outpatients, maternity, child and adolescent, genitourinary, sexualhealth, psychiatric services, child and adolescent mental health services etc.

Background

In terms of secondary mental health services for the framework we refer to the Goldberg-Huxley model¹ which can be used in setting up secondary services. Goldberg-Huxley model combines bio- psychosocial approaches and proposes a pyramidal scheme arguing that a majority of psychiatric cases can be treated in the community. The original model was proposed 40 years ago and is a widely recognised pathway to mental health care. The refined model in 1995 suggests that about 20.8 adults per 1000 population per year will be in contact with specialist mental health services². O’Sullivan et al have highlighted that the Goldberg-Huxley model underestimated the utilisation of specialist psychiatric services in a geographical of Edinburgh³. Of course, there have been significant changes in the last 25 years in society and perhaps prevalence of psychiatric disorders. Consequently changes in services in the UK with inadequate funding, closure of old asylums, reduction in inpatient beds, disintegration of generic community mental health teams, dissolution of health and social care partnerships and the merger of mental health trusts and community trusts have added to problems.

Psychiatric institutions often get a bad press due to overcrowding, lack of privacy and problems of confidentiality. There is no doubt that many psychiatric institutions are indeed frightening places which further contribute to stigma. Pressure on beds and funding of secondary services can be a real problem in many countries.

Of the people who come into contact with secondary care services, a small proportion will require assessment by specialists and a smaller proportion will require admission to a psychiatric unit. Therefore, it is quite possible that those who get admitted are likely to have serious mental illnesses such as schizophrenia, bipolar disorders or illnesses which are chronic and refractory. In the past, asylums or psychiatric institutions offered asylum in the true sense of the word with giving people space to recover. Even thirty years ago in the UK, inpatients would have included patients with anxiety and moderate depression. There is no doubt that Institutionalisation did create major problems for the patients but also

1- Goldberg, D. & Huxley, P. (1980) *Mental Illness in the Community: The Pathway to Psychiatric Care*. London: Tavistock Publications.

2- Goldberg, D. (1995) Epidemiology of mental disorders in primary care settings. *Epidemiologic Reviews*, 17, 182–190

3- O’Sullivan, T., Cotton, A. & Scott, A. (2005) Goldberg and Huxley’s model revisited. *Psychiatric Bulletin*, 29, 116

the public image of psychiatry and consequently psychiatrists and other mental health professionals suffered tremendously. In the UK as in many other countries, it led to a shift to community mental health teams and community mental health centres creating a welcome shift. However, the general assumption by the funders was that community services can be provided cheaply and again the focus shifted to common mental disorders and many people with serious mental illnesses slipped through the cracks. In the UK, the next wave was of further specialisation of services such as home treatment teams, crisis intervention teams, early intervention teams, assertive outreach teams, primary care mental health liaison team, medication support service, community rehabilitation teams etc thereby creating further barriers for the patients. The patients and their carers and families found it very difficult to traverse these fragmentations. In the UK, the concept of traditional generic community mental health team was deconstructed by the creation of diagnosis based path ways, specialist pathways and time limited pathway teams thereby causing discontinuity of care from a patient and carer perspective. Other nations planning to travel in that direction, need to remember these lessons. Such fragmentation has contributed to low morale among both primary care and secondary care staff as the former feel their concerns are not being taken seriously and the latter feel the pressure of the strain in the system and the barriers to the basic concepts of quality of health care as outlined by WHO⁴.

The Current context

The NHS Long Term Plan in the UK has made a renewed commitment to greater investment in mental health services faster⁵ and NHS England is already meeting the goals set as per the Lancet commission on Global mental health that high income countries should be spending at least 10% of their health services budget on mental health⁶. Several finance and funding challenges remain, despite the strategy to reform mental health care in The Five year forward view for mental health⁷ and the commitment to promote parity of esteem⁸. In 2018 King's Fund analysis revealed that whilst there is an emphasis on allocation of funding to support sustainability and performance, the gap between growth in funding for mental health providers and acute providers will continue. The analysis also highlights that despite the growth in income for mental health trusts in 2016/17 and implementation of the Mental Health Investment Standard many trusts continue to see reductions in their income⁹. As professionals we have

4- Quality of Care – WHO https://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf -last accessed on 16 June 2020

5- NHS Long Term Plan – can be accessed via this link <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf> - last accessed on 16 June 2020

6- Patel, V., Saxena, S., Lund, C., Thornicroft, G., et al (2018) The Lancet Commission on global mental health and sustainable development. *The Lancet*. 392 (10157), 1553-1598.

7- Five Year Forward view for Mental Health – can be accessed via this link <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-HealthTaskforce-FYFV-final.pdf> - last accessed on 16 June 2020

8- Royal College of Psychiatrists. Whole-person care: from rhetoric to reality (achieving parity between mental and physical health). Occasional paper 88. RCP, 2012.

9- The King's Fund, Funding and staffing of NHS mental health providers: still waiting for parity, January 2018. - can be accessed via this link <https://www.kingsfund.org.uk/publications/funding-staffing-mental-health-providers> - last accessed on 16

a moral obligation to advocate for our patients and there is a need to renew psychiatry's contract with society¹⁰.

Way Forward and Recommendations

There is little doubt that despite all the pledges, strategy and policy documents, there seems to be a lack of co-ordinated effort in the implementation of a well-integrated robust secondary care. When there has been an increased level of funding often this has been focussed on specialised care pathways as opposed to strengthening the broader generic secondary care. The injection of funding has come at a cost through reducing the bed base and inpatient care provision.

The future strategies should incorporate the principles set out in the NHS Long Term plan and Five year forward view for mental health:

- Integrated and co-ordinated services in secondary care
- Strengthening the primary secondary interface with a dynamic interface rather than water tight boundaries
- Optimising the potential of digital technology in improving access which has become more relevant in this Covid-19 world
- All acute hospital A&E departments to aspire towards achieving the core standards while being led by mental health trusts in the region
- Providing training to professionals across the health sector to raise awareness about mental health and encouraging early referrals for early intervention and care
- Addressing stigma and cultural aspects of how mental illnesses are perceived
- Sharing examples of innovation, best practice and learning - Involving community religious leaders, community leaders, teachers etc
- Closer working with third sector
- Joined up commissioning priorities linking health, social care and public health thereby aligning prevention and promotion

The care must be timely, safe, effective, efficient, equitable and person centred¹¹

June 2020

10- Bhugra, D. (2008). Renewing psychiatry's contract with society. *Psychiatric Bulletin*, 32(8), 281-283. doi:10.1192/pb.bp.108.020560

11- Quality of Care – WHO https://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf -last accessed on 16 June 2020

Conclusion

It is important to recognise that there will never be enough resources so in discussion with patients, public and policymakers professionals need to think out of the box to design, develop and deliver services. An agreement is essential to have secondary care services that are fit for purpose based on the local need.

mhGAP as a tool to promote investment and access

DR PETER HUGHES

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The mhGAP programme is a WHO programme to enhance community access to mental health⁸.

The programme began with WHO in 2008 in response to the lack of mental health workers in low and middle income countries and the clear burden of mental health conditions¹.

mhGAP means mental health Gap. This is the gap between what is available for people with mental health problems and the need. It can be as high as 99% in some countries and there is a gap even in developed countries².

There are many different aspects to the programme but the manual is the key tool for non specialised health workers to use to assess and manage mental health, substance abuse and certain neurological conditions³. These latter include epilepsy and dementia.

It is for prescribers and non prescribers and everything in mhGAP is evidence based, using research from all over the world.

Through this, the aim is that in countries with few mental health workers, people can access their mental health care needs close to their homes in a non stigmatising and economic way.

There is evidence that most mental health problems can be managed at primary care levels⁴. Cases that are complex or resistant to treatment can be referred on to specialist psychiatrists who have a very important role, not only in managing these difficult cases but also in supporting the primary care health workers through supervision and advice.

I first came across mhGAP in 2010 when I was working to integrate mental health into Primary care after the earthquake in Haiti. I was supporting primary care doctors in how to assess and manage mental

1- WHO (2010) *Mental Health Gap Action Programme (mhGAP): Scaling Up Care for Mental, Neurological and Substance Abuse Disorders*. World Health Organization

2- Hughes P, Thomson S. mhGAP Action Programme 6 Progress in Neurology and Psychiatry pg 4-6, Vol 23 Iss.4 2019

3- World Health Organization. (2016). mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP), version 2.0. World Health Organization. <https://apps.who.int/iris/handle/10665/250239>

4- Keynejad RC, Dua T, Barbui C, et al : WHO Mental Health Gap Action Programme (mhGAP) Intervention Guide: a systematic review of evidence from low and middle-income countries. *Evidence-Based Mental Health* 2018;21:30-34.

health in a primary care setting. We had no suitable manual to help these doctors then. Yet everyday we were seeing cases of depression, epilepsy, stress, psychosis and children's problems.

mhGAP arrived and filled a gap. We worked on training, supervision and ensuring a medication supply. Since then I have used mhGAP in many countries, and it is used in over 100 countries. It is also available as a phone app.

We know that patients prefer their health worker to use a phone app rather than look at a book during a consultation. It is less stigmatising to be seen in a community setting than the Psychiatric Hospital and is more efficient and economic⁵. It is also a natural place for mental physical and social to come together.

We know that people with mental disorders can die up to 20 years younger than those without⁶. Being seen in Primary care means that people can get comprehensive care that covers mental and physical health. They can be advised about diet, tobacco, alcohol, family planning and family spacing and people with disabilities may have more ready access to mental health.

mhGAP is human rights based so it brings together protection and mental health, as well as confidentiality. It helps prevent risk of human rights violations. The autonomy of the person is respected. They can make their own decisions on treatment and choose to not follow the recommendations given by a health worker if they so wish⁷. It complies with the Convention on rights of the person with disability⁸.

The question I often am asked is if this is a western document. No, it is a global document with input from experts from all parts of the globe. It is not a medical book, or one for psychiatrists, but a manual for all non specialist health workers.

mhGAP emphasises psychosocial treatments as well as medication. Psychosocial intervention is positioned first, before medication, with the important message that treatment must include psychosocial treatment and medication when necessary.

Psychosocial treatment means to be aware of physical, social, mental and spiritual needs, and to manage these. The message is that there is no treatment that does not include an explanation of the proposed plan, and the person who is ill is in the driving seat to make the decision about it.

5- Patel V, Araja R, Chatterjee S, Chisholm D, Cohen A, De Silva M et al: The Lancet. Global Mental health Vol 370, Issue 9591,p991-1005 Sept 15 , 2007

6- Thornicroft, G. (2011). Physical health disparities and mental illness: The scandal of premature mortality. *British Journal of Psychiatry*, 199(6), 441-442. doi:10.1192/bjp.bp.111.092718

7- Hughes P, Thomson S. mhGAP Action Programme 6 Progress in Neurology and Psychiatry pg 4-6, Vol 23 Iss.4 2019

8- CRPD-Conventions of the Rights of the Person with Disability <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html> June 2020 accessed

To keep the mhGAP programme going, it is essential to have good leadership, ongoing supportive supervision and medication supply⁹. We know these are the ingredients as it tends not to work without these components

The implementation of mhGAP starts with a local adaptation.

It cannot be overstated that there needs to be local adaptation taking into account local culture. This can be extensive, or more organic, as people work through mhGAP, and in their supervision. Culture cannot be overstated, and many countries have an adaptation exercise to meet local needs. There are adaptations for humanitarian settings with the mhGAP HIG¹⁰.

Then there is a phase of training, followed by supervision¹¹. Psychiatrists tend to be the key people in many countries to provide supervision and support for primary care.

The main message of mhGAP is that no one should ever miss out on care for their mental health and if there is one subject that needs to be covered is depression.

The conditions covered in mhGAP are carefully selected to cover the most common or the most disabling. The conditions reflect Primary care rather than a Secondary care service .

Although Psychosis is relatively rare in a primary care contact, the treatment can be hugely impactful and psychosis is covered, but the message for Bipolar Affective Disorder is to refer to a Specialist because the treatment is complex.

mhGAP covers children's conditions such as hyperactivity, developmental disorders and emotional disorders of children and we commonly find that there is a significant problem of children's conditions not getting picked up.

mhGAP covers epilepsy because there is a lack of neurologists and paediatricians to manage this and provides a great opportunity to talk through the psychosocial aspects of epilepsy.

Substance use is the most varied per region. In Somalia we will focus on Qat/Khat. In Ukraine we talk about alcohol much more. In the Middle East we talk of the pain medication tramadol abuse. Dementia is always an important but forgotten topic.

9- Hughes P, Thomson S. mhGAP Action Programme 6 Progress in Neurology and Psychiatry pg 4-6, Vol 23 Iss.4 2019

10- UN High Commissioner for Refugees (UNHCR), *mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies*, 5 May 2015, available at: <https://www.refworld.org/docid/55c078284.html> [accessed 7 June 2020].

11- Ali, S., Saeed, K. & Hughes, P. (2012) Evaluation of a mental health training project in the Republic of the Sudan using the Mental Health Gap Action Programme curriculum. *International Psychiatry*, 9, 43–45.

There is a catch all chapter for mild depression, anxiety, psychosomatic problems and stress disorders. This is so important and a very common issue throughout the world.

Challenges to mhGAP have been due to lack of supervision, lack of medication and lack of buy in. It needs support of the local psychiatrists to be supervisors and there have been programmes of face to face and distance supervision¹². It is challenging to keep going but very worthwhile. Without supervision the mhGAP programme withers and manuals are left unused.

The following vignettes provide examples of how mhGAP has directly helped local communities:

“this lady comes in every week with physical symptoms with no clear cause. We used mhGAP and saw that she had depression. We now will treat the depression as well as her physical symptoms” Uganda

“I saw this young man for his high blood pressure with his father. After mhGAP I now see him alone and he is able to tell me about his worries. His blood pressure has improved”

There are many stories of people with psychosis who have been tied up when no treatment is available. Helping someone with psychosis can help whole family and community, as well as transforming the life of the person affected.

Conclusion

The mhGAP programme has been hugely influential in how people access mental health in low and middle income countries and there is evidence that it is effective and well regarded⁵. However, the engine to keep it going can falter - that is the supervision, medicine supply and commitment.

Family doctors value using mhGAP, and patients value being listened to and their opinions being taken seriously about their care.

The mhGAP programme is an opportunity to bring together the physical, mental, social and even spiritual in a non stigmatising, effective and economic manner.

Current training and application of mhGAP now is taking COVID 19 into account. This means there is more online training and supervision. mhGAP can still carry on and shows its adaptability to circumstances.

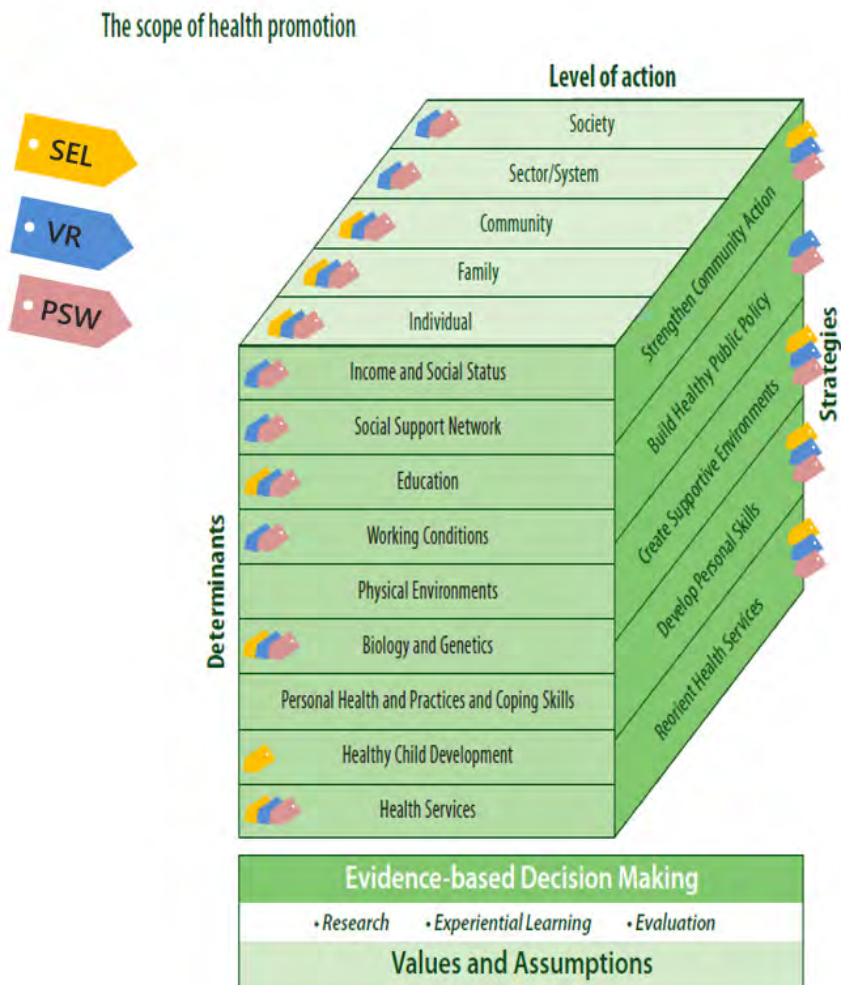
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Mental Health Promotion from Principles of Ottawa Charter: Taiwan Experience

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“Mental health is a human right, there is no health without mental health.” To build a healthier society and develop sustainability in mental health, we follow the Ottawa Charter for Health Promotion principles as the investment and access for mental health promotion.



Adapted from: Evans & Stoddart, 2003.

Figure 1. The scope of health promotion.

As shown in Figure 1, Strengthen Community Action, Build Healthy Public Policy, Create Supportive Environments, Develop Personal Skills, and Reorient Health Services are essential components of good public mental health policies and strategies.¹ On behalf of the Asia Pacific Region, below we briefly introduce the efforts that have been developed in Taiwan:

While “Building Healthy Public Policies”, we found the Asia Pacific Region all have Mental Health Act which focuses only on mental illness patients, their health services, rehabilitation, etc. However, which rarely emphasize on mental health promotion for all people. Therefore, a suggestion to have a “**Mental Health Promotion Act**” will be a key to turn focuses and resources to enhance “**Mental Health for All People**”.² At the next stage, based on the Mental Health Promotion Act, we can develop more **New Models for Mental Health Promotion** including,

- Towards New Era for Mental Health Promotion: Integrating Mental Health into All Policies;
- Develop local empowerment models, to focus on the mental health promotion and primary prevention of the entire public, to build community resilience and social support, and to pay close attention to the needs of different age groups, economic classes, urban and rural areas, and across different settings (e.g. workplace, seniors, people living with mental health problem or illness, etc.), is our priority mission!

Concerning “Develop Personal Skills”, we propose the Social and Emotional Learning (SEL) approach.

- Follow the idea of Canada, mental health promotion (MHP) takes a proactive approach, focusing on the early and continuous development of positive mental health (Canada, 2019). Hence, we choose the social and emotional education as grass-root tools to promote mental health since they are childhood. Through the last three decades’ research, it has been found that Social and Emotional Learning (SEL) can not only contribute to the well-being of students, teachers, and parents but also consider as an important national capital for a country in the 21st century. The report shows that every dollar invested in SEL, there will be a substantial economic return of 11 dollars.³ Therefore, we will advocate and collaborate with the government agencies and SEL-related NPOs to let the students’ stakeholders access SEL and then as coaches help the emotional intelligence development of the students.^{4 5}

Regarding “Reorient Health Services”, we propose both the Vocational Rehabilitation (VR) and Peer Support Worker (PSW) as the efforts in the mental health field we should work on now.

