WORLD MENTAL HEALTH DAY

DIGNITY IN MENTAL HEALTH

The 10th of October 2015

WORLD FEDERATION FOR MENTAL HEALTH
WFMH



WORLD MENTAL HEALTH DAY
IS A TRADEMARKED PROJECT OF THE

WORLD FEDERATION FOR MENTAL HEALTH

MESSAGE FROM THE PRESIDENT

This year the World Federation for Mental Health has chosen "Dignity in Mental Health" as the theme for World Mental Health Day on 10 October. "Dignity" is a word that has a number of meanings, none of them precise—but we all recognize dignity when we see it, and more importantly, we recognize the lack of it when it's absent.

With this year's theme we aim to show the ways in which dignity can be provided in all aspects of mental health, ranging from care for our patients/consumers to the attitudes of the general public. We hope you will support the theme with activities in your own region that educate people about the importance of dignity in mental health.

All too often people with mental disorders and their families find dignity absent in their dealings with health care providers and with society at large. They feel demeaned by the manner in which they are treated. Health professionals don't have the time needed to address difficult problems. Budget problems at the national level impact health and social care budgets at the local level, making coordinated care difficult to achieve. People with mental disorders frequently do not get coordinated care for other illnesses that may be present, resulting in neglect of their overall health—and ultimately, shortened lifespans.

Having said the above I should also underline that a somewhat broader conception of dignity should include reciprocal respect between providers and recipients of care. Synthesis and collaboration is certainly preferable to antithesis and confrontation. We must all realize that the enemy is the illness, not the professionals.

This year's World Mental Health Day material looks at dignity in mental health from several directions. In terms of mental disorders, we think about dignity in treatment and care, and consumers of mental health services can provide valuable insight about that. Person-centered care is of major importance.

We've included material about educating the public on mental and behavioral disorders to encourage a better understanding of these disorders. Approaching public education at an earlier point is an important part of this year's material. Mental health promotion is part of the foundation for spreading a message about dignity in mental health. An appreciation that good mental health is a valuable asset should encourage people to think about mental health more broadly and also think about ways to support it and thus also serve prevention by reducing the risk of mental illness. For example, starting early to teach young children and teenagers about social and emotional learning strategies lays a foundation for enlightened future approaches.

Incorporating dignity into an approach to mental health issues is fundamental to dealing with stigma and discrimination. There is nothing dignified about subjecting people with any illness to stigma, adding to the problems they already cope with through the illness itself. We need to work harder towards changing social attitudes and spreading public awareness of the nature of mental illness.

As we seek to change outlooks, the importance of recovery is a central part of the message. Dignity is inherent in recovery. Care should encompass not just the present stage of the illness but the prospect that, over time, improvement can be achieved and that recovery, both in its medical sense and in its broader psychosocial connotation is a realistic and certainly dignified perspective.

Prof. George Christodoulou
President, World Federation for Mental Health

A MESSAGE FROM THE CHAIR OF WORLD MENTAL HEALTH DAY

Our theme for World Mental Health Day this year is "Dignity in Mental Health," a topic that is fundamental to the provision of good mental health care. The World Federation selected the theme knowing that it is hard to define "dignity" precisely. Yet respect for dignity represents an essential component of care and can produce major improvements in attitude towards people who are experiencing a multitude of problems.

The World Federation for Mental Health's goal when it established World Mental Health Day in 1992 was public education at all levels of society. The Day, celebrated internationally on October 10, has more than fulfilled this aim. It provides an occasion for many regional and local efforts to put the spotlight on a selected aspect of mental health care--with the added bonus of participating in a broadly celebrated international event.

"Dignity in Mental Health" provides the kind of topic that is relevant everywhere, and can be defined according to local circumstances and needs. We have collected a group of papers from our expert authors who show that dignity in the mental health context can have many meanings and can be applied to every aspect of care. Further, a concern for dignity counters the discrimination and bias that are all too often encountered by people with mental illness.

Two of the articles in this year's material point to the wider applications of a "dignity" viewpoint. An article from Norway about mental health promotion in schools shows the value of starting education about feelings and behavior at an early age. A paper about refugees in California suggests that the perspective of a refugee about mental health has many layers, and recognizing the impact of a refugee's desperate experiences may confer true dignity.

As before, the campaign will encourage local organizers to use traditional media to expand local coverage through radio, television, newspapers and magazines. We have had a presence on social media for a while, but we hope to be more active on Facebook and Twitter during the "dignity" campaign to extend its outreach to a new group of younger people.

Many thanks for all your efforts to promote mental health awareness in your communities through World Mental Health Day events. Whether large or small, your events contribute to growing public awareness of mental disorders and the need to provide appropriate support for those who experience them, and their families.

Dr. Patt Franciosi
Chair, World Mental Health Day
World Federation for Mental Health

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SECTION I
LIVING WITH DIGNITY IN MENTAL HEALTH

1.1. RESPECT AND DIGNITY IN MENTAL ILLNESS

- Janet Paleo, WFHM Board of Directors, Co-Founder PROSUMERS, USA

When you think of treatment for people with severe and persistent mental illness, most people could come up with a range of treatments and modalities to help the person recover. These would range from hospitalization, medication, skills building and talk therapy. Even if a person had the best in all these areas, without being treated with respect and dignity these services really become meaningless.

Any good doctor will tell you that the belief that a medication will work for you is just as important as the medication itself. This concept has a corollary: how a person is treated when getting treatment is just as important as or more important than the treatment itself. Most people when they reach the point of having a "severe and persistent" mental illness have often given up on life ever being any better. If the person we seek help from doesn't have the time to remember who we are, the time to really ask about us and what our concerns are, then treatment is an upward battle; especially when the person providing the treatment is in burnout and pushed past the point of caring. Put a discouraged mental health professional and a person with low self-esteem together and you have a recipe for unsuccessful treatment. Unfortunately in our world today, this is very common. We have more people needing help than we have people to treat them. The more we ask people to put more onto their caseload, the less time they have to help each individual. The more they become discouraged, the less time they have for simple dignity and respect. When a practitioner has to look at a chart more than once a visit to remind himself about who he is talking to, that is completely unacceptable.

My first hospitalization was two years long. I had about fifty subsequent hospitalizations. I saw innumerable mental health professionals. I had professionals who would not even talk to me but to my case manager sitting next to me. In those fourteen years of seeking help, there are only a handful of professionals who led me to feel I was important and worthy of respect and dignity. Those people helped me to find recovery.