1- Evans, R. G., & Stoddart, G. L. (2003). Consuming research, producing policy?. *American Journal of Public Health*, 93(3), 371-379.

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3- Belfield, C., Bowden, A. B., Klapp, A., Levin, H., Shand, R., & Zander, S. (2015). The economic value of social and emotional learning. *Journal of Benefit-Cost Analysis*, 6(3), 508-544.

4- K.L. Lay, C.Y. Lin, T.C., Chang, L.J. Yang, H.T. Chen and Y.J. Wang. (2019). Evaluation of a School-Based Social and Emotional Learning Program Using Volunteer Parents as Instructors, presented at Biennial Meeting of the Society for Research in Child Development, 2019, Baltimore, Maryland, USA, March 21-23, 2019.

5- L.J. Yang, S. Tai and H.T. Chen. (2019). An Authentic Social and Emotional Learning Program for Elementary Schools and Its Implementation in Taiwan, presented at the 2nd Global Summit for Mental Health Advocates, 2019, Taipei, Taiwan, October 5-6, 2019.

- Vocational Rehabilitation (VR)- *The Development of Employment Promotion Status for People with Mental Disabilities in Taiwan.*

In Taiwan, people with mental disabilities have been included in the People with Disabilities Rights Protection Act since 1995, which was originally named Welfare Law for the Handicapped and Disabled and revised as Physically and Mentally Disabled Citizens Protection Act in 1997, People with Disabilities Rights Protection Act in 2008. In Chapter 4 “Rights and Interests of Employment” of People with Disabilities Rights Protection Act”, the law indicates the employment promotion policies including job training, prevocational training, sheltered employment, supported employment, open employment, job accommodation, prevocational evaluation, etc. Nevertheless, the environmental and personal factors such as social stigma, cultural values, the limitation of physical, mental, and neuro-cognitive conditions and social skills all result in the low employment rate of people with mental illness. Moreover, the status of low employment of people with mental illness has impacted the need for long-term hospitalization, high cost of insurance, and family burden. As stated above, we see more effort should be made to improve the situation of employment of people with mental illness. In the past 25 years, along with the policy improvement and our works on making recovery model, combating stigma, and creating resilience. The employment rate of mental disabilities has been increasing from 4.9 % to 15.4% (1994 – 2018).

- Peer Support Worker (PSW)

Follow the idea of Australia, peer work is an approach to engaging people with mental health issues as the central actors in the management of their mental wellbeing and in building meaningful and purposeful lives.⁶ Receiving social and emotional support, especially from workers with lived experience, can be an effective promotion and prevention strategy for the journey of recovery. By building a recovery-oriented relationship, peer support (PS) can help to provide a sense of empowerment, to foster hope, to improve quality of life, and to reduce hospitalization and symptoms. Actually, PS is not a new idea to Asia, but the way to legalized peer support worker (PSW) to achieve living with dignity, equality, and self-reliance is our long-term objective. Consequently, this year, we referred to the experiences from Australia, Canada, and Hong Kong then have started a pilot PSW scheme in Taiwan.

In addition, we also advance the Mental Health Literacy Program in Schools, through mental resilience education and promoting Mental Health Book Week to “Create Supportive Environments”; we promote the Laughing Qigong Program for Elderly in Communities, through learning emotional transformation and relaxation to have a healthy lifestyle and active aging, further to “Strengthen Community Action”.

6- Meagher, J., Stratford, A., Jackson, F., Jayakody, E., & Fong, T. (Eds.). (2018). *Peer work in Australia: A new future for mental health*. Sydney: RichmondPRA and Mind Australia.

Peer Workers and Mental Health – the Power of Support Groups

A South African perspective

SA DEPRESSION AND ANXIETY GROUP (SADAG)

CASSEY CHAMBERS, KRYSTLE ROSE KEMP AND JANINE SHAMOS

The South African Depression and Anxiety Group (SADAG) was founded in 1994 to support, guide and advocate for people affected by Mental Health issues. South Africa's mental health resources are limited, a problem which is exacerbated for those living outside of the larger urban areas. Not only is mental health care expensive, people living in outlying or rural areas often require long distance travel to access it, which is sadly not an option for many.

From the outset, SADAG's drive was to raise awareness around Mental Health and provide resources and access to information where they previously didn't exist. By creating awareness, we can help break the stigmas that are often associated with Mental Health. One of SADAG's main objectives is to establish Support Groups in as many areas as possible, so that everyone, no matter where they live, has access to support. To date, SADAG has facilitated the establishment of **over 150 Support Groups** throughout the country.

The majority of our Support Groups are run by patients, for patients. SADAG's model is to harness the power of lived experiences to break down barriers, debunk myths and to create a safe space for those who need it most. Support Groups are different to group therapy, and as such, leaders don't need to have a medical or mental health qualification. While Support Groups offer valuable resources, they should not be the first line of treatment or intervention, but rather function as supplementary support. Support Groups provide an environment of safety, non-judgement, unconditional positive regard and mutual understanding. Support Groups encourage simultaneous learning, the sharing of personal experiences, and self-help tips. Our Support Group Leaders are passionate and dedicated, offering free resources to their communities, where often there is little to no mental health help available.

Throughout the years of advocacy, SADAG has not only focused on mental health issues, but also on the factors within communities that contribute to mental health issues. We have trained Support Group leaders to start substance abuse groups, rape survivor groups, domestic violence support groups, and teen pregnancy groups to name a few - there are a multitude of different factors and conditions that can leave people feeling vulnerable and isolated. Collective action builds community members' awareness that they are not alone and that their experiences and concerns are shared by others.

For many people Worldwide, COVID-19 has resulted in fear, Anxiety and isolation. At a time when community, support and togetherness are essential, all of our groups have had to refrain from meeting in their normal capacity: a face-to-face environment. The international pandemic has reinforced our resilience and emphasised our need for support and community. SADAG, as the leading Mental Health NGO in South Africa, has not let the restrictions of COVID-19 prevent it from supporting our communities, but instead we have worked together and formulated plans to ensure the continuation of support.

One of the several ways we have achieved this is with online training and ongoing support and webinars. Many of our Support Groups have moved to online platforms to ensure the continuation of support for their members. We have also engaged in a nationwide five-part training webinar series for those interested in becoming Support Group Leaders, which was attended by over 200 participants. In what has been an amazing adaptation to social isolation restrictions, SADAG has created new opportunities for support by utilising technology to reach a wider audience. Using Zoom and online videos, the team is currently training over sixty new Support Group leaders from across the country.

In addition, due to the uncertainty of the pandemic and how long restrictions will be in place, SADAG is now training existing Support Groups on how to run effective online Support Groups via Zoom, WhatsApp, Google Hangouts and Microsoft Teams. They are also developing guidelines to help future Support Group Leaders who want to start new groups. The one major advantage with online Support Groups is that their membership is not restricted geographically, so more people can access help.

Participation in Support Groups has been shown to reduce stress and increase social connectedness, factors that are believed to contribute to a strengthened immune system. Support Groups allow members a space for personal growth, and help to reduce feelings of social isolation, Anxiety, shame, and bridge the gap between community Mental Health needs and therapeutic treatment.

In a country like South Africa that lacks Mental Health resources, compounded with the additional strain of the current pandemic, Support Groups are there to provide balance, support and improve treatment outcomes.

The Value of Mental Health Peer Work: Increasing investment and access for all

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There is a long and valued history of people with a lived experience of mental illness providing informal support to their peers (consumers, users, survivors). The value of self-help support groups, social and friendship groups, telephone support trees, and consumers connecting with each other on an informal basis, whether in hospital or community settings, has existed for well over 50 years.

Peer work is undergoing rapid but sporadic growth and expansion across the world and it is predicted that the peer workforce will be one of the largest 'go to' workforces in mental health, and potentially other sectors, over the coming decade. Greater investment is needed to recognise the value of peer work, and the important contribution it makes to holistic mental health care.

I gratefully acknowledge all the organisations across the globe who are genuinely and meaningfully inclusive of the Lived Experience Voice & Peer Workers – thank you!

More Peer Workers = Greater Access

Peer workers provide support for people who may be experiencing mental health challenges and can 'walk alongside' people who don't wish to, or aren't ready to, engage with mainstream services. This may be upon admission or discharge from emergency departments, hospitals and when transitioning into community living.

Many organisations also offer programs or services which are staffed by peer workers, and which provide step-up/step-down services, community supports and other alternatives to hospitalisation.

Peer-run services are those that are planned, operated, and managed by people with a personal lived experience of a mental health issues who have appropriate training.

Benefits of Peer Work

- Access to early intervention
- Reduces cyclic hospital re-admission of people with mental health conditions
- Greater satisfaction and quality of life
- Peers can often elicit information from a person that a clinician sometimes cannot
- Assists people to successfully transition back into the community
- Improvement in meaningful activities/outcomes, e.g. employment, housing, finances
- Instils hope: *if I can do it so can you, there are better times ahead*
- Better decision-making
- Provide genuine, unconditional, non-judgemental listening to another person
- Encourage personal responsibility
- Facilitate education & support groups
- Help people to discover their own individual & unique way of managing their recovery
- Provide support and encouragement to vulnerable peers
- Wellness coaching; physical health promotion
- Mentoring
- Suicide prevention and much more.

Peer work – an investment in the future

We need innovative leaders across the world who are prepared to invest *now* in new ways of working. Strong, compassionate leadership, at all levels, is urgently required to help fund and promote the increased use of mental health peer workers. These individuals, who draw on their own lived experience in their work, won't replace the crucial role of other professionals, but can offer an additional, unique service that encompasses empathetic listening, resource and information sharing, advocacy and linkages, and an important opportunity for social skill development.

Most importantly, they help to inspire *hope* – something desperately needed in these particularly uncertain times when people are feeling especially pessimistic and alone.

“I don't think I would be here today if I hadn't been able to reach out and speak with a peer worker when I needed to.”

But policies relating to peer work need to be about more than just changes in language or jargon. They need to be more than temporary, unfunded programs or tokenistic representation. We need a *fundamen-*

tal shift in the way we *all* think about and work with mental health supports so that equitable access, genuine empowerment, and respect for *everyone's* human rights become embedded.

Peer workers are uniquely placed to help foster the **hope** and **connection** that so many people living with mental health issues struggle to hold on to (even in the absence of 'social distancing' due to a global pandemic). However, it's essential that those working in this rapidly evolving field are provided with appropriate training, mentoring and supervision. Otherwise we are just setting them up to fail, and risk doing harm to those they are trying to support. We need to continue to advocate for appropriate qualifications and training for peer workers (developed and delivered by those with lived experience), as well as recognition of peer work as a valuable, discrete profession. This is now more important than it has ever been.

When you provide hope, you help people to move forward. The grass is greener, the sky is brighter, and music sounds better. Who better to provide such hope than someone who has lived experience of recovery – a knowledgeable and skilled mental health peer worker!

REFERENCES

- For further information, or references, please refer to this book on Peer Work in Australia, which includes Michael's chapter on the development of a national qualification for mental health peer work:
- Fong, T., Stratford, A., Meagher, J., & Jackson, F., & Jayakody, E. (Eds.) 2018, *Peer Work in Australia : A New Future for Mental Health*, Flourish Australia, Sydney Olympic Park
- Available at your favourite local bookstore or online: <https://www.amazon.com/Peer-Work-Australia-Future-Mental/dp/0648441709>

Setting the Stage for peer support: the challenge for Chile

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Health systems need to include community workers to support primary health interventions and there is an extensive evidence on their effectiveness and viability¹. This interest also exists in the community mental health service delivery model.

The National Mental Health Plan of Chile indicates that people are one of the main community assets for mental health interventions. Thus, it is necessary to integrate user perspective to generate new ways of collaborative work that affect quality, relevance, adherence, among other dimensions of mental health care². However, the Plan only recommends peer support strategies at the primary care level, referring to voluntary mutual support and not peer-worker-based interventions.

Chile has one of the most favorable conditions for the inclusion of peer workers in the mental health workforce in Latin America³. Chile has a successful process of progressive transformation of mental health services in primary healthcare⁴. It has also achieved a progressive implementation of the com-

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munity mental health model, which promotes the role of users as experts by experience⁵. Furthermore, there are pilot experiences in Chile that have promising results in the implementation of psychosocial interventions with peer workers, in terms of their acceptability and feasibility⁶. In the study by Agrest et al (2019) it was found that community intervention is more complex than traditional services from the user perspective, due to the stigma and the importance of understanding context. The model of peer-to-peer work is beneficial to the recovery, social inclusion and community engagement processes. Peer support should continue to be supported in Chile.

There are also social reasons to incorporate peer workers in mental health services in Chile. The country has high prevalence of common mental disorder, such as depression and anxiety⁷. It also presents an mismatch between the burden of mental illness and availability of public resources, as many Latin American countries⁸. Besides, the dissatisfaction expressed by social movements since October 2019 has exposed mental health as part of the problems associated with inequity. Similarly, measures of social distancing during the coronavirus pandemic are having a major impact on mental health⁹.

The pandemic has revealed the needs to actively involve communities in mental health care and the lack of peer workers in mental health services.

The government of Chile has convened a mental health commission to prioritize response actions during the pandemic¹⁰. This commission agreed to prioritize community development and primary healthcare. There is an important opportunity to strengthen mental health services with the active participation of users. Chile faces many challenges: it is necessary to adapt the administrative regulations to hire peer workers. A favorable attitude of professional mental health teams should also be strengthened, along with providing permanent training to peer workers, to facilitate the implementation of the strategy¹¹.

Chile has the opportunity to prioritize strategies to improve mental health outcomes, including peer workers participation in the workforce. As peer workers, your employment rights and duties should be

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considered. A peer workers policy can have an important impact not only on users but also in their context, territory and community. It is a strategy that makes it possible to address some social determinants that affect people's mental health.

Clubhouse International: Expanding Resources for People with Serious Mental Illness

JOEL D. CORCORAN

M.Ed.

Clubhouse International

Clubhouse International was founded in 1994 at Fountain House in New York City. Our focus is expanding and sustaining the Clubhouse model for psychosocial rehabilitation, an evidence-based practice with a 75-year history of offering successful and cost-effective solutions for people living with mental illness.

Through 310 Clubhouses in 32 countries around the world, Clubhouse International offers people living with mental illness opportunities for friendship, employment, housing, education, wellness and help accessing needed medical and psychiatric services in a single caring and safe environment. This socially inclusive approach reverses the alarming growth trends of higher suicide, hospitalization and incarceration rates associated with mental illness – and the increasing burden on communities everywhere.

“The meaning of Clubhouse for me personally is that it has saved my life and in doing so it is indirectly aiding in the healing of family and friends that are connected to me.” - Cynthia Anderson, Fountain House Stockholm, Sweden

Our Mission

Ending social and economic isolation for people with mental illness by growing the number and quality of Clubhouse rehabilitation programs worldwide.

What is a Clubhouse?

Clubhouses are a local solution to a global problem. One in four adults will experience mental illness in their lifetime. One in 25 will experience a serious mental illness – bipolar disorder, schizophrenia, major

depression. Four of the top ten leading causes of disability are neuropsychiatric disorders, representing 23% of all years lost to disability – more than cancer and HIV combined.

A Clubhouse is unique because it focuses on individual abilities and talents, rather than on their mental illness. Friendships, work and education are the heart and soul of Clubhouse communities, where people with mental illness reclaim their futures and build fulfilling and hopeful lives. Expanding, strengthening, advocating for this approach – the Clubhouse Model – is what we do at Clubhouse International.

“It is such a gift to no longer just be a patient or a client, always on the receiving end of others’ services and treatments. Today, I am someone who has something valuable to share, and a place to share it, and people to appreciate my contributions.” - Mike Tibbles, Pathways Clubhouse, Canada

What does Clubhouse International do?

We strengthen and empower a worldwide network of like-minded organizations connected by a rights-based approach to empowering and helping people with mental illness take charge of their recovery and futures. Together with the Clubhouses in our network, we have demonstrated the powerful impact of belonging.

Our International Network

- 310 Member Clubhouses, including 12 global Training Bases
- 20 Regional Clubhouse Coalitions

Every year:

- 100,000 people access Clubhouses
- \$200 million dollars (USD) in public and private funding for local Clubhouses
- 800,000 hours of programs and services provided in member Clubhouses
- \$50 million (USD) in earned wages by Clubhouse members

“I congratulate Clubhouse International on the impressive work done around our world to improve and better the lives and opportunities of so many. You have shown that concern, empathy,

support and re-establishing hope in individuals can make a major difference in a more inclusive society.” -Gro Harlem Brundtland, former Director General of the World Health Organization and Prime Minister of Norway

Our Areas of Focus

Quality – Which is achieved through Best Practice Standards, Training and Accreditation.

- Clubhouse International coordinates the **International Standards for Clubhouse Programs™** (Standards), a set of 37 comprehensive Standards developed and evaluated biannually through a robust, community- and consensus-based process.
- Clubhouse International is the Accrediting body for Clubhouses worldwide. **Clubhouse International Accreditation™** is a clear demonstration of a Clubhouse’s commitment to excellence. Today, 80% of our Clubhouses are Accredited, compared to just 46% in 2014. These Clubhouses are universally recognized as operating with a high level of compliance with the *Standards*. The Accreditation process is both evaluative and consultative. It is conducted by members of the Clubhouse International Faculty, which is composed of members and staff from Accredited Clubhouses around the world. Together, we oversee a rigorous process that includes a self-study, a multi-day site visit by a two-person trained faculty team, a written findings report and ongoing consultation.
- Training is critical to our ongoing success. Clubhouse International offers an array of intensive training experiences. We trained more than 150 Clubhouse groups at our 12 global training bases in 2019. We host regular webinars, regional and national conferences and a biennial World Seminar, New Clubhouse Development trainings, and provide individual support and mentoring to Clubhouses, start-up groups and burgeoning Clubhouse leaders. In all, we provided 43,536 in hours of training last year.

Expansion – We work directly with start-up groups around the world to start sustainable new Clubhouses. We’re currently working with 50 groups in 18 countries. It’s a process that includes formal training as well as ongoing assistance and mentoring to help local groups establish volunteer boards and raise the funding needed.

Education & Raising Awareness – We are working at every level, from local municipalities to state and federal governments, to establish support for new and existing Clubhouses and to help expand all funding and services for people with mental illness. We raise awareness via conferences, webinars, our monthly newsletter, social media and partnerships with other advocacy organizations. about the prevalence of mental illness and educate constituents worldwide on how Clubhouses are an important part of the solution.

Clubhouse: An Acknowledged Solution

In the October 2018 report of the **Lancet Commission on Global Mental Health and Sustainable Development** the Clubhouse model is acknowledged as one of the “essential components of a comprehensive response to the goal to achieve inclusion for people with serious mental disorders”¹.

In 2014, Clubhouse International was the co-recipient of the **Conrad N. Hilton Humanitarian Prize**, presented to nonprofits judged to have made extraordinary contributions toward alleviating human suffering.