The person who started my journey was a case worker, Cindy. I really don't remember how long I had been seeing her as I was in the midst of ten years of exiling myself from the world. In fact she had to come to my home to see me. I don't know how the visit started, but I remember her telling me that she also suffered from depression. It was a situational depression due to her baby dying only a few moments after being born. This sent her into the depths of an agony that she thought she would never recover from. I understood that depth of pain and her story caught my attention. Then she said the most remarkable thing. "I can't imagine what it must be like for you to live with that kind of pain for all these years. That is unimaginable for me. Yet here you are."

For the first time in my life someone acknowledged the pain within me. Someone understood what it was like to be me. Someone understood why it is next to impossible to live with the all-consuming pain which penetrated every cell of my being. Her acknowledgement of that pain was the most respect I had ever been given. Everyone else told me to get over

it, it wasn't that bad, or told me that I was remembering wrong. Even if all that had been true, in respecting a person, you start where they are and acknowledge them for that. The dignity came when she said, "Yet here you are." That in spite of all the tragedy and heartaches, I had survived. I am me. I am here now. I am a person. I have fought a great battle to be here at this moment and I have won. I didn't realize this until this moment.

Although it took me several more years to plant my feet firmly in recovery, this was the beginning. This also has me believe, without a doubt, working with someone who has gone through this journey is important for people to feel validated. Cindy knew my pain. Maybe not the length or depth of it, but she knew. Utilizing peers as professionals is an important piece to having people begin that journey to recovery. Peers know the pain and can acknowledge it more than any other person. Much like a mother talks to another mother or a mechanic talks with another mechanic or a veteran can talk to another veteran. It is common ground they both share and can build on.

Common practice in working with people with mental illness is to tell them what to do, make decisions for them, and treat them as if they are children. Yet these practices are not respectful nor do they have any dignity for the person with the illness. It is time for the world to start respecting all people in spite of their experiences, in spite of their differences and in spite of whatever label they have been given. We are not labels. We are not "those people" and we are not "your clients." You may provide a service to us. However, we don't belong to you. This is the beginning of respect and dignity. As Victor Frankl said, "See people greater than they know themselves to be." When we can see all people in this manner, we can truly have a culture of respect and dignity. Through respect and dignity, people can start really putting those other treatments to work. Recovery is possible!

1.2. GREETINGS, MY NAME IS MANDLA KONZA

- Mandla Konza, South Africa

I am a true African, a South African man from a Xhosa tribe, the Impondo Clan. I was born in the Eastern Cape at Ilinge Township in 1975 and I came to the Western Cape with my mother in 1977. In 1997 I was diagnosed with schizophrenia.

I believe that dignity starts at home, when your parents teach you to respect your neighbour, your community and country. Every person living with a mental illness must be treated with dignity too, and accepted and loved by their family and community. To improve the living conditions for persons living with mental illness, it is our responsibility as mental health care service users to inform our communities about our issues and needs.

In Xhosa we call God "Qamatha". Another Xhosa word, "Ukoluka", means "to go to the bush". This is a very old African custom that comes from our forefathers. In the mountain, young men are taught to respect themselves and be respectful of others, and to honour and love each other. In Xhosa culture there is a song called "Omdala uhlonipha omnane, nomncane uhlonipha omdala". It means, "The elderly respect the young, and the young respect the elderly".

My family has accepted my illness. When I started taking my medication, I used to sleep during the day. My family did not say I was lazy, but supported me. I have to say thanks to them that I have a goal in life. I attend a support group at the local library every week and have met some amazing people, all of whom show dignity and respect for one another. We discuss ways to improve the support groups in our area, and, of course, our disability rights: access to affordable and up-to-date medication, food and accommodation, job opportunities and education (including psycho-social rehabilitation).

We must work towards a better quality of life for persons living with mental illness in South Africa, and we must live with dignity, equality and without discrimination in our country.

Mandla Konza
Cape Town, South Africa

1.3. PROSUMERS: A DIGNIFIED PURPOSE

- Samantha Thornton, USA

Sitting in the lobby where I work as a Peer Support Specialist is a copy of Prosumer News. This is how I became familiar with Prosumers, an organization in Texas that encourages people with mental issues to be proactive in their recovery and provide back to the community. I spent 2 months reading Prosumer News cover to cover, before I explored the group further. I was struck by something almost immediately. The information was valuable, usable, and informed. The subjects were varied and appeared to have a good balance between types of material. It took me a minute to figure out why I found that peculiar. When I arrived at the "why"; I felt compelled to write this article about dignity.

We have our own news. Real news. Not watered down half information, or regurgitation of the same tired principles; but news. The news would likely be interesting to anyone who cared to read it. There is certainly room to grow, but the newsletter has stories about real people; and how they got and stay well. It has information on what is happening with laws and groups that concern us. It has information about opportunities to give back, participate, advocate, and join together as a voice. I now consider that newsletter sitting in our lobby a beacon of hope. Having our own news provides us with a sense of identity, value and validity in society.

This is of extreme importance to me, personally. As someone who has been diagnosed with a severe mental illness, I was used to being "talked down to" when exploring resources addressing me as a consumer. The informational and educational materials designed for us are often childlike, guarded, and simplistic. In any group of people, there are individuals that want, or need different presentation styles. We are no different. Some prefer concise, bullet point material and information; while others prefer narratives with explicit details. But, in the end what makes the Prosumer News different is the lack of condescending. This quality is something that is at the heart of providing us with dignity and respect.

Let me explain what I mean by guarded. When I am offered information by someone who knows about my condition, the information is often censored. Considered sick and/or disabled, it is regularly assumed, I must not be burdened with the truth. There can be a presumption of fragility. I have become intentional about looking things up myself. Now, that is the right idea anyway; but it seems like the presence of my condition is often associated with not being very intelligent, being fragile, and/or childlike. The respectful tone of both the Newsletter and the meetings has been important to me, as a person. While I still look things up myself and take charge of my life, I am instead inspired and encouraged to do so by Prosumers; rather than doing so out of necessity and misunderstanding.

What is true of the news carries over to the group itself. I discovered there was a group meeting locally that I could attend. As most peers are, I am very familiar with support groups of all kinds. It is not a process but a teaching group, where we learn, grow and find answers. I have been a part of groups and advocacy projects, often with facilitators who have no diagnosis of their own. Right away, something was different about Prosumers. A whole new attitude appeared to be present. The meetings were rich in current research, legislation, approaches, current events, and shared healing strategies that affect us. This happened both in the formal material presented and in the conversations before and after the meeting. The group has created a powerful culture. We were asked to participate and drive that conversation based on our knowledge; and in our own collective unique voice; locally, nationally, and internationally.