In particular, we can share the following outcomes:

- **Better employment results:** Longer on-the-job tenure is found to be highly correlated with Clubhouse attendance. Studies have shown that the Clubhouse model results in longer job tenure (median of 199 vs. 98 days) and higher earnings (median of \$3,456 vs. \$1,252) than other mental health programs.²
- **Reduced hospital stays:** Clubhouse membership has been shown to cut the number of hospitalizations by one-third and the average number of hospital days per year by 70%.³
- **Reduced incarcerations** during and after Clubhouse membership, thus cutting incarceration costs between \$20,000-\$65,000 per inmate per year.⁴
- **Better physical and mental health:** A recent study suggests that service systems like Clubhouses that offer ongoing social supports enhance mental and physical health by reducing disconnectedness.⁵
- **Cost-effectiveness:** The annual cost of Clubhouses (\$3,684) is estimated to be one-third of the annual cost of the Individual Place and Support (IPS) model with Vocational Rehab (\$13,376); about one-half the annual costs of Community Mental Health Centers (\$6,818-\$8,661); and substantially less than the annual cost of the Assertive Community Treatment (ACT) model (\$11,668).⁶

The Clubhouse concept is still a radically different way of working in the field of community mental health. Most models still focus on assessing a person’s level of disability and limiting the expectations based on that assessment. Most use teaching or treatment as the vehicle for providing rehabilitation. Clubhouse programs improve quality of life and opportunities for recovery, by promoting healthy life-

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styles, supporting individual empowerment, education and employment success. Clubhouses are also critical in helping members participate fully in their communities.

“When I go to the Clubhouse and have the chance to give back to my community, I feel myself as a healthy person, and that begins to have a momentum of its own.” - Paula Boyd, Putnam Clubhouse, California, USA

Our Vision

We envision a world where people living with mental illness recover and are an integral part of society. The success of our model helping people go from isolation to living fulfilling lives is powerful proof that change can occur.

Clubhouse International, our network of 310 Clubhouses in 32 countries and the thousands of people whose lives are transformed by Clubhouse all support the call to action for World Mental Health Day 2020. This is indeed the time for greater investment in mental health services across the spectrum, including Clubhouse. The time to act is now.

The Recovery College and Well-Being – The Experience from Inner City London

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Introduction

World Mental Health Day 2020, Mental Health for All: Greater Investment- Greater Access cannot be achieved without including people with lived experience of mental health and mental health service users.

If this is go to beyond just rhetoric, people with lived experience and their families need to be at the centre, and this requires investment so that they can take a more active role in their own self-care and the

care of their loved ones. Investment in Recovery Colleges is a good example of this type of investment, because approximately 80% of care in long term conditions including mental health is self-care.¹

The consumer/survivor movement began developing in the 1980's, and the 1990's marked the "coming of age" of the peer movement.^{2,3} A further empowering of people with lived experience of mental illness occurred in the USA⁴ in the 1990's with the first Recovery College and led to the establishment of the first UK Recovery College in 2009.^{5,6}



A Recovery College aims to engage people with mental illness in their own recovery and address inequality by holding the principles of co-production, co-delivery and co-learning at its core, bringing trained tutors with lived experience of mental health together with tutors with professional backgrounds in health and mental health wellbeing to deliver courses.

This helps to promote mutual understanding, respect, and addresses mental health stigma by increasing familiarity.^{7,8}

Image 1: Examples of our prospectus

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8- Corrigan PW, Michaels PJ, Vega E, Gause M, Larson J, Krzyzanowski R, Botcheva L. Key ingredients to contact-based stigma change: A cross-validation. *Psychiatric Rehabilitation Journal*. 2014; 37(1): 62-64

Principles of a Recovery College

A Recovery College aims to support mental health recovery using an educational approach that enables people to:

- recognise and make use of their talents and resources
- explore their possibilities and develop their skills
- obtain support to achieve their goals and ambitions
- find their own solutions coached by Recovery College staff
- choose their own courses, work out ways to make sense of and find meaning in what has happened and become experts in managing their own lives.⁹

The key to success is to respect the value of lived mental health experience equally to the value of professional training, therefore all activities are co-planned, co-designed, co-delivered, co-received and co-evaluated.

In this way everybody's expertise is brought together so that everybody can become an expert in their own self-care. Students who are service users, members of the general public and health staff learn from one another, promoting mental health literacy across the system.

It is important for those people who pay for and commission service to recognise the importance of this intervention in the pathway of care. Though Recovery Colleges have been in existence since 1990 by 2018 they were either planned or in existence in 22 countries.¹⁰

The Tower Hamlets Recovery College, London, UK

The Tower Hamlets Recovery College began in 2015 as an East London NHS Foundation Trust pilot scheme with non-recurrent funding from the Tower Hamlets Clinical Commissioning Group.

The overall aim of the Recovery College is to develop an innovative way to empower individuals living in Tower Hamlets with mental and physical health conditions, their families, carers and people who work with them to take a new approach to health promotion and dealing with long-term physical and mental health issues by embedding self-care and wellbeing into their day to day lives.

9- Perkins R, Repper J, Rinaldi M, Brown H. Briefing Recovery Colleges. London, UK: Centre for Mental Health. 2012

10- Crowther A, Taylor A, Toney R, Meddings S, Whale T, Jennings H, Pollock K, Bates P, Henderson C, Waring J, Slade M. The impact of Recovery Colleges on mental health staff, services and society. *Epidemiology and Psychiatric Sciences*. 2018; 1-8.

Image 2: THRC- an integrated approach



The vision is to make self-care the cornerstone of all health encounters, and this vision was reinforced in the pilot because we worked with service-users, carers, staff from local partners in health, wellbeing and education in Tower Hamlets to co-produce and co-deliver our vision for recovery, initially through workshops, a multiagency Steering Group and a Curriculum and Quality Group which developed Coproduction Guidelines.

Our vision was reflected in the imagery chosen for the branding of the pilot project, looking through a keyhole to a life beyond ill health with the Recovery College unlocking the future. This was co-produced over three workshops facilitated by the ELFT Associate Director of Communications and Engagement working with potential college students, staff, partners and the ELFT Forensic Directorate Nu-Leaf design service user social enterprise

The pilot was successful, delivered from a range of community facilities with a broad range of community partners and was able to meet the diversity of our population.

At the end of a successful pilot ELFT entered a competitive tender process and won an initial three-year contract, and subsequently another five year contract, to deliver a minimum of 20 courses per term, three terms per year from a range of community venues until 2024. Having recurrent short contracts make it difficult for good planning, and this is something that needs to be considered if we are to mainstream such services as part of investment to improve access to mental health.

What We are Offering Now

Our College is open to anyone who lives, works, studies or cares for someone in Tower Hamlets. We regard all students as equal irrespective of their background. Approximately 50% of our students also identify as staff (health, social care or charity) and the remaining 50% of students also identify as service users of mental or physical health services. For many students who may otherwise identify as a 'service user' or 'patient' the College allows them to identify with a learner role. It also provides an opportunity to learn alongside staff and members of the public as an equal, in an environment free of hierarchy and with equality of voice.

Alongside a range of courses, students can also access Individual Learning Plans (ILP). The ILP is a framework that enables a student to make the most of their learning experience. In a one-to-one meeting, an ILP Mentor supports the individual to find the courses that are best fit for their recovery journey, as well as establish achievable self-identified goals and possibly explore classroom adjustment to ensure their learning needs are met.

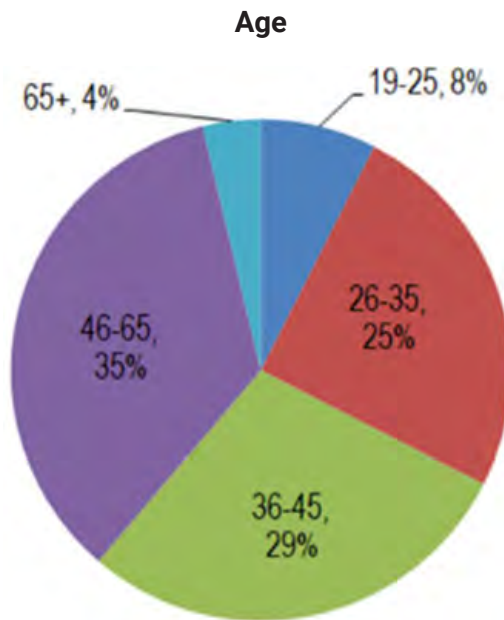
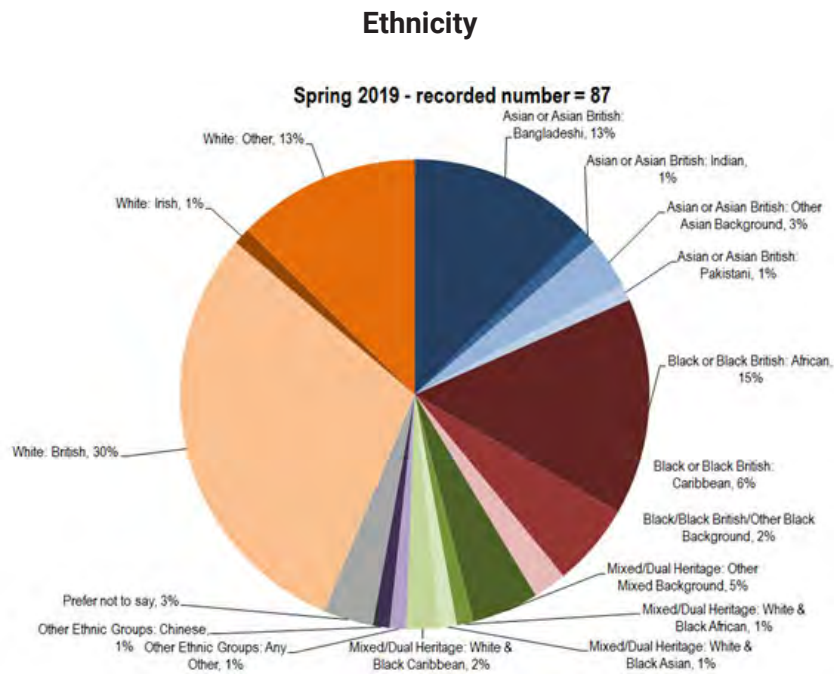
For students who also identify as a 'service user', there is an integrated pathway from being a student to joining the College as a paid Peer Tutor or Tutor Expert by Experience. The pathway involves attending the in-house Train the Trainer course which can be used anywhere, and then volunteering as a Peer Tutor for twenty hours after which, if they choose, they can progress to paid employment as a Sessional Peer Tutor. This pathway is intended to support students to move from identifying as a 'service user' (done to) to a staff member (doing with) and to ensure lived expertise is monetarily equal to professional expertise.

We currently have fifteen Peer Tutors, five who are paid and ten who are volunteers progressing to paid later in 2020. In addition to our volunteer Peer Tutor roles, we have a classroom assistant and two librarian volunteer roles currently held by people who also identify as 'service users'. All Peer Tutors are led by the Peer Tutor Lead who represents the lived experience voice at a senior level and provides supervision and bespoke Advanced Tutor Training to support continuing professional development and progression beyond the Peer Tutor role.

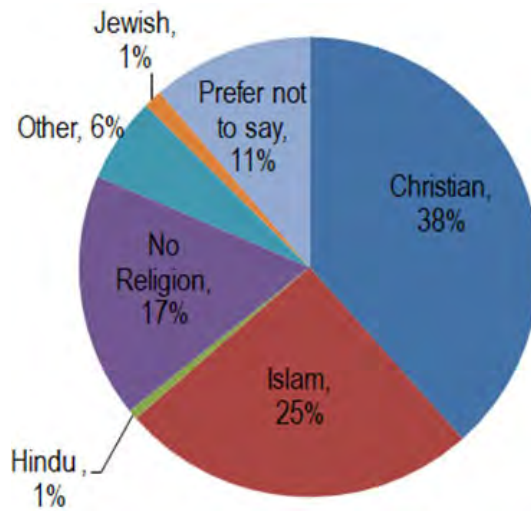
Are We Effective in Supporting Social Inclusion?

We are effective because one of our key objectives is support social inclusion attracting a variety of people living and working in the London Borough of Tower Hamlets

Image 3: THRC Spring Term 2019 - student ethnicity, age and religious belief



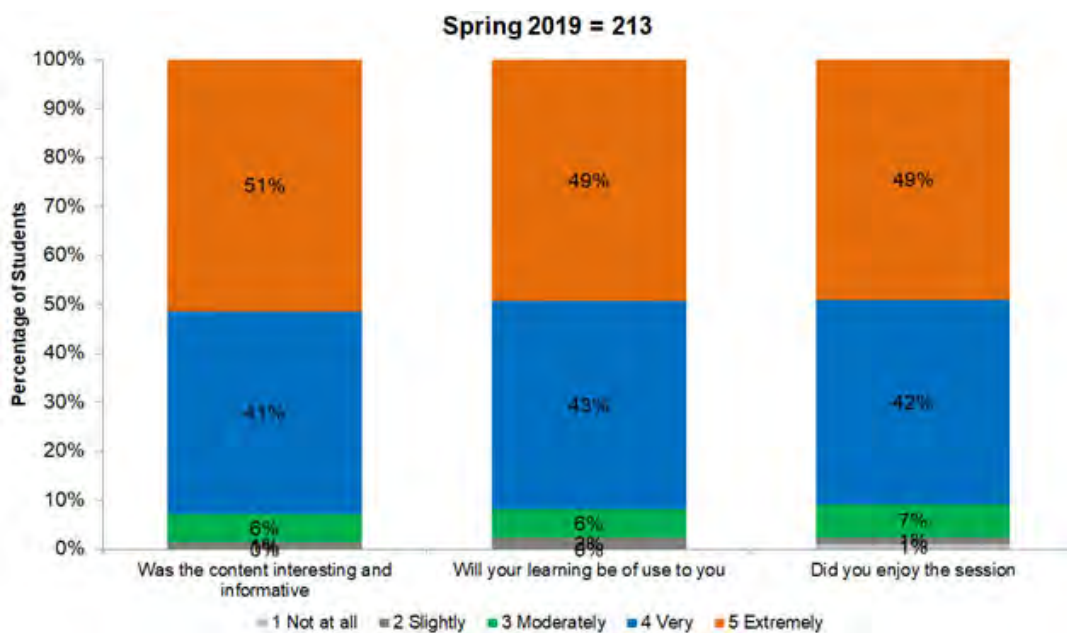
Religious belief



We are able to support the diversity of the population in our area promoting social inclusion, spirituality and breaking ethnic barriers as shown in the image above. Our courses are interesting and of a high standard, because we receive excellent feedback from our students about the course quality and usefulness.

In Spring 2019, 92% of students rated courses as very or extremely interesting and informative 92% of students rated the learning to be very or extremely useful to them and 91% of students enjoyed the sessions very much or extremely.

Image 4: Spring Term 2019 – Overall student course evaluation



Some of our students and peer tutors have progressed onto local courses, employment, further education, volunteering opportunities and engaged with local services that they were introduced to by engaging in Recovery College courses.

Conclusion

We have used the Recovery College as a tool to promote social inclusion, mental health literacy, reducing stigma associated with mental ill health and a platform for our students to engage with volunteering, further education and pathways to employment.

If we are to continue to promote the philosophy of holistic care, where every encounter matters then innovative approaches such as the Recovery College should be supported and encouraged especially as it is evidence based with good outcomes.

It is surprising that an approach developed in 1990 has only been adopted in 22 countries so far and has not yet an established in the pathway of mental health care. Self-care and well-being matter, and this needs to be routinely included in commissioning mental health services. Investment in this type of innovation should be available in all countries.

For further information please go to the website:

<https://www.elft.nhs.uk/tower-hamlets-recovery-college>

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SECTION C

Mental Health & COVID 19



Community activation, policy and COVID 19

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Introduction

The COVID-19 pandemic ignited what has been called a “fast, unpredictable tempest” when it comes to the mental health impact on the community.^(1:e29) The first cases of COVID-19 were confirmed in Australia in late January, 2020 and similar to many countries, the Australian government acted quickly to implement measures to prevent disease transmission, which included restrictions to travel and social gatherings.

On March 29, 2020 when the highest nationwide restrictions were imposed, the Government also announced a \$74 million funding package to boost mental health services.² This enabled swift development and implementation of the National Mental Health and Wellbeing Pandemic Response Plan.³ Aligned with the World Health Organisation’s policy statement emphasizing a planned response to mental health needs, the Plan aimed to strengthen outreach capability, improve connectivity and guide mental health interventions over the ensuing months and years.

Social restrictions started to ease from May 2020,⁴ and were effective in limiting the physical health impact of the pandemic. However, for many, including those with existing mental health challenges,⁵ the social isolation negatively impacted both their physical and mental health and wellbeing.^{7 8} For others, such as the elderly,⁹ migrants and refugees,¹⁰ it compounded isolation and loneliness.¹¹ Vulnerabilities were more evident for those who were required to quarantine.¹²

1- Pereira-Sanchez V, Adiukwu F, El Hayek S, Bytyçi DG, Gonzalez-Diaz JM, Kundadak GK, et al. COVID-19 effect on mental health: patients and workforce. *The Lancet Psychiatry*. 2020;7(6): e29-e30.

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8- National Academies of Sciences E&M. Social isolation and loneliness in older adults: opportunities for the health care system. Washington, DC: The National Academies Press; 2020.

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10- National COVID-19 Health and Research Advisory Committee. Mental health impacts of quarantine and self-isolation. National Health and Medical Research Council; 2020 May 19, 2020.

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12- National COVID-19 Health and Research Advisory Committee. Mental health impacts of quarantine and self-isolation. National Health and Medical Research Council; 2020 May 19, 2020.

In rural Australia, COVID-19 followed a period of severe drought and bush fires, and many already faced uncertain futures.¹³ At the height of nationwide social isolation measures in Australia, there was a 75% increase in online searches related to domestic violence.¹⁴ Mental health services in Australia reported a 40-60% increase in demand for March and April 2020, reporting a higher prevalence of loneliness, financial concerns related to job losses, health anxiety, and stress related to home isolation, including school closures and caring for children while working from home.¹⁵

Keeping the community connected through early mental health policy and mobilisation of support programs

Early development and implementation of mental health policies and programs was important to reduce the potential impact of COVID-19 in the community.¹⁶ Existing systems within Australia, such as strong primary care and well-developed community organisations, provided an excellent foundation for public mental health promotion and primary care service delivery.

High quality information and resources aimed to reassure the community that it was normal to experience anxiety during a challenging situation such as a pandemic.¹⁷ In fact, evidence from previous community crises shows that many people show great resilience during disasters and find new strengths, and supporting them to do so only increases this possibility.¹⁸ Therefore mobilizing existing community resilience was at the forefront of the Australian Government's response to COVID-19.

For people who required additional support for their mental health and wellbeing, there was early recognition of the critical need for trained healthcare providers, accurate assessment, and resources.¹⁹ Overcoming stigma about mental health remains a worldwide problem and Australia has invested heavily in national campaigns to reduce this stigma,^{20 21} providing a setting for high community acceptance of the Government's COVID-19 mental health and wellbeing campaign.

13- Rural Australian surged to seek supports to combat stress [press release]. <https://www.rdaa.com.au/documents/item/1068>: RDA & ACRRM, 8 May 2020 2020.

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20- Beyondblue. beyondblue Information Paper: Stigma and discrimination associated with depression and anxiety. Australia: Beyondblue; 2015.

21- Suicide Prevention Australia. Position Statement: Social Inclusion and Suicide Prevention. Leichardt, NSW, Australia:

Working with a network of trusted organisations to provide mental health support for everyone

As well as expanding existing programs and services, new targeted services were developed. The Australian Government Department of Health website, Head to Health²² included information about COVID-19, tips for maintaining good mental health and information about accessing mental health services. Working in tandem with a network of mental health support organisations, that were well known throughout the community, assisted in fostering trust and engagement.