Finally, when we can participate in community events as leaders, the picture will change. Having a mental health condition can result in a great deal of isolation and "otherness." Prosumers gives us a strong sense of community. It is a place where we learn and teach each other in very practical ways. We learn about how to be proactive in our recovery and communities.

Exploring how to help others and ourselves is a root in the foundation of recovery. As a person in psychiatric recovery, I have encountered many recovery approaches. No matter what you are recovering from, successful approaches have things in common. Outreach, purpose, and community are among them. Prosumers is a platform with which to address change with grace. This gives us a role with which to actively participate in society and invoke positive change that is in our best interests; with dignity.

1.4. LIVING WITH MENTAL ILLNESS IN THE FAMILY

- Spyros Zorbas, Greece

I read stories from relatives of people with mental illness, and their main concern is the many problems that arise with the onset of the illness–the crisis it causes in the family, the first hospitalization in a psychiatric clinic, feelings of hopelessness, depression and despair.

Anyone who has lived with a person with mental illness has experienced all of the above. I wouldn't be writing these words if the onset of my sister's illness 20 years ago had not affected my family to such a great degree.

I grew up together with my sister, and while we were going to school I saw the first symptoms of the illness. It was strange for me to understand. At that time, we as a family had no information, no clue about the subject and no kind of support. We became spectators to an illness, and we didn't have an interdisciplinary team that could provide support. The harsh reality, as I perceive it today at the age of 40, is that a patient with mental illness risks losing their identity and their goals. They forget the things that made them happy, they end up being isolated and shut themselves in, living in a vicious cycle where they do not know how to cope with what is wrong.

Often, we read that life with mental illness is not a straight line, but goes in circles. At the beginning, with the onset of the illness, things can be very difficult and demanding. In addition, the event of a forced hospitalization is also a very sensitive turning point.

Hospitalization may result in:

1. Patients having the medical treatment they need.

2. The family being able to think constructively about the situation.

The family can start to think of ways to be involved in the care plan of the patient (after hospitalization), and may come in contact with mental health facilities and professionals that can share the burden of patient care with them. We as a family were fortunate to experience both the above. Eight years ago, following a year when the illness got worse and there was an out-of-control crisis, forced hospitalization became a turning point.

A care plan, continuous to this day, took the form of systematic monitoring and psychosocial rehabilitation through day center programs, contact with psychiatric professionals and with recipients of mental health services through associations and self-help groups, interaction with pets, and entertainment through art and cultural events.

The good news is that with the stabilization of the illness, in the last eight years I've noticed completely new traits in my sister's personality starting to emerge. She has begun to show an interest in numerous issues of everyday life, whereas in the past that was only a farfetched dream.

There is a great sense of satisfaction in observing a relative, who, despite having a mental illness, becomes more engaged with life, sets goals and has a greater sense of what makes them happy. Even when the person still needs a care plan for a number of everyday issues, the reality of improvement and recovery is something that fills the family with joy and hope for a better future.

1.5. ULYSSES IN CALIFORNIA: DIGNITY IN REFUGEE MENTAL HEALTH

- Patrick Marius Koga, MD, MPH, USA and Ahmad Fahim Pirzada, MD, USA

"My name is Nobody."
- Homer, The Odyssey

We speak of "odysseys" when referring to journeys undertaken in extreme, terrible conditions. Told first by the Greek bard Homer around 700 BC, the Odyssey is the epic of Odysseus' ten-year struggle to return home after the Trojan War. Odysseus (called by the Romans, in Latin, Ulysses) battles mystical creatures and faces the wrath of the sea-god Poseidon, but in the end he returns home and retakes his throne of Ithaca.

In the course of his long, traumatic journey, Ulysses emerges as a transformed man. He has survived his losses and his posttraumatic growth has given him a greater adaptability and an immense spiritual and personal growth. And yet the wisdom of this 3,000 old epic story, otherwise treasured by the Western world as one of the archetypes of humanity, does not seem to have left much of an impression on the way refugee mental health is understood and practiced today by psychiatrists. Consequently, one and the same odyssey has two different and disconnected narratives.

One narrative is the Odyssey told "from outside in" –the psychiatric version

Every year, approximately 70,000 refugees and 400,000 immigrants resettle to the United States from overseas. According to the U.S. Department of Homeland Security, Office of Immigration Statistics 2012 Annual Flow Report, approximately 187,856 new refugee arrivals were admitted to the U.S., and 75,441 affirmative and defensive asylees were granted asylum during the period from October 1, 2009, through September 30, 2012. ("Affirmative" and "defensive" asylum proceedings are different legal processes for claiming asylum in the United States.) During the same period of time, according to the same data source, California received 18,731 (10%) of newly arriving refugees and 27,158 (36%) of affirmative and defensive asylees, making it one of the largest recipients of newly arriving refugees and affirmative and defensive asylees in the United States.

Most often, refugees arrive in California having lived under dire conditions with little or no access to healthcare services and with no understanding of western medical care practices or the concept of preventive health care. People from Iraq, Syria, Iran, Burma, Somalia, Afghanistan, Bhutan and Eritrea have faced civil wars, social, gender, and religious persecution, nutritional deprivation, loss of home, loss of family, loss of professional and social-economic status, and loss of country. The post-resettlement stressors worsen these pre-migration traumas. Many refugees feel isolated, anxious and depressed, which can have a profound impact on their physical and mental health. This makes it more difficult for them to practice healthful behaviors to stay healthy and vigorous enough to become self-sufficient. Thus most refugees suffer from mental disorders such as posttraumatic stress disorder (PTSD), depression and anxiety.

The other narrative is told "from inside out" by the refugee himself, by Ulysses

For all its scientific reality, the condition of the refugee has also a personal, human explanation that makes more sense to the so called "mentally ill." The problem of dignity in mental illness may take a fundamentally different note in this case. Granting dignity to the refugee's "mental illness" may not be enough, let alone accurate. Dignity may actually lie in recognizing the refugee's condition for what it actually is: the response of a normal human being living under extreme conditions.

Dr. Joseba Achotegui, Secretary of the Transcultural Section, World Psychiatric Association, has coined the term Ulysses Syndrome - The Syndrome of the Immigrant with Extreme Migratory Grief. The refugees grieve for their losses: family and loved ones, country, land, language, culture, social support system, professional personal identity and social status. The intense mourning will restructure the personality and the reality of the refugee, a worldview marred by the cascading multiplicity and chronicity of losses. In the process of role reversal and intergenerational gap and conflict, refugee parents feel they have lost the respect of their own children. Refugees from countries with cultural and religious values very different from those of the host country fight alienation by isolating themselves in ethnic enclaves; this further deepens the divide between the refugee and the host society. Biases and prejudices or even outright xenophobia and racism (truth be told, from both sides) damage both the refugees and the host society.