Communication

Understanding the facts about COVID-19 was the first step to help mobilise the community to act and behave in ways that were protective of themselves and others. Recognising the value of strong, consistent communication from a trusted source,²³ a targeted community-wide mental health communication campaign, with evidence based tips on how to cope by mental health experts, was broadcast through social media, television and radio. Weekly webinars by key government and health officials enabled two-way communication between the COVID-19 policy response team and the nation's healthcare providers.

Tips for maintaining good mental health

Having to stay at home and physically isolate from friends and, for some, family, constituted a radical societal change. The most important tip was to reframe the phrase 'social distancing' to 'physical distancing with social connection' to emphasise the importance of staying connected to other people. Tips to manage mental health during the isolation included maintaining a sense of control through setting up a daily routine, staying active, eating well, and staying socially connected with friends and family. Advice to manage the avalanche of information and misinformation about COVID-19 on social media platforms encouraged people to stay informed through using credible sources of information and to have time away from COVID-related news. Importantly, leaders in the community maintained a sense of hope and reminded the population about the temporary nature of the pandemic.²⁴

Suicide Prevention Australia; 2011.

22- Australian Government Department of Health. Head to Health: COVID-19 Support Canberra, Australia: Australian Government; 2020 [Available from: <https://headtohealth.gov.au/covid-19-support/covid-19>].

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24- Australian Government Department of Health. Head to Health: COVID-19 Support Canberra, Australia: Australian Government; 2020 [Available from: <https://headtohealth.gov.au/covid-19-support/covid-19>].

How to access mental health services

The Head to Health website provided a starting point, with information available to help people access different types of mental health support, and tips were provided to help assist in choosing a service.²⁵ Links were provided to a variety of Australian mental health services including Kids Helpline, Lifeline, Headspace, Mindspot, Phoenix Australia, and Beyond Blue. Dedicated government and private funding supported the development of a specific COVID-19 information hub, the provision of Coronavirus digital resources, and a 24 hour phone counselling service through Beyond Blue.²⁶ This was designed to help people experiencing COVID-related anxiety or stress, including changes to employment, school and health, and family concerns.

Telehealth services

New temporary telehealth services, delivered by telephone or video-consultations, were introduced and funded through Australia's national public health insurance scheme, Medicare.²⁷ These aimed to ensure continued access to regular health care such as chronic disease management, and COVID-19 care, as well as access to mental health care and support, while at the same time reducing the risk of transmission of COVID-19 in health care settings. Mental health telehealth services aimed to support both continued engagement for people with existing mental health problems, and initial contact with mental health services for those experiencing mental health challenges for the first time. This strategy acknowledged the importance of being able to connect with other people and the critical role of the therapeutic relationship. At the same time, people who needed face-to-face contact were provided ways to access this.

Supporting children and young people

Existing telephone, online, and digital work and study support services for children and young people were expanded, and additional staff were trained as counsellors to meet increased demand for services - these included Kids Helpline, Lifeline, and Headspace. The role of parents in talking to children and helping them to understand and cope with the pandemic was crucial. Head to Health provided tips for parents for making time to talk with children and find out what they already knew, explaining COVID-19 in a way that children could understand, and ways of tuning into children's feelings.

25- Australian Government Department of Health. Head to Health: COVID-19 Support Canberra, Australia: Australian Government; 2020 [Available from: <https://headtohealth.gov.au/covid-19-support/covid-19>].

26- Beyondblue. Coronavirus Mental Wellbeing Support Service Australia: Beyondblue; 2020 [Available from: <https://coronavirus.beyondblue.org.au/>].

27- Australian Government Department of Health. The Australian Health System Canberra, Australia: Australian Government; 2020 [Available from: <https://www.health.gov.au/about-us/the-australian-health-system#medicare-the-foundation-of-our-health-system>].

Keeping vulnerable people safe and connected to mental health services

The pandemic represented a particularly challenging time for older Australians who were both at greater risk of poor outcomes from COVID-19 infection, and often in institutional or isolated home settings. Funding was put in place to expand a community visitor scheme, where staff and volunteers helped the elderly to stay connected by telephone or online. In addition to increasing access via telehealth, existing psychosocial support services for community mental health clients were extended. Peer-support services for people with urgent, severe and complex mental illnesses were also bolstered with additional government funding. Due to pre-existing health issues, high population mobility and difficulties with service access, Australia's Indigenous Aboriginal and Torres Strait Islander peoples were at increased risk of COVID-19. Specific resources were developed by Indigenous people for Indigenous people.²⁸

Supporting the healthcare workforce

Frontline health workers reported high levels of anxiety and depression during the pandemic,^{29 30} with increasing severity reported for those engaged in direct care of patients with COVID-19.³¹ Rural clinicians are often community leaders and highlighted the need for support to maintain their own mental health and wellbeing during the pandemic.³² Early support is a key mechanism to prevent or minimise the impact of stress on mental health.³³ For healthcare workers this included the provision of consistent and clear guidelines to support them in their clinical roles³⁴ and a dedicated portal available on the Head to Health website, and included links to Mindspot, providing psychological tips for frontline staff, and TEN- The Essential Network for health professionals, developed by the Black Dog Institute.

28- Australian Government Department of Health. Coronavirus (COVID-19) resources for Aboriginal and Torres Strait Islander people and remote communities Canberra Australia: Australian Government; 2020 [Available from: <https://www.health.gov.au/resources/collections/coronavirus-covid-19-resources-for-aboriginal-and-torres-strait-islander-people-and-remote-communities>].

29- Naren T. 'Needless to say, I don't sleep well': A GPs life at the coronavirus coalface. AusDoc Plus 2020; April 30, 2020: <https://www.ausdoc.com.au/news/needless-say-i-dont-sleep-well-gps-life-coronavirus-coalface>.

30- Jenkins K. 'GPs need to be kind to themselves': Your mental health in a time of COVID-19. AusDoc Plus. 2020; May 14, 2020: <https://www.ausdoc.com.au/news/gps-need-be-kind-themselves-your-mental-health-time-covid19>.

31- Lai J, Ma S, Wang Y, Cai Z, Hu J, Wei N, et al. Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. JAMA network open. 2020;3(3) :e203976.

32- Rural Australian surged to seek supports to combat stress [press release]. <https://www.rdaa.com.au/documents/item/1068>: RDA & ACRRM, 8 May 2020 2020.

33- Greenberg N, Docherty M, Gnanapragasam S, Wessely S. Managing mental health challenges faced by healthcare workers during covid-19 pandemic. BMJ. 2020;368:m1211.

34- Desborough J, Hall Dykgraaf S, Rankin D, Kidd M. Importance of consistent advice during a pandemic. Australian Journal for General Practitioners. 2020; 49:369-72.

Finding new knowledge through research

Acknowledging the value of research in understanding the mental health impact of emergencies, substantial funding was provided for rapid research to improve the national mental health response to COVID-19.³⁵ Specific funding was dedicated to research focusing on the impact of COVID-19 on men, including new fathers, men in construction, and those who had lost their jobs.

Conclusion and recommendations

There have been learnings and positive outcomes that need to be harnessed – especially the closer and more agile working relationship between all levels of government and community organisations, more connected ways of working, and connecting with particular groups at increased risk. Vulnerable groups included those who were harder to reach, rural and remote communities, people in quarantine, people with chronic mental illness and their carers, those with limited capacity to access smart phones and related technology, people exposed to family and domestic violence, and those from different cultures and backgrounds. Collaboration between existing primary care services, clinical tertiary services and community mental health services was important. Australia's response has been to encourage help seeking, develop coping strategies and resilience, and support those with mental health conditions throughout the pandemic.

35- Additional \$20 million for Mental Health and Suicide Prevention Research [press release]. May 25, 2020 2020.

COVID 19 and Inequality

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Organized medicine and health care systems have consistently described their desire to achieve health equity. The coronavirus pandemic and its impact on Black/Ethnic (BME) communities shine a light on the pervasiveness of what has thus far been an unattained goal—accessible, high-quality, and evidence-based care for all groups regardless of race, class, gender, or sexual identity. Amidst this pandemic psychiatrists and mental health professionals are challenged to take a closer look at their role in meeting the needs of communities that have been made vulnerable by systemic and social factors. The disproportionate number of BME Americans who have died from COVID-19 is a call to action for all institutions and individuals that provide treatment, services, and care.

The word “inequity” is a useful descriptor in measuring outcomes. However it fails to fully define the core reasons for health disparities. The substance of inequity is racism. Medical and institutional racism have driven disparate outcomes for BME Americans since the Colonial period.

The National Academy of Medicine published a landmark report in 2002, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” that examined racism in health care. It outlined the societal impact of racism and its effect on health care outcomes for Blacks and discussed professional biases. It discussed the inequities in service delivery. For example, Black patients were often undertreated for their depressive symptoms. Black people are more likely to be over diagnosed with schizophrenia spectrum disorders. More likely to be prescribed antipsychotic medications usually with higher doses than their white counterparts despite similar symptoms.

Based on these treatment differences, health care systems and mental health professionals misinterpret or ignore the experiences of Black patients. Expressions of Black distress are often policed. Blacks are disproportionately represented in the justice system especially those with severe mental illness. Are more likely to receive harsher sentences than their white counterparts. Experts agree that the mental health services provided in jails and prisons are inadequate.

COVID-19 and the Experience of Collective Trauma for BMEs

Data has emerged regarding the effects of the virus on the economy. For BME Americans, the alarming rates of infection and disproportionate number of deaths reinforce their feelings of abandonment by American health care. Exposing their unenviable positions in the social order. The CDC characterized COVID-19 data from 14 states for the month of March. While Blacks accounted for 18% of the catchment area, they had a disproportionate hospitalization rate for infection of 33%.

Detroit, Michigan has large Black population offers an example of the racial and economic factors that contribute to community spread of the disease. Detroit has received little economic support from the federal and state government and in the wake of COVID-19. Historically, many communities are in medically underserved areas. Detroit is the major contributor to the state's disproportionate death rate of Blacks (33%-40%) from COVID-19 even though this group comprises only 14% of state residents. In Chicago, 70% of COVID-19 deaths occurred in Black communities. Other cities such as New York City, Albany, and New Orleans show comparable findings.

American racism and adversity play a role in the higher psychiatric disease burden and trauma for Blacks. They face traumatic events common to modern society, but also experience the impact of racism. Moreover, it starts early in their developmental process. Black children are more often exposed to adverse childhood experiences than white children. Prior studies have shown that Black people have higher rates of posttraumatic stress disorder than white people. Covid-19 pandemic and health disparities have added to this trauma.

COVID-19 and Black Mental Health

Preexisting social conditions and stressors are particularly problematic for Black Americans suffering from mental and substance use disorders. As psychiatrists, we are responsible for dealing with the next wave of the traumatic consequences of COVID-19. The effects of isolation, unemployment, and grief placed on already vulnerable populations at risk for greater loss. The Census Bureau's Household Pulse Survey shows that anxiety and depressive symptoms may be more prevalent during the pandemic.

BMEs may be more burdened by anxiety associated with COVID-19 given the economic impacts. They have historically had higher rates of unemployment, are more likely to work blue-collar jobs, and are less likely to have employer-sponsored insurance. BMEs are more likely to use public transportation and fit into the category of essential workers. Socioeconomic status may factor into disparate health outcomes

The Path Forward: A Strategy for Health Equity

The plight to eradicate the disparity is not the sole responsibility of the BME community. Psychiatrists and leaders of any background should address these issues directly and forcibly. The experience of Blacks and other marginalized groups in America is one of constant invisibility. BME patients repeatedly feel unseen and unheard in clinical settings. The perpetual feeling that Black lives are *less than* even in health care is one that cannot be taken lightly.

Compounding particularly the black communities fear of the COVID-19 pandemic are the multiple and continual experiences of collective trauma through witnessed violence and maltreatment. Blacks are frequently exposed to recordings of fellow men and women being violently assaulted or killed by those in authority. Psychiatrists must acknowledge and validate their patients' feelings and experiences.

The generational trauma and enduring pain of African Americans weigh heavily on their mental health. The disparate effects of these illnesses and deaths are not new. In the 1960s racism was recognized as a public health issue and that fact remains the same today. These disparities cannot be removed without conscientious action and effort. We cannot simply offer prescribed treatments, services, or care. The medical profession often builds partnerships with these groups to target the social drivers of health. Little is done in the way of anti-racist educational training or advocacy for policies that produce the needed resources for BMEs. Health equity can be accomplished only with a redistribution of wealth and resources. Along with meaningful reforms that remove barriers for social programs and economic prosperity.

Black Americans represent approximately 13% of the U.S. population. Black physicians account for only 5% of the physician workforce and are even less represented in the psychiatric workforce. Black psychiatrists cannot be responsible singularly in achieving equity.

The events of the past weeks highlight the imperative need that leaders in psychiatry must acknowledge their role in community engagement. The national outrage over the deaths of Breonna Taylor, Ahmaud Arbery, and George Floyd should herald a call to action for leadership to promote the sanctity of Black lives and the well-being of Black patients.

Finding ways to incentivize organizations and health care systems to support education, research, and culturally informed workforce development should be the mainstay to accomplish health equity. APA has worked to develop the racism taskforce. Geared towards policy making and raising money/resources to follow these concerns. Fostering relationships with private organizations facilitate these agendas. Promoting the concept of 'buying Black.' Supporting Black owned businesses and initiatives in communities. Investing money in properties and partnering with these grass root organizations in the community.

Major organization should do their part. For example, the AMA started an initiative on the west side of Chicago called the CDFI initiative and fund. By this they are contributing 2 million dollars to the community. To help finance the needs of the community. Partnership with such organization lead to funding of underserved communities.

According to the Washington post the US Government spent \$500B dollars to bail out financial institutions in 2008. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) authorizes the US Treasury to spend up to \$877B of taxpayer money to help corporations during this crisis. This begs the question why funding is not being spent to assist those in BME communities. This drives the importance of establishing relationships with local and state legislatures. Comprehensive efforts will be required if we are to come through this pandemic with minimum morbidity and mortality of BME populations.

Mental Health and Covid-19: A Need For Action

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A number of paradoxes and contradictions have been highlighted during the Covid pandemic for Mental Health.

- Therapeutic relationships need contact, so they can be compromised by the loss of physical presence materialized.
- Social life is hindered by lockdown and by the necessary lifestyle changes that people have been required to make, but community-based services availability has been reduced, outpatient care stopped in many places, and emergency care in hospitals is privileged.
- Psychiatric institutions (and all forms of residential care, e.g. nursing homes, social care homes, especially of a large scale) were in many cases sources of infection, but people are staying longer as they can be hardly discharged, their human rights have been compromised and social contacts are limited.
- Whilst the adoption of more hygiene and health protection is necessary, there is an equal requirement for a robust social intervention.
- Solidarity (also at the community level) is needed, and has buffered the traumatic impact of Covid-19, but this won't happen per se and requires a catalyst role for community services.

Comprehensive responses are proving to be more important than individual approaches, as integrated services respond to whole life needs of the person and the community.

Vulnerable people impacted by poverty, racism, ageism, homelessness, isolation and marginalisation, especially those with pre-existing Mental Health problems should receive interventions first of all, and the response should be especially tailored to their life needs and social circumstances.

This is a moment of difficulty but also possibility for human endeavour to change and improve mental health around the globe.

After the outbreak of the Covid-19 pandemic, governments are called to reformulate mental health policies. Health - as a right per se - is included within the wider range of human rights and connected to social determinants and human development (Sustainable Development Goals, SDGs).¹ As declared by the Lancet Commission on Global Mental Health and Sustainable Development, "an historic opportunity exists to reframe the global mental health agenda in the context of the broad conceptualisation of men-

1- United Nations. *Sustainable development goals. Knowledge Platform*. 2. <https://sustainabledevelopment.un.org/?menu=1300>

tal health and disorder envisioned in the SDGs".² SDGs allow to broaden the global mental health agenda from a focus on reducing the treatment gap for people affected by mental disorders to the improvement of mental health for whole populations and reducing the contribution of mental disorders to the global burden of disease.

The World Federation for Mental Health issued an Appeal for National Plans for Mental Health during the Coronavirus Global Emergency.³ This required to all countries and their governments to ensure that national mental health plans are designed to manage the mental health consequences of the global coronavirus health emergency. It is undisputed that the current COVID-19 emergency will have long-lasting consequences and effects on the mental health of all people, affecting the general population with astonishingly heightened stress. The real impact on mental health is occurring today, when people encounter the consequences of human and economic losses together with depressive and anger feelings, post-traumatic symptoms and other conditions. On the other hand, impoverishment of services, their reduction and mergers, and the shortage of staff that are already present due to the underlying economic crisis in most countries can leave mental health at the bottom of the list of health priorities. This is especially impacting on people with pre-existing mental health conditions.⁴

In Europe, where for 20 years so far the International Mental Health Collaborating Network (a voting member organization of the WFMH) aims to bring together good practices and services. The IMHCN, established by a first group of leading mental health organizations, under the aegis of WHO Geneva in 2001, is currently working for a whole life, whole system, whole community approach to mental healthcare. There are several organizations who have already (or are trying to) set up a whole community system of care with a demonstration of cost-effectiveness. Places like Trieste (and the Region Friuli Venezia Giulia) in Italy, Lille in France (which are WHO Collaborating Centres), Asturias in Spain, Cavan and Monaghan in Ireland, Cornwall, Plymouth and South Wales in the UK, Lyngby (Copenhagen), Utrecht in the Netherlands, Prague, etc. have closed their psychiatric hospitals or have at least severely limited and / or eventually excluded the use of coercion and seclusion⁵. These services have reacted to the limitations imposed by the Covid-19 policy in proactive way, not just closing outpatient services but providing outreach, home supports, integrated personalized interventions, prevention of hospitalization, remote online support including group therapies, and responding to primary needs of those in social isolation or deprivation.

2- Patel V, Saxena S, Lund C, et al. *The Lancet Commission on global mental health and sustainable development*. www.thelancet.com Published online, October 9, 2018 [http://dx.doi.org/10.1016/S0140-6736\(18\)31612-X](http://dx.doi.org/10.1016/S0140-6736(18)31612-X)

3- The World Federation for Mental Health (2020) Appeal for National Plans for Mental Health during the Coronavirus Global Emergency. <https://wfmh.global/mental-health-and-covid-19-appeal/>

4- Mezzina R, Sashidharan SP, Rosen A, Killaspy H, Saraceno B. Mental health at the age of coronavirus: time for change. *Social Psychiatry and Psychiatric Epidemiology*, published online, 29 May 2020. <https://doi.org/10.1007/s00127-020-01886-w>

5- International Mental Health Collaborating Network. www.imhcn.org

Mental Health in All Policies

After the many appeals, some countries finally start to face the mental health problem in the post Covid. The UN policy brief, presented by Secretary General Gutierrez, goes in the right direction: to recognize the essential services for people with severe disorder, to involve the whole society and above all the stakeholders as protagonists, to make national plans and to invest, to involve the community, to increase and reorganize services, and above all deinstitutionalize.⁶

Apart from a pocket of countries, Ministries has so far issued skeletal service notes aimed at reducing risks and little more. But if not now, when?

To achieve Mental Health for All, access should be greater, not only to psychiatric care and services, but to a welfare community, e.g. to responses to social determinants of health and disease, to social programs, to social and collective resources, to human relationships.

The promotion of mental health was at the center of a recent European initiative (EU-Compass for Action on Mental Health and Wellbeing, 2015-2018)⁷, where the concept of cross-governmental action (cross government: Mental health in all policies approach), even led to speculation about the exclusion of the Ministry of Health. Mental Health in All Policies (MHiAP) is an approach to promote population mental health and wellbeing by initiating and facilitating action within different non-health public policy areas. MHiAP emphasizes the impacts of public policies on mental health determinants, strives to reduce mental health inequalities, aims to highlight the opportunities offered by mental health to different policy areas, and reinforces the accountability of policy-makers for mental health impact.

Investing in mental health. How much and for what?

According to WHO Mental Health Atlas (2017)⁸, mental health expenditure is less than 2% of global median of government health expenditure, with a large variation between regions, e.g. mental health expenditure per capita in Europe is more than 20 times higher compared to Africa and South East Asia. The range between high-income and low-income countries on mental health expenditure per capita remains huge. Most of the reported expenditure is allocated to mental hospitals in particular, except in high income countries where less than 43% of spending is on mental hospitals (35 USD out of the total of 80 USD). In Europe, 100% of services are fully insured (no out of pocket).

6- UN Secretary-General Policy Brief: COVID-19 and the need for action on mental health. https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf

7- European Union. EU-Compass. *Joint Action on Mental Health and Well-being. Mental Health in All Policies. Situation analysis and recommendations for action.* 2017

8- Mental Health Atlas 2017. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Current investment in Mental Health in Europe is uneven and not related to the country GDP. In 2015, the overall costs related to mental ill-health are estimated to have exceeded 4% of GDP across the 28 EU countries, but ranging from 2.1 in Romania to 5.0 in Norway. (OECD)⁹

Some countries like Italy have invested only 3.5 % of their total Healthcare funds, also due to the closure of large psychiatric institutions for many years (recently forensic hospitals), while others have reached much higher rates as 15% like France (with more than 80.000 inpatients) or despite a substantial reduction of beds (the UK).¹⁰

HIC should invest at least 10% of their healthcare budget, while LIC at least 5% (see table)¹¹

Large psychiatric hospitals still exist in Central and East Europe, representing almost the sole response for people with severe mental health issues. Expected changes from the very progressive Helsinki Declaration (2005), the European WHO Mental Health Action Plan (2013-2020), the Green paper (2006), the European Pact for Mental Health and Wellbeing (2008) and other relevant policy documents have not occurred in a systemic way. The urge for human rights based on the CRPD and its implementation in Europe, despite efforts like the WHO QualityRights Programme, have not achieved a substantial implementation.¹²

Investing resources in mental health means many things. First of all it means attention, appeal to public opinion, focus on collective needs to promote a better quality of life.

It can even mean more money to psychiatric hospitals, asylums and other places of seclusion. Already in the world they absorb more than 80 percent of the resources allocated to mental health.

We want investments that increase the social capital of communities and individuals, which are mediated by programs and services that increase user confidence.

We want investments that bring people with psychosocial disabilities, who are the new poor and who are tied to addictions and who are denied the possible autonomy of a life project, out of poverty.

We want productive investments that transform people's lives and the community services themselves, which are often their most important support.

9- OECD/EU (2018), *Health at a Glance: Europe 2018: State of Health in the EU Cycle*, OECD Publishing, Paris. https://doi.org/10.1787/health_glance_eur-2018-en

10- European Union. EU-Compass. *Joint Action on Mental Health and Well-being. Mental Health in All Policies. Situation analysis and recommendations for action*. 2017

11- Patel V, Saxena S, Lund C, et al. *The Lancet Commission on global mental health and sustainable development*. [www.thelancet.com](http://dx.doi.org/10.1016/S0140-6736(18)31612-X) Published online, October 9, 2018 [http://dx.doi.org/10.1016/S0140-6736\(18\)31612-X](http://dx.doi.org/10.1016/S0140-6736(18)31612-X)

12- Mezzina R, Rosen A, Amering M, Javed A (2018). The practice of freedom: human rights and the global mental health agenda. In *Advances in Psychiatry* (ed. KD Fountoulakis, A Javed). Springer: New York, 483-515

Thus we need to emphasize the importance of community based services, operating 24 hrs a day, 7 days a week, to mainstream them in healthcare organizations and integrating them with welfare services, promoting prevention of disability through early interventions, contrast to institutionalization, and responding to whole life needs, from housing to work to social inclusion.

Such services need to be planned, delivered and evaluated in co-production with stakeholders, starting from people with lived experience and their carers. The low level of coercive care is one of the most encouraging indicators, as in Italy.¹³

Key messages

1. The Covid-19 has distressed human environments and individuals worldwide, especially those with existing mh conditions and related services. It has also created a need for more integrated community interventions, also addressing social determinants of health.
2. Mental healthcare is underfunded everywhere in the world including Europe, but nonetheless remarkable cost-effective good experiences have been developed involving the society at large and addressing social determinants.
3. Mental health must be involved in all policies, and investment must enhance community services, close to people and their living environments, moving away from institutions, as UN and WHO are claiming today.

Table

Investments for mental health should be enhanced (Lancet Commission, 2018).

LMICs should increase their mental health allocation to at least 5% and high-income countries to at least 10% of the total health budget. This increase should be in addition to allocation for other developmental priorities that will also be supportive of mental health. Although additional resources are essential, immediate opportunities exist for more efficient and effective use of existing resources—for example, through the redistribution of mental health budgets from large hospitals to district hospital and community-based local services, the introduction of early interventions for emerging mental disorders, and the re-allocation of budgets for other health priorities to promote integration of mental health care in established platforms of delivery.

13- Mezzina R. Forty years of the Law 180: the aspirations of a great reform, its success and continuing need. *Epidemiology and Psychiatric Sciences* (2018), 27, 336–345. Cambridge University Press. doi:10.1017/S2045796018000070

The Need for Fundamental Change in Mental Health: A Demand For Action from us All

Finally, we stress the need for a Worldwide Campaign for action to enhance peoples mental health, a movement calling for fundamental change in the Thinking, Practice and Systems, made up of international, national and local Mental Health organizations, an alliance of organizations and individuals from Low to Middle and High income countries.

Mental Health Interventions During and Post COVID-19

South African experience of mental health interventions during the Coronavirus pandemic

DR INGRID DANIELS
TARYN DU TOIT

Introduction

The COVID-19 pandemic has had an unprecedented and rampant impact on societies across the world. The first case of Coronavirus was confirmed by the Minister of Health, Dr Zweli Mkhize, in South Africa on 5 March 2020, after a South African citizen who returned from Italy was diagnosed with the virus. Until that stage South Africa was largely unaffected while the disease raged uncontrollably in the north with a staggering 95 324 Coronavirus infection rate reported globally (WHO, 2020).

The South African government decreed a National State of Disaster and officially went into a hard lockdown on the 27 March 2020 with 61 infections and 2 deaths reported. The decision to lockdown much earlier compared to Europe and elsewhere was primarily to reduce the transmission and death rates but to also urgently strengthen the capacity of the health system and psychosocial emergency response of an already over-burden public health system to cope with the predicted infection peak between June - November 2020.

South Africa had particular geo-physical, comorbidity, socio-economic and transmission risk factors to take into account. The country recognised that, unlike high income countries, it had distinct challenges and concerns pertaining to these risks. Concerns pertaining to the rapid spread of the virus amongst large populations living in congested and overcrowded townships where isolation or quarantine was virtually impossible became focal points for management. There were further concerns regarding an already over-burdened public health sector that would be under enormous pressure to cope with large demands for emergency, ICU and ventilation facilities.

As countries were going into lockdown and physical distancing and, isolation became a prerequisite to prevention and contamination, concerns about the impact of COVID-19 on mental health of individuals were further identified globally.

Mental Health Context in South Africa

According to Bradshaw et al. (2007), mental illnesses and neuropsychiatric conditions ranked the third highest in contributing to the burden of disease in SA, while Williams et al. (2008) found that 16.5% of South Africans suffer from a mental disorder – a staggering 75–85% have not had the benefit of receiving treatment.

The virus does not discriminate and therefore everyone was exposed and vulnerable. Greater mental health distress amongst South Africans became prevalent as COVID-19 infection rates increased over the weeks while the locked down economy impacted on many households.

The impact of the virus on poverty in many communities was exposed in the most dramatic way. The divide between rich and poor and privileged versus under-privileged revealed gross inequalities within the South African context. Lund et al. (2011) stated that “mental ill health and poverty interact in a negative cycle in low-income and middle-income countries.” Funk, Drew, and Knapp (2012) noted that “the poor are disproportionately affected by mental disorders” (p. 166). Thus, they were also unduly affected by COVID-19 and the mental health consequences.

Seedat (2020) warned that, “In the face of the restrictions and accompanying economic hardship, South Africa’s youth and persons with pre-existing mental illness may be especially hard hit by the potentially severe and long-term mental health consequences of the Covid-19 crisis. The stress, fear and emotional pain induced by the rapid and aggressive spread of infection, as well as the scale of prolonged grief from the sudden and massive loss of life, will be felt for a long time, and by successive generations.”

As the infection rate increased over the weeks, the COVID-19 pandemic not only presented a health emergency but also a mental health crisis and a dire need for humanitarian aid in the intervention packages of care.

Mental Health Interventions during COVID-19

In an unparalleled, never before seen strategy, South Africa’s COVID-19 State of Disaster regulations identified psycho-social support and interventions as essential while dealing with the devastating consequences of the virus.

However, coordinated national COVID-19 mental health intervention plans were found to be lacking. Thus, mental health implementation responses varied greatly across and within the nine provinces of South Africa. Even though mental health COVID-19 provincial plans were often fragmented, pockets of best practice were identified. Mental health non-profit organisations who preempted the lockdown were better prepared and able to reorganise their services while others experienced the lockdown as a barrier

and limitation to provide accessible mental health care during the emergency and extended lockdown periods. The unpredicted mental health consequence of the virus impacted heavily on frontline essential health workers which included a wide range of health professionals during this time.

Cape Mental Health (CMH) the oldest community-based non-profit organisation in South Africa, with a proud history spanning 107 years, committed to providing comprehensive, proactive and enabling mental health services to persons with intellectual disability and those with mental illnesses in the Western Cape Province was one such organisation who maximised the lockdown advance notice to design its remote mental health service. The organisation has a track record of mental health service excellence in poor, under-resourced and densely populated communities. The Western Cape Province, in which it operates, was the epicenter of the pandemic in South Africa with the largest infection and death rates seen not only in the country but also on the African continent at the time.

The pandemic created the opportunity to shift, reinvent and reorganise the way the organisation provides mental health care from facility to home and face to face counselling to virtual interventions and most importantly to retain contact, reduce isolation and continue virtual interactions with beneficiaries and all who required mental health support. In the planning stage of this model, the organisation recognised that approximately 98% of their beneficiaries had cellular phones which became a vital tool for migrating the mental health service remotely.

Despite the lockdown restrictions, the organisation was able to keep their 'doors open' by maintaining and building relationships and communicating with those in need about the services using remote technology such as; cellular phone applications, virtual IT technology or any other platforms, Skype, telephonic counselling and assessments, social media engagement, as well as video-conferencing where possible.

The entire switchboard or telephony system of the organisation migrated to a cellular phone. All telephone calls to any of the organisations' programmes were automatically diverted to one cellular phone operated by the receptionist at her home to relay all messages. Data management to render the service was centralised within our Administration Department.

A comprehensive basket of mental health services were offered during the lockdown period to ensure regular contact with service users and their families or caregivers to lessen their isolation, nurture their mental health and offer messages of hope. The remote mental health package of care provided included the following;

Counselling and Support

- Online counselling services, mental health support, COVID-19 crisis and case management were provided by a dedicated team of social workers through their preferred means of communication

(cellular phone applications, SMS messages, telephone calls or e-mails) to service-users with emotional adjustment problems, psychosocial disability/ mental illness, intellectual disability and anyone requiring support during this time.

Psychosocial Rehabilitation

- Psychosocial rehabilitation services were provided to adults with psychosocial disabilities/mental illness through daily contact with mental health users who participate in Fountain House and community-based psychosocial rehabilitation groups. Photos, video clips, voice and text messages from service users with mental illness testified of their enthusiasm. Implementing activities such as art and crafts, washing of hands, physical exercises, and life skills training, to enhance resilience and mental health were activated daily. Daily mental health check-ins were done to facilitate additional support and services to those in need were also provided.



Left: a service user has made a flower vase out of a plastic bottle as a gift for a family member.

Service-users enjoy the creative activities that are sent by cellular phone applications and video clips – especially easy-to-follow recipes for baking and using recycled materials to make things.

Special Education and Care & Training Workshops

- Activities were shared remotely across all Special Education and Care Centres for children with severe and profound intellectual disability, youth and adults with moderate and mild intellectual disability and those with severe and profound intellectual disability at Training Workshops Unlimited. This intervention at the Special Education and Care Centres was identified as a best practice mental health innovation during the COVID-19 pandemic by the Mental Health Innovations Network <https://www.mhinnovation.net/organisations/cape-mental-health>
- Parents gave encouraging feedback on programme activities carried out in the home and the impact on their children. Supporting parents, guardians and families in providing a structured routine, stimulation activities, and reinforcement of the life skills acquired when their children and adults with mental disability were able to attend our daily programmes was critical to maintain gains made in their rehabilitation.



“As a parent with a special needs child, we rely on our special care centres and their trained teachers to send through the activities via cellular phone applications.

Doing the daily activity and singing the songs I can see from my child’s facial expression that he remembers. Seeing the smile and enjoyment when they do some of these activities is just priceless.

I am happy and grateful for the help in the form of the daily activities so I don’t need to think about what I need to do next as my child’s day is planned already.

This is for our special needs children but the whole family can enjoy it and take part.”

Community-based Accommodation

- Implementing a comprehensive and safe COVID-19 regulated community-based living for residents with intellectual disability and those with mental illness in two community-based accommodations continued. They were supported by care-workers and cross psycho-social rehabilitation programme activities were implemented.

Awareness and education about COVID-19

- Awareness and education about COVID-19 was done with practical examples to facilitate basic protective measures supported by Easy-to-Read (ETR) materials were made available to those service users with limited or no literacy skills. These have been circulated to our partners in the sector as well as service users. Refer to Appendix 1: Physical Distancing – Easy to Read; Appendix 2: South Africa Coronavirus – Easy to Read; Appendix 3: What is Coronavirus – Easy to Read. Infographics were also designed and circulated to provide information about the virus. Refer to Appendix 4:
- Weekly motivational messages during lockdown reach out to service beneficiaries and their families and the public at large through social media and daily cellular phone applications messages, e.g., was managed by the PR and Communications Team.



Employee Assistance Programmes

- Employee Assistance Programme (EAP) for staff members, who required support and/or counselling at this time as well as any corporate clients in need of support and counselling (the sessions all took place using online platforms), were actively provided.
- Weekly motivational messages and COVID-19 related updates were sent via the organisation's team grapevine and a Weekly COVID-19 Newsletter was circulated internally to update and ensure that all staff remained informed and supported.

This model has been highly successful - 190 850 contacts over a 12 week period was made with 2 417 direct beneficiaries across all programmes since the start of lockdown in South Africa. See Appendix 5 – CMH Consolidated Statistics – COVID-19 Mental Health Interventions.

Concern regarding the mental health of frontline health workers and others intervening in the treatment of COVID-19 increased significantly. High COVID-19 infection rates amongst health workers including mental distress, anxiety, depression and COVID-19 fatigue were observed. The Covid-19 pandemic ravaging through the country required a mental health response to the health workers as critical essential personnel. As a result, a nationwide Healthcare Worker Support Network, spearheaded by the SA Society of Psychiatrists, the SA Medical Association, the Psychological Society of SA, the SA Society of Anesthesiologists and the SA Depression and Anxiety Group launched a toll-free 24-hour helpline managed by 200 volunteer psychologists.

The most successful mental health COVID-19 mental health interventions evident were where strong partnerships and multi-sectoral collaborations existed to ensure that an effective holistic bio-psycho-social and humanitarian response was delivered in the package of care.

Conclusion

South Africa continued to see a daily average increase of COVID-19 infections of over 8 000 during July as it peaked upwards. The COVID-19 infection rates are bleak with more than 538 000 individuals infected, 387 000 recovered, 9064 deaths (COVID-19 Statistics SA, 07 August 2020). At this stage, South Africa had the 5th highest infection rate in the world.

Unlike many countries who locked down further during the peak in infections, South Africa relaxed many of the lockdown measures resulting in increased transmission exposure due to their particularly unique risk factors. This situation was predicted to get significantly worse over the next weeks as COVID-19 infections spread.

As infections increase so will the mental health consequences thereof. The mental health consequences of COVID-19 will remain beyond and after a cure has been found. Mental health management and interventions will be of critical importance beyond the COVID-19 pandemic while COVID-19 mental health intervention plans are urgently required to strategically address in the growing need.

On return to facilities after lockdown, hybrid models and approaches to intervention may be introduced since the COVID-19 remote mental health services have shown significant success in contacts with beneficiaries during this crisis in South Africa.

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5. Funk, M., Drew, N., & Knapp, M. (2012). Mental health, poverty and development. *Journal of Public Mental Health*, 11 (4), 166–185. Retrieved from [http://eprints.lse.ac.uk/47609/1/Mental%20health%20poverty%20and%20development%20\(Isero\).pdf](http://eprints.lse.ac.uk/47609/1/Mental%20health%20poverty%20and%20development%20(Isero).pdf).
6. Seedat S. (2020). OPINION | Covid-19: May be prudent to over-estimate the mental health consequences of the virus. Retrieved from <https://www.health24.com/Medical/Infectious-diseases/Coronavirus/opinion-covid-19-may-be-prudent-to-over-estimate-the-mental-health-consequences-of-the-virus-20200526-2>

ADDITIONAL RESOURCES

- Facebook: <https://www.facebook.com/capementalhealth>
- Twitter: https://twitter.com/CMH_NGO

- LinkedIn: <https://www.linkedin.com/company/cape-mental-health>
- Instagram: <https://www.instagram.com/capementalhealth/>
- Youtube: <https://www.youtube.com/channel/UCfIINdS7CE9FBu42cSKkiMA>



BE CONSCIOUS

Being aware and taking care of your mental health has now become a critical task to cope with the ongoing pandemic. It is important for you to know that fear and anxiety can lead to strong emotions of hopelessness. You need to address these stress factors to in order to cope during this trying time.

IDENTIFY:

Taking care and responsibility for yourself and those around you during the COVID-19 pandemic can be stressful. It is important to identify the following stress factors:

- Fear and worry about your own health and the health of your loved ones
- Changes in sleep or eating patterns
- Difficulty sleeping or concentrating
- Worsening of chronic health problems
- Worsening of mental health conditions



TAKE CARE

There are many ways in which you can take care of your mental health. Focus on these three activities to help you cope with being in lockdown:

- Maintain daily activities from your normal routine where possible.
- Find ways to be productive and make good use of the free time you have
- Allow time for introspection and reflection to ensure you're identifying stress factors and how to cope

STAY POSITIVE

It is important that we remain positive and hopeful during this trying time.

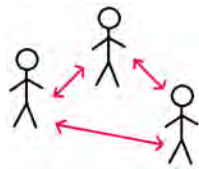
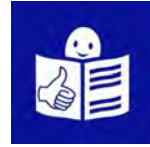
Now more than ever, is the time to work together to curb the spread of the virus.

Use this time to meaningfully connect with your loved ones and check up on those you care about.





Physical Distancing



Physical distancing means you should stay away from other people.

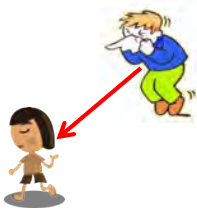
It is important to stay away from other people to make sure you do not get or spread the Coronavirus.

To stay away from people you can follow the rules below.



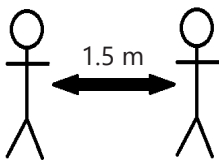
1. Stay at home as much as you can.