While such extreme grief is not the same as pathological grief, it generates a situation of permanent crisis. If this continues for years it may lead to a breakdown and an actual mental illness. Nevertheless, refugees do not perceive themselves as having mental disorders, and this is not only because they belong to cultures of shame, which place a strong social stigma on the mentally ill. Refugees see themselves as normal human beings for whom their "clinical picture" is a result and a symptom of living under extreme conditions, not a root-cause of their suffering. This requires a depathologized naming of human suffering ("Ulysses Syndrome" instead of "depression") and social (training, employment, social support, social capital) rather than pure medical or psychological interventions.

Ulysses' most memorable quality is not his bravery or strength – though he is brave and strong – but rather his cleverness and resilience. In fact, Homer refers to his protagonist throughout the epic as "wily Odysseus."

"Yea, and if some god shall wreck me in the wine-dark deep, even so I will endure... For already have I suffered full much, and much have I toiled in perils of waves and war. Let this be added to the tale of those."
- Homer, The Odyssey

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SECTION II
THE FRAMEWORK FOR DIGNITY IN MENTAL HEALTH

2.1. SUPPORTING DIGNITY THROUGH MENTAL HEALTH LEGISLATION

- Michelle Funk, Natalie Drew and Marie Baudel, WHO, Switzerland.

The notion of dignity can simply be defined as the inherent and inalienable worth of all human beings irrespective of social status such as race, gender, physical or mental state[1]. Dignity is deeply embedded in international human rights instruments. In fact the very first article of the Universal Declaration of Human Rights states that "All human beings are born free and equal in dignity and rights"[2, 3]. Protection and respect of human rights are the necessary prerequisites to ensure that people are not stripped of their dignity.

Yet, all around the world, many people with mental and psychosocial disabilities are deprived of their human rights. They are not only discriminated against but also subject to emotional, physical and sexual abuse in mental health facilities as well as in the community.[4, 5] In addition, poor quality of care due to a lack of qualified health and mental health professionals and dilapidated mental health facilities can lead to further violations[6, 7].

Mental health legislation is an important means of addressing this situation and ensuring that the dignity of people with mental and psychosocial disability is preserved. Such legislation must be in line with international human rights instruments and in particular the UN Convention on the Rights of Persons with Disabilities (CRPD) that recognises that "discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person". Legislation can establish and enforce the basic requirement for human rights protection which can in turn lead to changes in ingrained attitudes and beliefs surrounding mental health.

As a basic requirement, legislation must prohibit inhuman and degrading treatments and guarantee equal rights for people with psychosocial disabilities, not only in the context of mental health care, but also in all aspects of community life. Strong safeguards must be put in place against coercive interventions, and effective remedies and redress must be accessible when abuses do occur.

In addition, mental health legislation must promote voluntary admission and treatment and require that the services users' free and informed consent be obtained prior to the administration of any type of treatment and care. Law should also promote the rights of service users to make care and treatment decisions for themselves and, in line with Article 12 of the CRPD, provide for supported decision-making options to ensure that people remain at the centre of all decisions affecting them. Enabling individuals to formalise advance planning documents (such as advance directives) is another way to respect people's autonomy, identity and dignity.

Many countries have specific legislation concerning people with mental or psychosocial disabilities. Other countries integrate mental health provisions into disability, general health or other legislation. While the approach adopted will depend largely on each country's legislative traditions, it is essential that provisions be made for people with psychosocial disabilities in employment, education, social welfare and other laws, in order to ensure that they are entitled to enjoy the same rights, supports and opportunities in life, on an equal basis with others.

Mental health legislation can have a decisive role to play in fostering conditions for the provision of quality mental health care, reducing stigma, discrimination and marginalisation and ending institutionalisation. Furthermore, the participation of people with psychosocial disabilities in the drafting process is critical to ensuring that their dignity is respected and that their human rights are effectively protected and fulfilled.

Michelle Funk, the Dept of mh and subst. abuse. WHO, www.who.int

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2.2. TOTAL HEALTH FOR ALL IN THE 21ST CENTURY: INTEGRATING PRIMARY CARE, MENTAL HEALTH AND PUBLIC HEALTH

- Eliot Sorel, MD, USA

The World Health Organization (WHO) defines health as, " a complete state of physical, mental, and social well-being; not merely the absence of disease or infirmity." Mental health is, therefore fundamental to total health and wellbeing. There is no health without mental health...!

Health is a right to be enjoyed by all regardless of creed, nationality, economic status or diagnosis. In the early 21st century most mental disorders are diagnosable and treatable. Yet more than 500 million people around the world suffering from mental disorders are still being challenged by shame, stigma and discrimination; by lack of access to care; by inadequate resources allocation commensurate with the burden of diseases represented by mental disorders; by the lack of primary prevention; by fragmentation of care and the lack of integration in treatment; and by policy decisions that regrettably perpetuate this violation of human rights.

The United Nations General Assembly High-Level Meeting on Non-communicable Diseases (19-20 September 2011) raised the expectation that health had reached, at long last, one of the highest levels of policy decision-making. Non-communicable diseases, in aggregate, represent the highest burden of disease, and strain health systems and countries' economies. They include cardiovascular disease, cancer, chronic obstructive pulmonary disorders and diabetes. However the UN session disappointed by omitting mental health from its ambitious agenda. This exclusion was incredible – mental disorders are among the most prevalent non-communicable diseases, affecting more than 500 million people worldwide, with a global burden of disease of approximately 14% and a global burden of disability of 30-45%.

A robust advocacy campaign for the inclusion of mental disorders on a par with other non-communicable diseases, involving print and electronic media as well as direct appeals to the Executive Committee and General Assembly of the World Health Organization resulted in the WHO General Assembly Resolution (May 2012) that included mental disorders along with other non-communicable diseases, with a recommendation for a global mental health action plan. That plan became a reality in 2013, when the WHO launched its Global Mental Health Action Plan 2013-2020, including the collaboration and integration of mental health and primary care.

By virtue of mental disorders being diagnosable and treatable, we have now the ability to return people to productive lives and positive relationships in the majority of cases. The main barriers to successful treatment – lack of access to care, shame, stigma, and discrimination – prevent individuals in all countries from seeking treatment on a timely basis, particularly in low- and middle- income countries.

Mental illnesses often co-occur with other non-communicable diseases such as diabetes and cardio-vascular disorders. Ideally, the treatment of comorbid conditions should be well coordinated and integrated. Existing health systems' fragmentation, along with lack of integration, makes current health systems unsustainable. Enhancing primary and secondary prevention (including access to care and care integration) must be one of the highest priorities for 21st Century health systems. This priority is essential for diminishing the global burdens of disease and disability and their economic consequences for all nations.

The response to these challenges must begin with a paradigm shift in 21st Century health systems – from 19th/20th Century hospital-specialty based models to collaborative-integrative team models, across disciplines, working together, well-

connected through information and communication technology, and in a shared location. Primary care, mental health, and public health integration is an essential dimension of the paradigm shift that will enhance access, quality, and affordability, and reduce shame, stigma and discrimination.
Achieving total health for all in the 21st Century requires adopting this paradigm shift with these key components:

- Education for health and wellbeing and the integration of health, nutrition, and fitness across generations and systems (families, educational systems, workplaces, and health systems).

- A public health, primary prevention, health, and wellbeing strategy, focusing on health promotion, health protection, and illness prevention across the lifecycle, with a robust beginning in the perinatal phase of life.

- Primary care, mental health, and public health collaboration/integration.

- A global health policy of parity, non-discrimination, and dignity for all.

The World Psychiatric Association addressed these issues at its Bucharest meeting on 24-27 June 2015 and issued a Statement on Collaborative and Integrated Care urging that:

"United Nations member states adopt collaborative and integrated care as a means toward achieving total health for all in the 21st Century, and be it further resolved that.

This goal be included in the updated United Nations Sustainable Development Goals; and be it further resolved that.

United Nations member states allocate the necessary human, financial, and technological resources for training, education and implementation of this resolution."

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2.3. OUR DESTINATION: DIGNITY

- Eduardo Vega, M.A., USA

As the counterpoint to pervasive stigma and discrimination that impedes so much progress, "Dignity" has become the great rallying cry for change in mental health services and public perception, domestically and internationally.

On August 24, 2015, the first national Destination Dignity Mental Health March on Washington will be convened at 12 noon, with the goal of activating public awareness for change. The Destination Dignity Coalition is a broad-based group calling for action by all people affected by mental health challenges, and their families and supporters, to stand up for the dignity that all of us deserve and the hope that is essential to living successfully. This historic event, the first at the National Mall, is also geared towards activating the voices and power of the millions of Americans who personally live with mental illness symptoms and their supporters to create a 'tipping point moment' for progress.

Dignity is every individual's birthright. But too often, those of us with mental health challenges have had their dignity taken away – by stigma and discrimination, forceful or negative treatment, by silencing and shame. At the Center for Dignity, Recovery and Empowerment, we put "Dignity First" because without the ability to hold your head up, without support for your value and potential, the challenges of mental illness are that much worse.

Recovery happens. Around us every day and across the world people face their challenges, endure incredible pain and difficulty and still contribute as valuable members of their communities. Even where people are significantly disabled by their symptoms for some time, most recover lives that are fulfilling to them as well.

But recovery from mental health and substance use conditions is not like recovery from a broken leg or the flu. The mind and person are subject to all kinds of things in the social and personal environment, including other people's ideas and attitudes. Elements like these can amplify vulnerability and distress on the one hand, or maximize resilience, hope, focus and personal resilience on the other.

So many of us who have been working in mental health over the years have come to recognize this. Over time, sitting back from our work in services, evaluating our efforts in policy change, examining the origins of stubborn barriers to what we know as obvious, indicated and crucial, we have come to recognize, as US Surgeon General David Satcher stated over 15 years ago, that "stigma is the most formidable obstacle to progress in the arena of mental health."

Combined with clarity about the big underlying challenge, and the stories of so many who've directly experienced shame and humiliation when what they needed most was hope and support, leaders across the world at the highest level have identified as a priority, or even their lives' work, the need to reduce prejudice, eliminate discrimination and shame, and restore dignity and equity to the subject of mental health in every sphere.

Individuals, governments and nations around the world have invested in the cause of stigma change for very good reasons. Because we've realized that the economics of service funding, the systemic rates of disability and unemployment, the lack of health sector engagement, the very history of treatment of people with mental health conditions, is grounded in biased views, misinformation, shame and fear.

Biased ideas in the public become prejudiced views that foster behaviors and also lack of action. The pervasiveness of these has led us to expect less than we should of our policymakers, our educational institutions, our communities and ourselves. They have fostered a world in which we believe, as so many of us affected by mental health conditions are often told, that we should not expect too much.

Status quo assumptions about what is possible have worked for centuries against the health, human dignity, and recovery of people experiencing mental ill-health. Even as we harbor low expectations and a sense of futility ourselves about disparities in funding and public support for mental health, our services have been built upon cynical deficit thinking –systems in which involuntary commitment and dangerousness are the requirements for help, institutions in which dehumanization is constantly reinforced, in which unjustifiable levels of unemployment and disability are seen as givens, in which restraints, abuse, denial of human rights and even death are viewed as acceptable and tolerable.

Changing this dynamic, raising the bar of expectations for consumers, for our services, our systems and our communities, is not easy. Changing minds and communities to those environments in which recovery has its best chance is not inexpensive. It is not quick.

But it can be done. It must be done.

And this is the crucial part, for the change to be real and lasting, it must be done in public. It must be done by people coming out publicly to defy prejudice and low expectations, to show our strength and voice, to claim their dignity.

The single thing that best disconfirms legacy views and bias about people with mental health conditions is when people see that we are them. That we are successful important valuable members of our families, communities and businesses. That we are everywhere.

By calling on the millions out there who live in silence to join their voices and "Come Out for Dignity" we are announcing that we will no longer let cultures of fear take away our rights and dignity, or keep us and those we love silent. We will stand together against dehumanization and discrimination.

Working together, with people in recovery coming out in front as the living messengers of hope and recovery, we can reclaim mental health from stigma. We can raise dignity from a concept to a working principle for all affected, in every system that touches us.

We can create a world where everyone affected by mental health conditions has the best chance possible to succeed and recover free from fear and isolation. In this new world of dignity communities will not just support people faced with mental health conditions, but value their strength, resilience and hope as essential.

Recovery thrives in an environment of dignity. And so many of the changes we need systematically will only materialize with change in culture at a broad level.