Try not to touch or get very close to the people you live with.



2. Stay away from people who are sick or people who have symptoms of the flu.

Keep at least 1.5 meters away from them at all times.



3. When you go to the shops or clinic try to keep 1.5 meters away from other people.

Do not kiss and hug, shake hands, high five or fist bump.



4. Do not meet up with friends or family face to face.

Keep in contact safely by calling them or messaging them on your phone.

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The Lockdown in South Africa



A lockdown means you must stay home.

The President said all South Africans must stay home from Thursday 26 March 2020 until Friday 17 April 2020.

Staying at home will help stop the Coronavirus spreading.



Nobody is allowed to leave their home during the lockdown **unless they have a good reason.**

For example,



1. You are allowed to go get your medication.

You can go to the doctor **if there is an emergency.**



2. You are allowed to go to the bank and to collect your grant.



3. You are allowed to go shopping

but you may only buy essential things.

These are things you or your pets cannot live without.



4. You are allowed to put petrol in your car.



5. You are allowed to go to a funeral of a passing loved one

but only 50 people are allowed.



The Lockdown in South Africa



You are allowed to drive cars and take public transport to get to the places explained above.



But there are rules to this,

- Only 3 people are allowed in a car.
- Taxis and buses must only take half the number of people they normally would.



Only some people are allowed to **go to work** during the lockdown because these people do services that other people cannot live without.



During the lockdown you cannot leave your home if you do not really have to.

For example,



1. **You cannot** travel far distances or leave South Africa.
Go to shops, banks and clinics **close** to your home.



2. **You cannot** go any places just for fun.
 - **No** meeting up with friends or family.
 - **No** gathering in the street.



- **No** walking your pets or going out to exercise.



The Lockdown in South Africa



During lockdown you can get arrested or fined by police if you leave your home when you **do not have a good reason**.

A fine means you have to pay money.

It is important to check you have a good reason to go out before you leave your home.

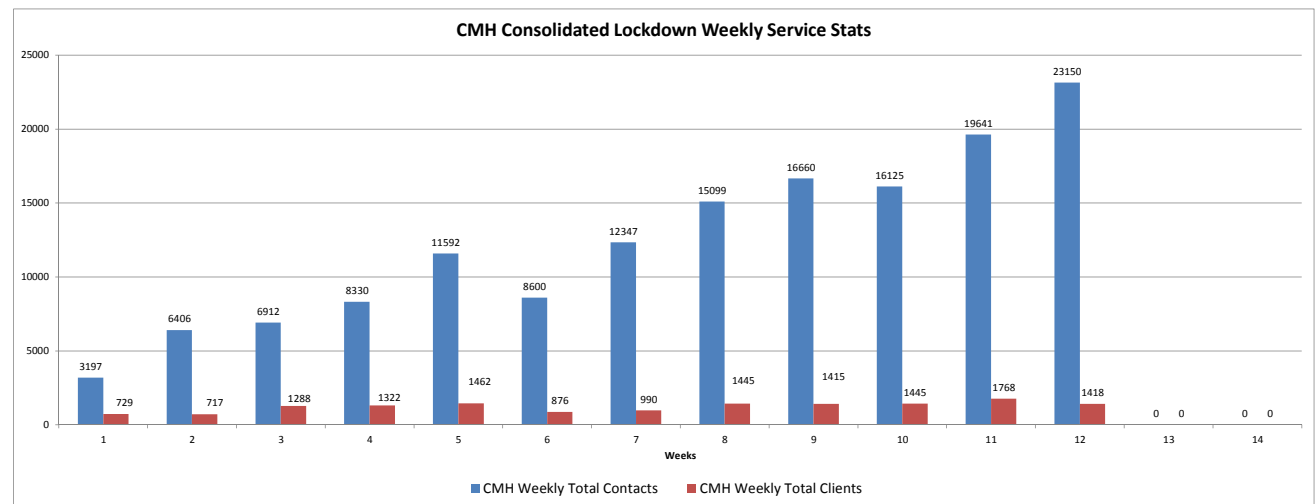
If a police officer stops you when you leave home tell the officer where you are going and why.

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Cape Mental Health Consolidated Stats: Contacts and Clients																		
Programmes→			SWS		FH		Rainbow		SECC		TWU		Garden Cottage		Kimber House		CMH Weekly Total	
Weeks↓	Days		Contacts	Clients	Contacts	Clients	Contacts	Clients	Contacts	Clients	Contacts	Clients	Contacts	Clients	Contacts	Clients	Contacts	Clients
1	23-27 March	4	0	0	471	189	210	124	1072	134	1514	387	96	8	44	11	3197	729
2	30 March - 3 April	5	1843	0	862	196	391	127	1390	139	2153	363	110	8	48	11	6406	717
3	6-9 April	4	2422	590	845	111	308	127	1112	139	2388	429	103	8	42	11	6912	1288
4	14-17 April	4	3204	610	1324	115	418	119	1232	154	2379	424	99	8	92	11	8330	1322
5	20-24 April	5	5283	750	1277	115	459	126	1919	154	2919	424	77	8	117	11	11592	1462
6	27 April-1 May	3	4755	183	741	194	464	128	897	154	2153	326	30	8	24	11	8600	876
7	4-8 May	5	6518	175	1422	189	737	146	1208	154	3021	453	51	8	127	11	12347	990
8	11-15 May	5	7808	481	1126	197	942	164	1906	154	4055	594	86	8	118	11	15099	1445
9	18-22 May	5	7463	287	1212	217	998	173	2232	159	4542	560	59	8	154	11	16660	1415
10	25-29 May	5	6039	239	1535	224	1300	173	2403	167	4608	623	58	8	182	11	16125	1445
11	1-5 June	5	6736	541	1511	241	1127	175	2515	177	7502	615	79	8	171	11	19641	1768
12	8-12 June	5	7189	208	1402	234	1442	174	3275	177	9622	606	63	8	157	11	23150	1418
13	15-19 June	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	22-26 June	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clients reached/Contacts in June 2020			13925	749	2913	241	2569	175	5790	177	17124	615	142	8	328	11	42791	1976
TOTAL FOR PERIOD			73185	1182	16641	241	8796	175	26951	177	63980	623	1053	8	1276	11	190850	2417
Total number of service users				1483		241		198		184		623		8		11		2748
% service users reached in June 2020 to date				51		100		88		96		99		100		100		72

Accumulative for June 2020





What is Coronavirus (COVID-19)?



Coronavirus is a disease that started in China.
It is also called COVID-19.



The Coronavirus has spread from China to countries
all around the world.

Many people in South Africa have gotten the Coronavirus
over the past few weeks.

People who get Coronavirus usually have:



1. A fever.
A fever means your body is too hot inside.



2. A Cough.



3. Difficulty breathing normally.
For example, feeling like you cannot breathe in properly.



4. Feel more tired than usual.



5. A sore body.



What is Coronavirus (COVID-19)?

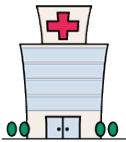


If you feel any of these things in your body or you have been close to someone who has the Coronavirus, it is very important that you call this number:



[021 928 4102](tel:0219284102)

The person on the phone will help you know what to do.



If you cannot call the number above go to your nearest clinic to get help.



Go to the clinic quickly if you are having difficulty breathing. Make sure you are wearing a face mask if you go to the clinic.



Do not panic.

Remember that if you feel like you have the flu you still might not have the Coronavirus.

It can also be normal flu.



Remember that most people do not get very sick from the Coronavirus.

But it is important to know if you have it so you can stop it spreading to others.



What is Coronavirus (COVID-19)?



Follow these rules below so you do not get or spread the Coronavirus.



1. Stay at home.



2. Wash your hands **often** with soap and water.
Count to 20 **slowly** while washing your hands to be sure they are clean enough.



3. Only touch your face **after** you have washed your hands.



4. Cough and sneeze into a tissue.
Throw it away and then **wash your hands**.
You can also cough or sneeze into your elbow.



5. Try keep away from people who are sick.
Also keep away from other people if you are sick.



6. Clean the objects and surfaces you touch a lot with cleaning chemicals **that kill germs**. Clean things like table tops, taps and door handles a few times a day.

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COVID-19 and Employee Mental Health: The reality behind the rhetoric

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Introduction

Life with COVID-19 and subsequent lockdown measures has changed everything familiar about 21st-century living and we find our inner world disrupted and our emotions in turmoil.

Coronavirus disease 2019 (COVID-19), an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), was first identified in December 2019 in Wuhan, China. On the 30th of January 2020 the WHO declared the outbreak a Public Health Emergency of International Concern, and a pandemic on 11 March. On 5 March 2020, Minister of Health, Dr Zweli Mkhize, confirmed that the virus spread to South Africa, with the first known patient being a citizen who tested positive upon his return from Italy.

On 13 May 2020, Antonio Guterres, Secretary-General of the United Nations (UN), urged all governments, civil society, health authorities, and other role players (including employers), to address mental health as an essential part of their responses to the COVID-19 pandemic. The UN published a Policy Brief regarding the need for mental health action stating that *“Although the COVID-19 crisis is, in the first instance, a physical health crisis, it has the seeds of a major mental health crisis as well if action is not taken”*. The UN predicts a long-term *upsurge in the number and severity of mental health problems globally because of the impact of the COVID-19 pandemic on people*. Also, the International Labour Organisation (ILO) and Institution of Occupational Safety and Health (IOSH) position mental health promotion during the return to work process as being an essential part of the OSH response to the COVID-19 pandemic. A mental ill-

ness crisis is looming as millions of people worldwide are surrounded by death and disease and forced into isolation, poverty and anxiety by the pandemic of COVID-19 according to UN health experts.

Early in June 2020, more than 6 million cases of COVID-19 have been reported in more than 188 countries, resulting in more than 380 000 deaths. In South Africa, by the 23rd of June, over 100 000 positive cases had been identified, 53 444 people had recovered, and 1991 people had died.

Psychological impact of COVID-19

In public mental health terms, the primary psychological impact is elevated levels and rates of stress or anxiety. As social distancing measures were introduced to flatten the curve and contain the spread of the virus, many people's usual activities, routines or livelihoods were significantly impacted which lead to a rise in levels of loneliness, depression, harmful substance use, and suicidal behaviour. From the outset, there was particular concern about the impact the pandemic will have on the mental health of frontline health care workers in particular

"The impact of the pandemic on people's mental health is already extremely concerning," according to Dr Tedros Ghebreyesus, Director-General of the World Health Organization. "Social isolation, fear of contagion, and loss of family members is compounded by the distress caused by loss of income and often employment." Dr Dévora Kestel, Director of the Department of Mental Health and Substance Use at the World Health Organization, recommends the scaling-up and reorganisation of mental health services on a global scale to build a mental health system that is fit for the future. She suggests developing and funding national plans that shift care away from institutions to community services, ensuring coverage for mental health conditions in health insurance packages and building the human resource capacity to deliver quality mental health and social care in the community.

Prof Soraya Seedat, Head of the Department of Psychiatry at the University of Stellenbosch Medical School, suggests that it "may be prudent to over-estimate the mental health sequelae and the resources that will be required" in a News24 article on 27 May 2020. She quoted research that suggested, thirty months after the SARS outbreak in 2003, a third of survivors met criteria for any psychiatric disorder; a quarter met criteria for post-traumatic stress disorder (PTSD); and approximately 16% had depressive disorders.

Authors Horesh and Brown argue that, like other mass traumatic events, the Covid-19 pandemic is expected to result in PTSD, with typical features of hypervigilance (centered on protective measures to avoid infection), intrusive thoughts (related to infection, health, fears of dying), avoidance, and negative mood and cognitions (around fears of the world-changing and the future being bleak) that will be subjectively distressing and persistently impact on day-to-day functioning over time. They aptly liken COVID-19

to an ongoing “cardiac stress test” on the world’s infrastructures and systems, magnifying their functional and structural vulnerability, including that of the field of traumatic stress.

The South African Depression and Anxiety Group (SADAG, 2020) reported that calls to their help-line doubled since the beginning of the lockdown on 27 March. In an online survey in April 2020 they found 59% of respondents stating that they felt “stressed/very stressed” before lockdown, rising to 65% during the lockdown. The survey found the main challenges during lockdown to be:

- 55% - anxiety and depression
- 46% - financial stress and pressure
- 40% - depression
- 30% - poor family relations
- 12% - feelings of suicide

Mental Health in the Context of the COVID-19 Disruption

In addition to the expected mental health issues as described above and reports of psychological distress since the onset of the COVID-19 pandemic, the concept of pre-traumatic stress disorder, albeit not considered mainstream psychiatry yet, at least warrants some attention at this time.

In 2013, American psychiatrist and climate change activist Dr Lise Van Susteren coined the term ‘pre-traumatic stress disorder’ (though the honour should properly go to satire website *The Onion*, which in 2006 featured an article on a condition with the same name) to describe stress reactions related to possible rather than past events. According to Van Susteren, the two conditions are phenomenologically alike, but in pre-traumatic stress disorder ‘we have in our minds images of the future that reflect what scientists are telling us’.

The most prominent study so far of pre-traumatic stress disorder was done in 2014 by Dorthe Berntsen and David C Rubin. They defined the condition as ‘disturbing future-oriented cognition and images as measured in terms of a direct temporal reversal of the conceptualisations of past-directed cognition in the PTSD diagnosis’. Looking at a group of Danish soldiers before, during and after their deployment to Afghanistan, Bernsten and Rubin found that pre-traumatic responses – involuntary intrusive images and thoughts, high levels of arousal and attempts at avoidance – were experienced at the same level as post-traumatic responses. Their second finding was that pre-traumatic stress reactions are a strong predictor for the development of post-traumatic symptoms.

To measure the pre-traumatic responses of the soldiers, Bernsten and Rubin created the ‘pre-traumatic stress reactions checklist (PreCL)’, adapting the first eight items of the PTSD checklist contained in

the DSM-IV – the then-current Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association – while leaving the remaining nine items unchanged.

In reconceptualising the temporality of trauma, Bernsten and Rubin are not so much laying the groundwork for a new pathology (anticipatory or pre-traumatic stress disorder is not found in the Diagnostic and Statistical Manual of Mental Disorders) in as much as they are attempting to expand our current understanding of PTSD.

‘Future research’, they write, ‘should examine whether [the PreCL] also may be used as a screening instrument in relation to non-military traumatic events as well as other subjectively stressful events, such as exams, medical procedures, or childbirth.’

Although everyone is experiencing crisis at some level, it can be argued, people are not experiencing it in the same way. Furthermore, some groups are more vulnerable to developing mental health issues during the COVID-19 pandemic, for example, those with existing mental illness, lower socioeconomic status, and individuals who experienced previous trauma (Burgess *et al*, 2019; Gray *et al*, 2003; Martin-Soelch & Schnyder, 2019)

Enter the concept of *Pre-Traumatic Stress Disorder (Pre-TSD)* which the authors postulate may contribute to the discourse around the psychological impact of the COVID-19 pandemic; a syndrome involving *involuntary, intrusive images, and flash-forwards of haunting events that could be experienced because of a major disruption* (Berntsen & Rubin, 2015; Bomyea, Risbrough, & Lang, 2012)

The result of Pre-TSD, as described above, is fear of the future and loss of control (feelings of constant uncertainty and insecurity). If these factors are not addressed proactively, the mental wellbeing of people is affected, possibly predisposing the individual to the development of anxiety, depression or PTSD (Wild *et al.*, 2016).

The symptoms of continuous pre-traumatic stress experiences are postulated to be (Heinrichs *et al.*, 2005; Elwood *et al.*, 2007; Wild *et al.*, 2016).

- Racing thoughts and constant worrying
- Constant feelings of uncertainty and insecurity
- Loss of objectivity and fearful anticipation
- Short-temperedness, irritability, impatience, and mood swings
- Indecisiveness
- Inability to focus and concentrate
- Forgetful- and absent-mindedness (“automatic mode” - doing without thinking)
- Poor judgment and risky decision-making

The characteristic COVID-19 related concerns that could predispose to pre-traumatic stress are (United Nations, 2020; ILO, 2020; IOL. 2020(b)):

- **Job-related concerns:**
 - Lay-offs, pay cuts, future employment possibilities, commuting and travelling, social interaction at work.
- **Personal concerns:**
 - Ability to provide for the family, family health and wellbeing, personal health and wellbeing, childcare and schooling, and social interaction with family and friends.
- **Country concerns:**
 - Food security, the country's economy and its ability to recover from the disruption.

However, in human behaviour, the presence of the negative, i.e., pre-traumatic stress symptoms, does not mean the absence of the positive, i.e., experiences of hope (Demerouti, Mostert, & Bakker, 2010). Hope and a sense of "taking action" combined with excellent social support, at work and in life, are mitigating factors for stress experiences. These positive factors should be promoted to buffer the impact of pre-traumatic stress experiences on individual functioning.

Research Background

Assessment Instrument

Afriforte (the commercial arm of the WorkWell Research Unit, Faculty Economic and Management Sciences, NWU, Potchefstroom), developed an instrument to objectively assess the COVID-19 experiences of employees: *MyCovid19Experiences*®. The instrument was developed following a validation research project conducted during April 2020 (www.lifewithcovid19.co.za/dashboard). The *MyCovid19Experiences* instrument measures the following dimensions:

- Hope levels
- Concern levels
- A self-rating of Covid-19-specific concerns:
 - Job loss, Pay cuts, Ability to provide for family, Family health and wellbeing, Own health and wellbeing, Country's Economy, Food security, Commuting and travelling, Future Personal finances, Future Social interaction, Future Employment, and Childcare and Schooling
- The *norm-based* incidence of stress-related psychological (Pre-TSD risk) and stress-related physical ill-health symptoms

Reliability and validity of the stress measurement

The stress-related psychological (Pre-TSD) and physical ill-health measurements consist of eight and seven items, respectively. Regarding the reliability of the constructs, statistical analysis indicated much higher alpha and omega reliability coefficients for both constructs in terms of the acceptable guideline in the social sciences of α and $\omega > 0.70$ (Sijtsma, 2009). In terms of validity, confirmatory factor analysis was conducted to model the factors. The factor loadings for the latent variables of both constructs were acceptable in terms of statistical cut-off points, i.e. loadings > 0.50 ; small standard errors for all loadings indicating the accuracy of estimation, and also acceptable communalities in terms of variance explained (Kline, 2011). Therefore, the measurement properties of stress-related ill-health symptoms are acceptable according to the most stringent standards of statistical modelling today.

Sample

A sample of 1656 South African employees who completed the *Mycovid19experiences* assessment between 15 May - 15 June 2020 were selected from the Afriforte database (South Africa in Lockdown 4 and 3). Although the sample is a non-probability convenient sample, it would provide a good indication of the experiences of South African employees over the 30-day timeframe. The characteristics of the sample are displayed in Table 3.

Table 3: *Characteristics of the Sample*

	#	% of sample
Gender		
Male	835	50.4%
Female	821	49.6%
Age Group		
20-29 (career enterers)	245	14.8%
30-39 (career builders)	549	33.1%
40-49 (mid-career)	472	28.5%
50-59 (mature career)	306	18.5%
> 59 (pre-retirement)	84	5.1%
Children		
Yes	1297	78.3%
No	359	21.7%

Relationship Status		
Divorced	91	5.5%
Engaged	77	4.6%
In a relationship: Seeing someone informally	68	4.1%
Life-partner	79	4.8%
Married	962	58.1%
Other	13	0.8%
Single	336	20.3%
Widowed	30	1.8%
*Worker Type		
No Data	1243	75%
Working On-site	37	2.2%
Working Remotely	376	22.7%

* This breakdown was only available for selection by participants since 5 June 2020. The results of the “early” remote worker sample are discussed in the article.