It is a long way to our Destination Dignity. But we are on the road already. And the more of us join together the sooner we will make it.

* *Eduardo Vega* is President and Chief Executive Officer of the Mental Health Association of San Francisco, and Director of the Center for Dignity, Recovery and Empowerment. Learn more at DestinationDignity.org.

SECTION III
PROMOTING DIGNITY

3.1. DIGNITY IN MENTAL HEALTH

- Betty Kitchener AM, CEO Mental Health First Aid International

To make dignity in mental health a reality, every member of society needs to work with each other to make mental health visible and not something to be ashamed of. People need to know that mental illnesses are illnesses just like other illnesses. They need to know how to recognise mental health problems in a person and how to give them help. They do not need to be mental health practitioners to have these first aid skills.

In Australia, the Mental Health First Aid (MHFA) program was developed to teach people, members of the public, how to recognize and assist other people who are developing mental health problems or are in a mental health crisis situation. The MHFA Action Plan gives guidance on how people can do this. This Action Plan and the curriculum of the 12-hour face-to-face course or a blended course (eLearning and face-to-face sections) are based on extensive research, which established a consensus of the expert opinions of people with mental illness, their family members and mental health professionals.[1]

Mental Health First Aid **ACTION PLAN**

MHFA INTERNATIONAL

A pproach, assess and assist with any crisis
L isten non-judgmentally
G ive support and information
E ncourage appropriate professional help
E ncourage other supports

VISIT **www.mhfa.com.au** FOR INFORMATION ON COURSES



The Action Plan goes by the acronym ALGEE. Because the word Algee does not have any meaning in English we have adopted a koala as the mascot of the MHFA Program and given him the name Algee.

1. https://mhfa.com.au/research/mhfa-australia-course-development

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

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

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

A mental health first aider needs to look out for and assist with any possible crisis such as:

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

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

ACTION 2: Listen non-judgmentally

It is important to listen non-judgmentally at all times when providing mental health first aid. When listening, any judgments about the person or their situation need to be set aside, and not expressed. Most people who are experiencing distressing emotions and thoughts want to be listened to empathetically before being offered options and resources that may help them. When listening non-judgmentally, the first aider needs to adopt certain attitudes and uses verbal and non-verbal listening skills that:

- Allow the listener to really hear and understand what is being said to them, and

- Make it easier for the other person to feel they can talk freely about their problems without being judged.

ACTION 3: Give support and information

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

ACTION 4: Encourage the person to get appropriate professional help

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

ACTION 5: Encourage other supports

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

It is important to care for yourself

After providing mental health first aid to a person who is in distress, you may feel worn out, frustrated or even angry. You may also need to deal with the feelings and reactions you set aside during the encounter. It can be helpful to find someone to talk to about what has happened. If you do this, though, you need to remember to respect the person's right to privacy; if you talk to someone, don't share the name of the person you helped, or any personal details which might make them identifiable to the person you choose to share with.

There is very good evidence that MHFA can teach people skills to help others and become more accepting and less stigmatizing in their attitudes. A meta analysis of the major evaluation trials demonstrates that MHFA increases participants' knowledge regarding mental health, decreases their negative attitudes, and increases supportive behaviours toward individuals with mental health problems. The MHFA programme appears recommendable for public health action.

As a result, the program has spread across Australia and to 23 other countries: https://mhfa.com.au/our-impact/international-mhfa-programs

What we need is everyone in communities across the world to have the skills to recognise and assist people who are developing mental health problems and not to think only mental health professionals can help. Getting help in the early stages of any illness usually gives a much better outcome. First aid courses are common in many countries. We need the same provision of mental health first aid courses.

Citizens can create a more supportive and caring community for those people with mental health problems by intervening early so that the person can get good support and hasten recovery. This will contribute to advancing the cause of 'Dignity in Mental Health' globally.

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3.2. MENTAL HEALTH IN SCHOOL

- Hilde Elvevord Randgaard, National Coordinator for Zippy's Friends, Norway.

School is one of the most important settings for promoting mental health of young people (WHO, 2001). Research implies that mental health promotion in schools, when implemented effectively, can produce long-term benefits for young people, including emotional and social functioning and improved academic performance. The Norwegian Directorate for Health therefore launched the National Action Plan Mental Health in School. The Norwegian Education Act § 9a states that all pupils have the right to a positive physical and psychosocial environment that promotes health, wellbeing and learning. DreamSchool and Zippy's Friends are interventions that connect education and health, when aiming to strengthen well-being and the psychosocial environment in school. It directly addresses schools' primary purpose, motivating students and boosting their sense of belonging, through their direct participation in school life.

Adults for Children receive support for coordinating Zippys Friends (1st to 4th grade in primary school) and Dream school (secondary and upper secondary).

Zippy's Friends helps children develop social and emotional skills. To identify and express our feelings is important to develop our self-esteem, and to deal with emotions. The support of others is another important factor to promote mental wellbeing and to prevent mental illness.

Since 2004 the intervention has been tried out, evaluated and implemented in over 600 schools in Norway. The evaluation of Zippy's Friends in Norway shows that the program has a positive effect on COPING as reported by children and parents. Teacher also report a positive impact on the SOCIAL CLIMATE in class, ACADEMIC ACHIEVEMENT and the extent to which the children's MENTAL HEALTH's impact on the school situation. Better inclusion and less bullying is the results of running the program. (Holen, S. 2012)

Zippy's Friends has provided a good basis for trying to connect the aims, culture and competencies from several systems. All the participants have clearly defined roles and responsibilities. For example, the educational and psychological counseling services and the school health service are responsible for supporting the teachers at specific points in time as they are going through the program. Participating in this program seems to produce good results and encourages interdisciplinary collaboration and exchange experiences.

1st to 4th grade teachers run the program in their class. Methods to help the children to find solutions to their difficulties in daily life is an important focus in Zippy's Friends. This means that the teachers have to acknowledge and pay attention to what the children are saying and expressing.

As a help to develop their communication skills with the children, they have to practice in their training and in the everyday life in the classroom. Parents can play a part in Zippy's Friends by doing home-activities. By knowledge to the methods of acknowledging their child's feelings they can help their children to cope and to find solutions.

Teachers' Guide for Zippy's Friends:

How to Deal with Children's Responses

Recognize and confirm the child's feelings:

I understand that you are.....(upset, angry etc.) I understand that this is difficult for you
What can you do?

When the children come up with a solution

What will happen next?

Does it make you feel better? Does it make the other child/children feel better?

Do you have other suggestions – is there anything else you can do?

Invite the other children to suggest alternative solutions!

Is this something that could work for you?

Is it something you would like to try?

Does this make you/ the other child feel better?

Activity to Identify and Express Feelings:

Drawing – a language for emotions:

Let the children sit in a circle. Ask the children to draw something that makes them sad or happy.

Let the children explain the situation, and the feeling. Then ask them if there was something that helped them to feel better, or if they can think of anything now.

Use the teacher's guide.



DreamSchool

DreamSchool is a school-based intervention promoting mental health and well-being, designed to create a positive learning environment. The intervention aims to enhance the psychosocial environment through a whole-school approach, where secondary schools are provided with tools to promote mental health and well-being. The intervention supports the schools' primary activities.

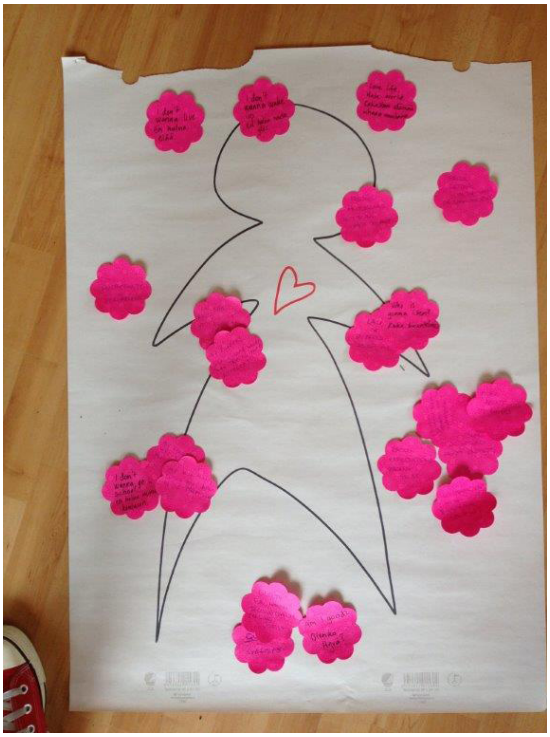
The Intervention

The core element in the intervention is the Peer Mentors, pupils who are recruited, trained and later responsible for receiving and following up new and younger pupils. Another part of their assignment is to create social settings for the pupils, during the school day. They can also act as mentors for individual pupils with special needs. Furthermore, they organize group sessions with health-promoting themes for peers.

The mentors are older students, trained and supervised by staff in school, in order to be qualified for their assignment, which is to recieve and make new pupils feel welcomed and taken good care of when they are transitioning from one level in school to a new, which for most Norwegian kids means you have to change schools and maybe leave your friends behind.

An additional element in the intervention is a classroom-based process, the DreamClass, which is carried out at the beginning of term. This process generates an action plan for the class, involving both pupils and teachers in creating a secure and creative learning environment. The intervention involves all members of the staff and all pupils. Participation, building strength, competence and resources are key-words.

The main focus in the DreamSchool-model is on what generates positive mental health and wellbeing and a positive psychosocial environment. The different elements in the model (the DreamClass-process and the things the Peer-mentors do) aim to identify factors that generate positive mental health and how these can be implemented in schools. By focusing on resources and possibilities among students, staff and the school itself, the intervention initiates processes that will empower the individual student and staff-member, as well as the group (class) to take part in improvement of conditions that affects their psycho-social wellbeing



The Feel-good-guy is a practical example for how to work with pupils, based on methods from participatory and learning and activities (PLA):

You can use this activity when you want to engage the whole group and work with any given topic. In this example, we will use the setting from the DreamClass:

1. Start by dividing the bigger group into smaller groups (4-6 people). The best way to work is to sit in a circle on the floor or around small tables.

2. Draw a gingerbread-man on a big sheet of paper for each group.

3. Provide everyone in the group with a pen and post-it stickers.

4. Introduce the assignment:

"Please take a moment and think about what you find is important for you to feel at ease and at your best in the class. Don't talk to anybody about it or start a discussion, just keep your thoughts to yourself for a while. You can then put each thing you've come up with on a post-it sticker. You can write on as many stickers you like, but please, use one sticker for each thing. That will make it easier later on when you are going to work with the different suggestions. Keep the stickers to yourself until everybody is done. Nothing is wrong – we just want to pick all your brains on this specific topic.

When everyone in the group seems to have finished putting their thoughts on this subject onto stickers the next step is to tell the others about what you've think is important.

You go around the group, put one sticker after the other onto the Feel Good-guy and tell the others a little about it. The rest of the group listens and can ask for clarification, but there isn't supposed to be a discussion. The more important it is for you, the closer to the heart you put your sticker."

When all the stickers are out there the group is asked to organize the stickers into groups according to themes. Similar stickers can be put together. Eventually the group is asked to come up with their "top three" and present them to the bigger group.

The facilitator puts all the suggestions on a whiteboard or similar and closes the process by letting the participants choose what they think would be the most important suggestion for the class to work with: Each pupil gets 10 stickers of stars or hearts and is asked to divide them between the different suggestions. You can put all your stars on one of the themes or divide them between several.

When you've found a "winner" the next step is to find concrete suggestions for how to achieve the goal. If the class has chosen "to feel respected and accepted" as their most important theme, you ask the participants for a new round of post-it stickers, but this time with suggestions for how to be respectful and to actually make others feel accepted. You can help them by asking things like: "What can I do? What can we do in the classroom? What can the teacher do?" etc.

3.3. REBRANDING DEPRESSION AND MENTAL HEALTH; TAKING ACTION TO END STIGMA

- Kathryn Goetzke, MBA.

Background

According to both the U.S. Center for Disease Control and the World Health Organization, depression is rapidly becoming a global burden. More than 350 million people are affected by depression, making it a leading cause of disability worldwide (WHO, 2012). Although research suggests that depression is treatable, less than 50% of people with depression seek and receive treatment (WHO, 2012).

Research suggests the stigma associated with depression is the reason that so few people seek treatment when it is available and proven effective (Corrigan, 2002). We believe if we eradicate stigma we improve treatment, increase funding, and reduce the treatment gap. We also reduce the impact depression has on the work force, communities, families and individual lives around the world. Finally, eradicating stigma gets people into treatment and helps reverse the growing cost of mental illness, estimated in 2010 at 2.7 trillion U.S. dollars, and estimated to rise to 6.0 trillion U.S. dollars by 2030 (Insel, 2010).