Results

Concerns about the future

Participants were asked to rate how much more concerned they are about the future since the outbreak of the COVID-19 pandemic. The results are provided in Table 4.

Table 4: *Concerns about the future*

	Not at all Concerned	A little bit Concerned	Quite Concerned	Very Concerned	Extremely Concerned
Overall sample (n=1656)	2%	17%	32%	30%	19%
Gender					
Male (n=835)	2%	17%	32%	30%	19%
Female (n=821)	2%	17%	32%	30%	19%
Age Groups					
20-29 (n=245)	2%	15%	25%	37%	21%
30-39 (n=549)	2%	18%	31%	30%	20%
40-49 (n=472)	1%	19%	34%	27%	18%
50-59 (n=306)	3%	16%	34%	30%	17%

> 59 (n=84)	4%	18%	40%	24%	14%
Children					
Yes (n=1297)	2%	16%	32%	31%	20%
No (n=359)	3%	21%	34%	27%	15%
Worker Type					
Remote workers (n=376)	3%	22%	32%	27%	16%

From the total sample, 49% of employees indicated high concern levels while only 2% reported not to be concerned about the future following the COVID-19 outbreak. There is no difference between males and females, however, concern levels appear to be higher for younger age groups (between 20- 39 years) and employees with children.

Hope about the future

Participants were asked to rate how hopeful they feel about the future given our current situation. The results are provided in Table 5.

Table 5: *Hope about the future*

	Extremely Hopeful	Very Hopeful	Quite Hopeful	A little bit Hopeful	Not at all Hopeful
Overall sample (n=1656)	11%	31%	35%	19%	4%
Gender					
Male (n=835)	13%	33%	32%	18%	4%
Female (n=821)	9%	30%	38%	19%	4%
Age Groups					
20-29 (n=245)	11%	37%	29%	19%	4%
30-39 (n=549)	11%	31%	34%	21%	3%
40-49 (n=472)	11%	31%	38%	17%	3%
50-59 (n=306)	11%	31%	33%	19%	6%
> 59 (n=84)	7%	31%	36%	18%	8%
Children					
Yes (n=1297)	11%	31%	35%	18%	4%
No (n=359)	10%	33%	34%	20%	3%
Worker Type					
Remote workers (n=376)	10%	34%	40%	14%	2%

From the total sample, only 4% of employees indicated despair about the future (not at all hopeful); 77% of the sample experience decent hope levels. This is a particularly positive result as it indicates that although concern levels are evident the presence of the positive (HOPE) is also evident for a large proportion of the sample of South African employees. Slightly less overall hope is evident for older age groups (50 and older) and a larger portion of this age group experience despair. Also, remote workers appear to be more hopeful.

Rating of concerns

Participants were asked to rate specific concerns about several aspects of their lives given the current Covid-19 situation. Figure 1 displays the ranked concern ratings.

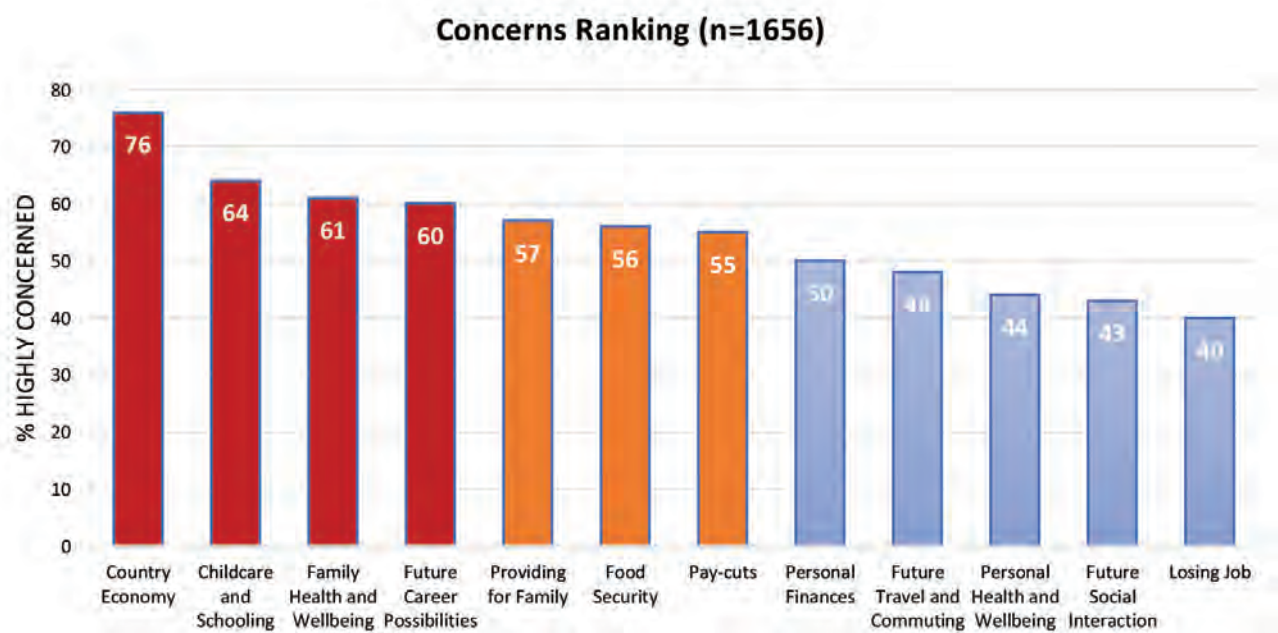


Figure 1: Concerns ranking for a sample of South African employees

The top concerns for the sample of South African employees are the *Country's Economy*, *Childcare and Schooling*, *Family Health and Wellbeing* and *Future Career Possibilities*. *Providing for my Family*, *Food security*, and *Pay-cuts* are also ranked as areas of concern for over 50% of the employee sample. Interesting to note that only 40% of the sample of the sample ranked *Losing their jobs* as a huge concern. The top three concerns per biographical breakdown are provided in Table 6.

Table 6: Top three concerns per biographical Breakdown

	Top Concern	2 nd Concern	3 rd Concern
Overall Sample (n=1656)	Country's Economy	Childcare and Schooling	Family Health and Wellbeing Future Career Possibilities
Gender			
Male (n=835)	Country's Economy	Childcare and Schooling	Future Career Possibilities
Female (n=821)	Country's Economy	Childcare and Schooling	Family Health and Wellbeing
Age Groups			
20-29 (n=245)	Country's Economy	Family Health and Wellbeing	Future Career Possibilities
30-39 (n=549)	Country's Economy	Childcare and Schooling	Family Health and Wellbeing
40-49 (n=472)	Country's Economy	Childcare and Schooling	Future Career Possibilities
50-59 (n=306)	Country's Economy	Food Security	Future Career Possibilities
> 59 (n=84)	Country's Economy	Personal Finances	Providing for Family
Children			
Yes (n=1297)	Country's Economy	Childcare and Schooling	Providing for Family
No (n=359)	Country's Economy	Family Health and Wellbeing	Future Career Possibilities
Worker Type			
Remote (n=376)	Country's Economy	Childcare and Schooling	Family Health and Wellbeing

The *Country's Economy* is the top concern for all biographical groups. However, for the pre-retirement employee group (>59), *Personal Finances* and *Providing for Family* are more dominant concerns, this might be related to fears that retirement provisions would be inadequate because of the impact of the Covid-19 disruption on the economy.

Stress Results

Pre-TSD risks (Psychological Distress)

This section shows the norm-based incidence of Pre-TSD risks, i.e. compared to the norm for psychological distress, an individual is at high risk, moderate risk, or low risk of experiencing Pre-TSD symptoms. The results of the participants are aggregated to a group level to indicate the group incidence of Pre-TSD risks. The typical Pre-TSD symptoms include, *inter alia*, frequent upsetting thoughts, constant feelings of uncertainty, mood swings, irritability, etc. Table 7 displays the incidence of Pre-TSD per biographical group.

Table 7: Pre-TSD per biographical group

Norm-based Incidences	High Pre-TSD risk	Moderate Pre-TSD risk	Low Pre-TSD risk
Overall sample (n=1656)	46%	28%	26%
Gender			
Male (n=835)	40%	27%	34%
Female (n=821)	52%	29%	19%
Age Groups			
20-29 (n=245)	42%	26%	32%
30-39 (n=549)	46%	31%	22%
40-49 (n=472)	45%	27%	28%
50-59 (n=306)	46%	25%	29%
> 59 (n=84)	49%	33%	18%
Children			
Yes (n=1297)	46%	28%	26%
No (n=359)	45%	30%	25%
Worker Type			
Remote workers (n=376)	53%	25%	22%

From the total sample of South African employees, **46%** are at high risk Pre-TSD and associated symptoms; only 26% are at low risk. Females (52%), Remote workers (53%), and the pre-retirement group (49%) are at higher risk. Further analysis indicated that widowed (n=30) and divorced (n=91) employees are also at higher risk of experiencing PTSD. High levels of psychological distress can result in risk behaviour, and the development of anxiety syndromes and depressive disorders in the long run. Pre-TSD experiences have a negative impact on the functioning of employees at work, i.e., lower productivity, increase in mistakes and errors, poorer customer service, and higher risks for accidents and injuries at work.

Stress-related Physical Distress

Experiences of chronic psychological distress result in people experiencing stress-related physical ill health symptoms such as, frequent headaches, nausea, heartburn, eating problems, palpitations, sleep problems, and muscle pains and aches. Chronic psychological and physical distress can cause changes in blood pressure, blood glucose and cholesterol levels, and cause impaired immune responses, to mention a few. This section displays the incidence of stress-related physical ill-health symptoms in terms of norm percentile categories, i.e. compared to the norm an individual is at high risk, moderate risk, or

low risk of experiencing stress-related physical ill-health symptoms. Table 8 displays the incidence of Stress-related Physical Distress per biographical group.

Table 8: *Stress-related physical distress per biographical group*

Norm-based Incidences	High Stress-related Physical Symptoms	Moderate stress- related Physical Symptoms	Low Stress-related Physical Symptoms
Overall sample (n=1656)	35%	30%	35%
Gender			
Male (n=835)	24%	30%	46%
Female (n=821)	47%	30%	23%
Age Groups			
20-29 (n=245)	28%	33%	39%
30-39 (n=549)	35%	30%	35%
40-49 (n=472)	38%	31%	32%
50-59 (n=306)	38%	26%	36%
> 59 (n=84)	36%	29%	25%
Children			
Yes (n=1297)	36%	29%	34%
No (n=359)	32%	33%	35%
Worker Type			
Remote workers (n=376)	49%	30%	21%

From the total sample of South African employees, **35%** are experiencing a high incidence of stress-related physical ill health symptoms. Females (47%), Remote workers (49%), and mid- and mature-career employees show higher risks for experiencing stress-related physical symptoms. The latter result is a concern in terms of the overall physical health impact of the Covid-19 disruption on this older group of employees who might be more vulnerable for developing metabolic syndrome risks in future.

Hope versus Psychological Stress

From a theoretical perspective, Hope (the presence of the positive) is a mitigating factor for the development of Pre-TSD. Figure 2 shows the relationship between Hope and the experience of Psychological Distress (Pre-TSD) for the sample of South African employees.

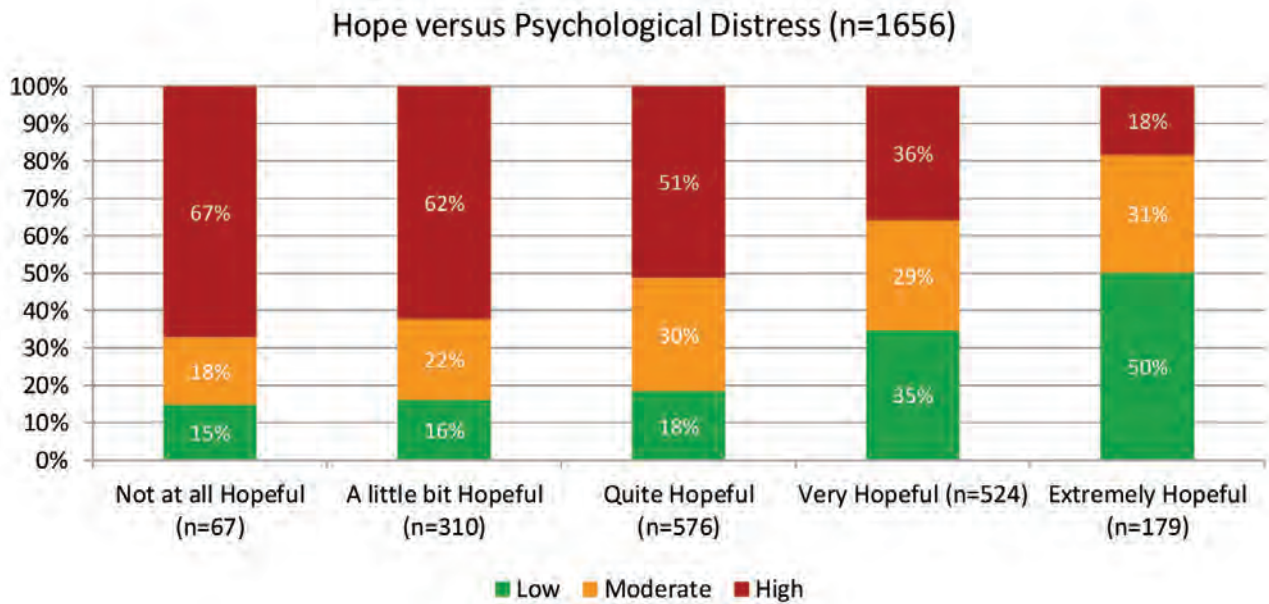


Figure 2: Hope versus Psychological Distress

The results for a sample of South African employees confirm the mitigating effect of Hope on the development of Pre-TSD. As Hope levels increase, the experience of Pre-TSD symptoms decrease for the sample of South African employees. Proactively, promoting Hope would have a positive impact on employee functioning. This is an important result for employers to take note of.

Summary of Results

- High concerns levels about the future is evident for **49%** of employees following the COVID- 19 outbreak. Concern levels are higher for career enterers and career builders (age group 20- 39 years) and employees with children. There is no significant difference between male and female employees.
- Most employees are hopeful; decent hope levels are evident for **77%** of employees despite concerns about the future. Slightly less overall hope is evident for older age groups (50 and older) and a larger portion of this age group experiences *despair*. Remote workers appear to be more hopeful.
- The top concerns for the sample of South African employees are the *Country's Economy, Childcare and Schooling, Family Health and Wellbeing and Future Career Possibilities. Providing for Family, Food security, and Pay-cuts* are also ranked as areas of concern for over 50% of the employee sample. Only 40% of the sample ranked *Losing their jobs* as a huge concern.
- **46%** of employees are at high risk of Pre-TSD and associated symptoms. Females, Remote workers, the pre-retirement age group, and widowed and divorced employees are at higher risk of Pre-TSD in

the sample. Risk behaviour, anxiety syndromes, and depressive disorders are future risks for 46% of employees.

- **35%** of employees are experiencing a high incidence of stress-related physical ill health symptoms. Females, Remote workers, and mid- and mature-career employees show higher risks for experiencing stress-related physical symptoms. The overall physical health impact of the Covid-19 disruption on this older group of employees is a concern – might contribute to metabolic syndrome risks in future.
- The results for the sample of South African employees support the mitigating effect of Hope on the development of Pre-TSD. As Hope levels increase, the experience of Pre-TSD symptoms decrease. Promoting Hope could have a positive impact on employee functioning. This is an important result for employers to take note of.

Recommendations

Mental health service providers, the Medical insurance industry, and Employers should take note of these results.

Mental health service providers can expect an increase in patient volume. An objective assessment of an individual's experiences with a reliable instrument such as the *Mycovid19experiences*® could assist service providers to ascertain the level of mental health impairment for customised intervention purposes, e.g., an individual with high concern levels, low hope levels, and high levels of Pre-TSD and stress-related physical symptoms requires urgent assistance and mental health evaluation, including evaluating behavioural risks at a personal level, such as suicide ideation, substance abuse, and other possible dysfunctional risks.

The *medical insurance industry* should prepare for an increase in mental health expenses over the next two years. Medical insurers could consider making use of COVID-19 related mental health risk instruments for example the *Mycovid19experiences*® diagnostic instrument, as an insured benefit to members as part of their underwriting risk management and disease management strategies.

To proactively address the mental health risks of employees due to COVID-19 related concerns, collaboration between medical insurers and corporate employer groups is required.

Conclusion

Employers are best positioned to proactively mitigate the mental health impact of the COVID-19 disruption on a large number of citizens. Mental health promotion should be part of the COVID-19 business recovery strategy. The COVID-19 disruption significantly increased the stress levels of employees and

moreover, our work (and life) environments have changed drastically. Employees, in addition, need to adapt to these changes, adding to increased stress experiences.

Furthermore, it is well-known that high stress levels affect employee functioning at work and contribute to lower productivity and higher risks for mistakes and accidents in the workplace. Employers should ensure that they stay connected with staff by assessing the stress experiences and mental health of their staff objectively (understand where staff are) and facilitating an objective “touch base session” with teams. The purpose of a touch base session would be to normalise fears (we are all in the same boat), promote hope, create a sense of control by showing how being at work, working safely, and staying healthy mitigate COVID-19 fears and concerns.

Social support at work (team support) should also be promoted.

A fit-for-purpose “Employee Touch Base COVID-19 platform”, based on the results of this research, is available to employers to proactively address mental health risks in the workplace and set employees up for success during the business recovery process.

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SECTION D

Call to Action



World Mental Health Day 2020 Call to Action

In late May 2020, rage erupted among individuals and communities as mortality and morbidity from pandemic, systemic racism and structural violence amplified each other in the United States (US) and in vulnerable populations around the world. By June 2020, anger over police brutality against Black people, most publicly displayed in the murder of George Floyd, found expression among people from Seattle to London, Frankfurt to Madrid, Sophia, Tunis, Gaza, Pretoria, Sydney, Seoul and Tokyo.

Some sectors are just beginning to acknowledge that systems of racism are woven into the fabric of our societies and govern access to safety from violence, quality health care, education, livelihoods and income, and a host of other resources that influence how and when we live or die.^{1,2} Yet, none of this is new. Negotiating the threats to survival that inequality and unfairness yield, or simply being exposed to them on an ongoing basis, assaults the health, wellbeing, and life trajectories of affected communities and individuals.² Conversely, the social drivers that protect overall health and wellbeing—early childhood interventions, antidiscrimination laws and policies, safe and affordable housing, employment opportunities, access to quality health services— are also foundational to mental health.³

The social conditions that permeate living, learning, working, worship, and educational environments—social determinants—contribute to our mental health throughout the course of our lives.⁴ Adverse experiences across the lifespan, such as stigma in all its forms of prejudice, stereotypes, and discrimination; poverty and income inequality; interpersonal and collective violence; or forced migration are key determinants of the emergence of mental disorders, cardiovascular disease, and of course, infectious disease morbidity and mortality as well.^{3,5-7} However, diagnosing or correlating mental or other health conditions to these exposures does not absolve us as advocates, professionals, or as a community, from the ethical responsibility to understand and confront social processes that fuel these problems.

In this moment, the COVID-19 pandemic and accompanying civil unrest, economic disruption, and unemployment underscore the longstanding consequences of health inequities and poor investment in public health.^{8,9} These inequities occur in a global environment already marked by inadequate access to effective mental health care for those who need it¹⁰⁻¹² and higher mortality rates for people with long-term mental health problems and co-occurring medical conditions.¹³ This moment also highlights where we need to take action. Greater investment and greater access to mental health and wellbeing demands that governments, civil society, donors, and multilateral organizations act on these considerations:

1. Recognize and respond to racism in all its forms as a threat to health and wellbeing across the lifespan.

The extraordinary vision articulated in the United Nations 2030 Agenda for Sustainable Development seeks to eradicate poverty, respect human rights, and leave no one behind. With this agenda, UN member states aspire to a life of thriving for all people regardless of the social, cultural, or health-related limitations that influence long term outcomes and the ability to live a good life. With these commitments come explicit acknowledgment of the “interlinkages and integrated nature of the Sustainable Development Goals [SDGs],” and implicit recognition of the danger to dignity, health and wellbeing that stems from inequality based on race, ethnicity, gender inequality, ability or any other human characteristic. Indicators for SDG 10, in particular, will track reductions in the proportion of the population who report personal discrimination or harassment in the previous year on grounds recognized by human rights law.¹⁴

The public health community long ago determined that racism is a threat to health, mental health and wellbeing.² Systems of racism, promote ideas of inferiority of a specific population, entrench these in the belief systems and norms of the larger culture, allowing the legitimacy of forms of discrimination that marginalize and devalue these groups.² Its effects are pervasive and support implicit and explicit bias, which not only leads to negative psychological responses in stigmatized people, but influences how others respond to egalitarian policies or laws that affect the group¹⁶. Institutional or structural racism supports policies that sustain unfair allocation of resources and reduces access to opportunities (through segregation, forced migration and removal). Discrimination is the behavior and route by which people’s access to economic, educational, medical and other social resources are curtailed.¹⁵ The consequences of these processes include limited life chances, psychological distress, mood and anxiety symptoms, increased risk of mental disorders and precursors to chronic medical conditions. Thus, the mental health community must also challenge and dismantle the structural, as well as individual, forms of racism that contribute to poor health and wellbeing in general, and poor mental health, specifically.

2. Stimulate and accelerate efforts to achieve the SDG targets.

The Lancet Commission on Global Mental Health and Sustainable Development emphasized the relevance of mental health for achieving the health related SDG targets and for sustainable development in general.¹⁶ Recent analyses that systematically map social determinants of mental health to the SDGs show that interventions to reduce gender-based violence, child maltreatment, racial discrimination and xenophobia; cash transfers or basic income grants, improved employment; safe neighborhoods; reductions in violence, early response to environmental threats; access to quality education and supportive social networks could improve population mental health outcomes.⁶ Reaching these targets by 2030 will require greater investment as well as greater political will, at a time when, due to COVID-19, global direct foreign investment could decline by as much as 40% this year.¹⁷ As of July 2020, the world was

not on track to achieve most SDG targets, including those for poverty reduction, food security, inclusive and equitable education, or income equality.¹⁷

3. Invest in social and behavioral interventions.

The global mental health community has highlighted the need to support community environments that promote mental wellbeing as a grand challenge.¹⁸ Using community empowerment as an approach to mental health promotion, seeking the mental health benefits of community-led advocacy and intervention participation, placing people at the center of service design, delivery, and scope; and deepening our understanding of how intervening on social determinants affects population mental health can move us closer to meeting this challenge.¹⁹

We must continue to invest in psychosocial and behavioral interventions that reduce stigma, strengthen interpersonal relationships, bolster social supports, and create social networks to serve as buffers for individuals to cope with assaults on determinants of health while we work on dismantling the structures that cause harm. Schools, clinics, and places of employment can work to bring small groups of people together who have common backgrounds to share coping strategies, build confidence, and support livelihoods.²⁰ The pandemic has stimulated such community-engaged responses to vulnerable populations—responses that may also meet needs after the crisis.²¹

4. Ensure access to quality and affordable mental health care and primary care.

In tandem with greater attention to social determinants of health, the redesign of health systems to integrate mental health care with other chronic disease care and the establishment of parity between mental and other medical conditions remains a grand challenge for global mental health.²² The journey to universal health coverage (UHC) creates a pathway to meeting this need, and it is timely. The rise in mental health problems accompanying the COVID-19 pandemic, as well as the possibility of neurocognitive sequelae of SARS-CoV-2,²³ serve as reminders that the separation of health from mental health is artificial at best, harmful at worst. Injuries to health frequently have mental health consequences, and poor mental health increases the chances of poor health outcomes. People with severe mental disorders continue to experience disproportionate mortality associated with medical conditions.²⁴

Persistent under-investment in community mental health services, over-investment in psychiatric hospitals, inadequate human resources are supply-side barriers to quality care; whereas stigma associated with seeking care and mismatch between providers and lay people in concepts and attributions of ill-

ness contribute to demand side barriers.²⁵ Nevertheless, evidence-based models of care that integrate mental health into primary care are available,²⁶ as are mental health interventions that can be delivered in differently resourced health systems,^{27,28} but funding for sustained implementation must be increased.

5. Reduce disparities in mental health care.

Essential to the success of UHC is the reduction of health disparities. This requires understanding how intersectionality influences health disparities that emerge from race and ethnicity, gender and transgender identity, living with a severe mental health condition, poverty and inequality, and other disadvantaged statuses. Being a woman, an immigrant, a member of an ethnic minority group, a person living with a chronic mental health condition—each of these aspects of a life contributes to risk of and resistance to poor mental health outcomes.²⁹ Working to reduce these disparities requires understanding which groups receive less care and why, and tailoring efforts to engage people in care, ensuring affordability, and employing care delivery models that facilitate access and continuity.³⁰

Conclusion

The tragic events of 2020, in themselves, serve as a call to action to every individual and every community that values human dignity and human rights. Racism drove the brutality witnessed in the United States, but no society is innocent of discrimination and its ill effects— be it by caste, by race, by ethnicity, gender, or disability. This call should resonate with particular force within the global mental health community. We have found our raging soul,³¹ we have marching orders from those who have given their lives, and a plan of action from the 2030 Agenda for Sustainable Development. We have the energy of youth around the globe united for justice, we understand the pain of exclusion, and we must respond with purpose and intentionality.

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SECTION E

World Mental health day Toolkits and Resources



Patient Led Assessment of the Care Environment (PLACE)

This year WFMH wants to empower people with lived experience to become actively involved in their care they are offered.

Environments are very important, as highlighted in Healthy People 2030 and in Tackling Stigma and Social Isolation.

We need to invest in good quality mental health facilities and mental health service users should be involved in assessing quality of the facilities offered.

The UK PLACE programme is a good example of this, and we are grateful to NHS England / NHS Improvement and NHS Digital for sharing their knowledge and expertise.

Patient Led Assessment of the Care Environment (PLACE)

Good environments matter.

Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. Patient Led Assessments of the Care Environment (PLACE) is a system for assessing the quality of the patient environment and provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

PLACE was introduced in England in 2013, it is an annual voluntary self-assessment and is the only national programme that collects data relating to the patient environment, it provides a consistent approach so that all organisations are assessing the same things to the same standards.

The assessments involve local people (known as Patient Assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, they look at hospital cleanliness, food and hydration, support for patients' privacy, dignity and wellbeing, general building maintenance and décor, whether the environment is dementia friendly and provides for those patients, visitors and staff with a disability. The team must include a minimum of 50 per cent patient assessors.

The results are published and show how hospitals are performing both nationally and in relation to other hospitals providing similar service.

Details of the scheme can be found on the link below:

<https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/>

Assessment forms and supporting guidance documents, including patient assessor training slides can be found on the link below:

<https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place#supporting-guidance-documents>

Gill Donachie Patient Environment Senior Policy Lead NHS Estates and Facilities Division Commercial Directorate NHS England/NHS Improvement

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WHO's recommended links

WHO's website on suicide prevention

Includes links to suicide data and technical and communications materials for audiences including government policy-makers, nongovernmental organizations, journalists and the general public

https://www.who.int/health-topics/suicide#tab=tab_1

Preventing suicide: a community engagement toolkit (2018)

A step-by-step guide for people who would like to initiate suicide prevention activities in their community. It describes a participatory bottom-up process by which communities (including community leaders, health workers, parliamentarians, teachers, social workers, police and firefighters and business leaders) can work together to identify, prioritize and implement activities that are important and appropriate to their local context and that can influence and shape policy and services.

Developed in collaboration with the Mental Health Commission of Canada.

<https://www.who.int/publications/i/item/suicide-prevention-toolkit-for-engaging-communities>

Investing in mental health: evidence for action (2013)

Presents key reasons for investing in mental health from the perspectives of public health, economic welfare and social equity and highlights priorities for investment in mental health.

https://www.who.int/mental_health/publications/financing/investing_in_mh_2013/en/

Move for Mental Health: Let's Invest

In a time of physical distancing, what better way to show your support, unity and desire for change than to gather virtually with your fellow advocates to move for mental health? Possibly none.

In the spirit of World Mental Health Day and the strength and solidarity of the mental health movement, the WFMH is proposing that we all try to do more for World Mental Health Day this year.

We are encouraging our partners to hold virtual (or in person where possible) commemorative events for WMHD. Not only are you bringing much needed attention to the mental health discourse, you are showing those that are facing discrimination and stigma that there is no reason to be ashamed or afraid.

Your actions will put a face to this invisible illness; you will humanize the issue, and show the decision makers in the government and the community that your cause has validity.

This may all sound like hard work, but it doesn't have to be. If social distancing restrictions allow you can gather together 10-50 of your friends, family and colleagues, pick your gathering place or starting and ending points, make some clever but peaceful signs and you're ready to march for mental health whilst respecting the public health policy in your country!

And if you can't meet in person, why not join the virtual March for Mental Health?

On 9th - 10th October 2020, the World Federation for Mental Health will join partners around the world to March for Mental Health. A 24-hour Facebook livestream will feature rallying content from expert voices, lived experience and influencers.

Mental health campaigners in a range of different countries will lead one hour each (Argentina, Peru, Liberia, Sierra Leone, Ghana, Nigeria, Kenya, South Africa, Pakistan, India, Nepal, Sri Lanka, Indonesia, Philippines, Tonga, New Zealand, Australia, UK, US), and the remaining 5 hours have been allocated to and will be led by civil society partners working globally within themes including youth mental health, disability and mental health, LGBTQIIA+ and mental health, HIV/AIDS and mental health and ageing and mental health.

The public will be encouraged to join the March, by watching and sharing the live stream; by using a series of Instagram filters to stand up and be counted as they call on leaders to invest in mental health for all; or simply to join an activity on TikTok. The live stream will be hosted on a dedicated microsite that will also feature live social media feeds and archive content from the March.

World Federation members are encouraged to join the March: you can join national partners in the countries that will be featured in the dedicated hours or join global partners in any of the thematic hours

depending on your own priorities. You can even go for both depending on what works for your timezone. To learn more about the march see: www.gospeakyourmind.org

How to Organize a Physical March or Vigil

We have gathered some general information for you to use as you plan your March for Mental Health . Please note that requirements are different in every country and community – please find out the laws and requirements for your particular area and avoid any legal issues that might disrupt or cancel your march. The two types of demonstrations we are highlighting are:

Vigil or Rally- These are gatherings where people stay in one place. They are generally solemn and reflective and intended as a peaceful way of honoring or highlighting a person or group of persons or a subject of great concern.

March- A march is a gathering of people who move from one designated point to an agreed upon destination. Marches are good if you have a large crowd or when you want to cover a large area.

1. Pick a date (10/10 would be great!) and secure a location. Check to see if you need a permit or some type of permission to hold your March or Vigil in public – it will be critical to know your rights regarding any type of public gathering. Pick a heavily populated route or public gathering point.
2. Decide on your cause and the message you want to send to those watching. Make it simple, peaceful and strong. Create banners, signs and handouts to use – be sure that all are focused on your message, are strong but peaceful, spelled correctly and big enough for people to see.
3. Schedule speakers to address your crowd. You can schedule speakers to start your event, end your event or both. Keep the speeches short and to the point, remember this is a demonstration not a symposium.
4. Get the word out! Contact your advocates, friends, partners, etc - try to include as many groups as possible to show the strength and solidarity within the community. Creating a unified coalition among different groups (mental health groups and professionals, medical groups, families, patients, doctors, nurses, etc) is essential to forming a broad-based social movement and getting the most attention.
5. Assign tasks and determine roles for all involved. If working with different groups – bring all leaders together to utilize and unify everyone’s abilities, networks, and message.
6. Contact the media and write press releases announcing your plans – include your ‘who, what, when, where’ information to be sure all facts about your demonstration are available.
7. Be sure to take pictures, keep notes of the full event and send all your information to wmhd2020@wfmh.global when you are done – so we can show the world we are united and we won’t keep silent any longer!

This could be the single largest advocacy effort for mental illness across the globe! We hope you will join in and do anything you can to show your support. 5 people or 500 people – we can all make a difference if we just do something!

Effective Slogans

- Show the importance of an issue
- Show the relevance of an issue
- Put a “face” on the issue
- Address each specific audience
- Reflect an understanding of what would motivate change
- Are culturally relevant and sensitive
- Are memorable

Examples

- Mental Health Matters
- Move for Mental Health: let’s Invest!
- Celebrate World Mental Health Day – Open your Mind!
- Nothing about us without us
- March for Mental Health Reform!
- ALL illnesses deserve the same care and treatment!
- Close to 1 billion people are living with a mental disorder ... Look around you – do the math.”
- There is no health without mental health!
- Mental Discrimination: Open Your Eyes to Our Reality

World Mental Health Day 2020

Sample Proclamation

WHEREAS, close to 1 billion people around the world are living mental disorder;

WHEREAS, relatively few people around the world have access to quality mental health care;

WHEREAS, the coronavirus pandemic has resulted in a deterioration in the mental health and well-being of many people;

WHEREAS, mental illness such as anxiety disorders, depressive disorder, bipolar disorder, and schizophrenia, when not appropriately diagnosed and treated, are leading causes of poor work performance, family disruption, and contribute greatly to the global burden of disease;

WHEREAS, many mental health conditions are treatable or preventable and the human toll they represent have traditionally received too little attention and concern by the general public, the general healthcare system, and elected and appointed public policy makers, resulting in inadequate priority being given to these disorders;

AND WHEREAS, the World Federation for Mental Health has designated the theme for World Mental Health Day 2020 as *“Mental Health for All: Greater Investment, Greater Access,”* and urges increased investment in appropriate and equitable mental health services including support for the social determinants of health to address mental health promotion and prevention;

THEREFORE, I, _____, _____(TITLE) _____ OF THE _____(TOWN/COUNTRY AGENCY, ORGANIZATION, MINISTRY)_____ DO HEREBY PROCLAIM 10 OCTOBER 2020 AS WORLD MENTAL HEALTH DAY IN ___TOWN/CITY/COUNTRY_____

and urge all governmental and nongovernmental mental health organizations and agencies to work in concert with elected and appointed public officials to increase public awareness about, and acceptance of, mental illnesses and the people living with these disorders; promote improved public policies to enhance diagnosis, treatment, and support services for those who need them through adopting a whole systems approach; and to reduce the persistent stigma and discrimination that too often serve as barriers for people seeking services and supports available to them.

I further urge all citizens to join and support the local, state/provincial, and national non-governmental organizations that are working to make mental health a priority in communities throughout our nation.

Together, we will all make a difference and promote mentally healthy communities and citizens!

Signed _____

Title _____

Ministry/Office/Agency _____

Date _____

(SEAL)

Sample Media Release for Signing

The World Mental Health Day Proclamation

October 10, 2020

FOR IMMEDIATE RELEASE

_____ MAYOR (OR OTHER OFFICIAL) OF _____ (town, city, or country) _____

PROCLAIMS OCTOBER 10 WORLD MENTAL HEALTH DAY IN _____ (locale) _____.

The (official's title/position/office), the Honorable _____(name)_____, designated October 10 as World Mental Health Day 2020 in _____(locale)___ through the signing of a Proclamation issued by (legislative body, office, department).

The Proclamation signing ceremony was organized by ____ (organizing organization or agency) _____, and was attended by (members of the organization, public officials, community leaders, and private citizens, etc.).

The Proclamation urged all non-governmental organizations and governmental agencies to work co-operatively with elected and appointment public policy makers and officials to promote the enhancement of equitable and appropriate mental health services in primary healthcare settings, and to increase ready access to services by those experiencing serious mental health problems and disorders such as schizophrenia, anxiety disorders, bipolar disorder, and depression! It also stressed the need for all members of the community to increase their understanding of mental disorders and to help reduce the stigma and discrimination that persists around mental illnesses and the people who live with these serious health disorders.

The theme for World Mental Health Day 2020 is *"Mental Health for All: Greater Investment, Greater Access,"* and addresses the need to promote early access to care and the prevention of mental health difficulties and promotion of mental well-being.

The World Federation for Mental Health (WFMH) established World Mental Health Day in 1992; it is the only annual global awareness campaign to focus attention on specific aspects of mental health and mental disorders, and is now commemorated on all continents of the world and in nearly all countries on October 10 through local, regional and national World Mental Health Day commemorative events and programs.

Put a brick in the wall

Close to one billion of the world population are living with mental illness and the majority have no access to care. In many low, and medium income countries most of the help is provided by family members or NGO's (non-governmental organisations).

The current COVID-19 pandemic has shown that our health systems are not well equipped to deal with crises and emerging illnesses.

To support this year's World Mental Health Day goal of providing greater access the World Federation for Mental Health would like to provide direct support to some small NGO's in low income countries who have difficulty in obtaining the support required to continue the good work that they are doing.

We are calling on our supporters and members to help us to do this and have set up a virtual wall to which you can make a donation.

Click on one of the bricks below to make your donation:

less than \$10	\$35	\$50
\$100	\$500	\$1.000
\$5.000	\$10.000	more than \$10.000

All donors will be named on the 2020 World Mental Health Day Virtual Wall

Thanks

I would like to thank everybody who has contributed to World Mental Health Day 2020 'Mental Health for All: Greater Investment – Greater Access,' including this year's Royal Patron HRH Princess Iman Afzan Al-Sultan Abdullah and our WFMH President Ingrid Daniels.

The annual World Mental Health Day established in 1992 through the energies of Dick Hunter, and supported by the Carter Centre, has been actively supported by the WHO, United Nations and many individuals, institutions and professional colleges around the world with an interest in promoting mental health advocacy. I am very grateful to you all.

All our WFMH Secretary Generals and WFMH Past Presidents since 1992 have worked to ensure that this annual event on October 10th continues to grow with a clear message to ensure that mental health is a priority, and each of use receives the dignity of care that we are entitled to.

Every world citizen has a role to ensure that mental health is a global priority. I know that each of you is playing a part – for this I am grateful.

WFMH cannot do this alone, and we welcome partnership and are grateful to all our volunteers. This year's educational material has been provided by people with lived experience, carers, health professionals from many specialities, governments and those who commission services. All our contributors have volunteered their time and expertise to provide this years wonderful material – thank you.

Thanks to Pamela Collins and Deepa Rao for our World Mental Health Day Call to Action 2020. It should not just be rhetoric – it requires us to act. I am very grateful to the 2020 WMHD technical team Mario Merlo, Steve Maingot, and Oghenechuko Okor, Master's of Architecture Student at Columbia University, New York, USA who provided the image for the front cover.

My thanks to the WFMH 2019-2021 Executive, Regional Vice Presidents and Board of Directors for their support, and to WFMH voting and non-voting organisational members and WFMH individual members for their support.

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