Historical Image of Depression

The most common image historically shown to represent depression is a person with their head in their hands looking isolated, alone, and helpless; the feelings often associated with a depressive episode. This image, or brand, has been used over and over again to reinforce the image of helplessness and hopelessness in relation to depression. Unfortunately, this image does little to showcase the fact that even with depression there is hope, as it is one of the most treatable disease states in the world.

Rebranding Disease States

A number of disease states have successfully 'rebranded' their images using three key strategies: celebrity engagement, positive imagery, and education on the biology of the associated organ and body. For example the Komen Foundation, founded in 1980, is now the world's largest nonprofit source of funding for the fight against breast cancer. To date, it has invested more than $2.6 billion in groundbreaking research, community health outreach, advocacy and programs in more than 30 countries.

Its efforts have helped reduce death rates from breast cancer by 34 percent since 1990 and have helped improve five-year survival rates for early stage cancers from 74 to 99 percent (Komen, 2015). However, the Foundation battled the highly stigmatized disease of breast cancer when it was first founded. Through celebrity engagement, the pink ribbon, and speaking about the biology of the breast it was able to transform the global view of breast cancer.

Hope for Depression and Mental Health

iFred, the International Foundation for Research and Education of Depression, is rebranding depression, the greatest single contributor to the global burden of disease in mental health, with the sunflower, the color yellow, a focus on hope, education on the biology of the brain, and celebrity engagement. We envision the sunflower and color yellow as symbols for depression the way the pink ribbon is the symbol of breast cancer. We are rebranding through planting fields of sunflowers around the world, running Cause Marketing Campaigns, offering a free curriculum to children based on research that hope is a teachable skill, and partnering with celebrities to promote our message that depression is treatable.

Other organizations are also doing amazing things in global mental health. Celebrities like football pro Brandon Marshall are taking a stand. He is talking about his mental health challenges through what he calls Project 375. He is reinforcing the global mental health color being used—lime green—and taking public his experience with borderline personality disorder, showcasing how he got help and now manages his disorder, and is successful in life. His leadership in mental health encourages others to do the same and shows again that through treatment, there is hope.

Autism Speaks, a leading US organization that raises awareness of autism, has done an incredible job rebranding autism using celebrity engagement, the puzzle piece and color blue for branding, and educating the public on the biology of autism. This innovative organization changed the way autism is perceived and is making incredible strides in ending stigma and creating awareness for a once very misunderstood disease. As additional organizations related to autism adopt the blue color and imagery, the branding message is reinforced based on the concept "power in numbers."

What is Next?

We believe that by rebranding depression we can end the stigma of depression, increase funding, and work to prevent depressive episodes. We hope if your organization works with depression, you will join our efforts and use sunflowers as your global symbol, lead sunflower plantings, making Gardens for Hope to engage your communities, and get the free "hope curriculum" taught in your school systems so that children are taught basic skills for prevention. If your focus is on global mental health, we suggest you join the World Dignity Project, a global mental health project that advocates "dignity for all," and the Global Mental Health Movement, a global group of organizations working for mental health, to show how we are all working together to gain momentum for our individual, yet collective, goals.

Ultimately, it is beneficial for all nonprofits to have a universal branding guideline for all those who work in the field of mental health, so that when organizations showcase new initiatives the same positive imagery, colors, icons, and awareness dates are used, to show the strength and solidarity of the global universal message more powerfully. While projects are diverse and different in scope, all goals are ultimately aligned in that each and every one of us deserves mental health; it is a basic, fundamental human right. If we have this new, universal way of sharing our unique messages it shows a collective solidarity movement, reinforces positive imagery and hope, and moves us all forward more quickly and more powerfully than each of us working to get there on our own.

Key Takeaways

1. Plant Sunflowers, a universal symbol of hope, and post a "Gardens for Hope" sign found at www.ifred.org, sharing a message to honor the 350 million people worldwide impacted by depression.

2. Engage your community and educational leaders to implement the Schools for Hope Program, www.schoolsforhope.org, a free research-based curriculum developed to provide children with the mental health tools to promote emotional well-being from an early age.

3. Engage with celebrities and encourage leaders to share their stories about how they successfully manage and treat their depression and live successful, meaningful, fulfilling lives. Share the stories of celebrities, like Brandon Marshall's Project 375 (www.project375.org), to shine light on how individuals with mental health challenges don't just survive, but thrive.

4. Join the World Dignity Project (www.worlddignityproject.com) to advocate for those affected by mental illness and bring "hope, shelter, and dignity" to all, and become a part of the Global Mental Health Movement (www.globalmentalhealth.org) focused on uniting our voice on mental health. Together we are greater than the sum of our parts.

5. Share stories and start conversations building public awareness and educating society on brain biology, successful treatment and the importance of caring for mental health proactively. Together, we can end stigma.

SECTION IV
INTERVENTIONS TO SUPPORT MENTAL HEALTH DIGNITY

4.1. MENTAL HEALTH FOR ALL: MENTAL AND PHYSICAL HEALTH PARITY – THE ROLE OF GENERAL PRACTICE

- Mike Pringle CBE, President of the Royal College of General Practitioners.

Forty years ago, as a medical student, it was clear to me that gastric and duodenal ulcers were important problems in my teaching hospital. It was acknowledged that the commonest cause of ulcers was 'stress' but the mental health aspects were not addressed. This physical manifestation of psychological distress was routinely treated by surgery – exotic plumbing, stomach reduction and nerve ablation.

Of course our understanding and management of ulcers have been transformed since, but even as a student I was struck by the disconnect between the mind and body proposed by the French philosopher Descartes, and its profound influence in medicine. Mental health was something that was addressed by psychiatrists and psychologists; for most doctors the focus was the body.

Once I experienced family medicine I recognised that the two aspects were combined in the role of the expert generalist. It was in general practice that holistic respect for the integrity of the human mind and body was possible.

In the UK, every person should be registered with a family doctor practice and the vast majorities are. This registration offers the perfect platform for longitudinal personal doctoring in which the health and wellbeing of individuals, in all its dimensions, is complemented by a population, community approach. The funding of health services, being free at the point of delivery and paid out of taxation, should remove barriers to presentation and care for mental health problems.

Although the Commonwealth Fund in the United States has given the UK's National Health Service the highest ranking in the affluent world, there are no grounds for complacency. First, societal stigma remains. It is still much more acceptable to be off work for a physical than a mental illness. There is still antipathy, even fear, towards those with serious mental health problems such as schizophrenia and dementia.

It might be supposed that the health service would offer a contrast to societal stigmatization. Yet there was and continues to be a reluctance among many family doctors to fully engage with serious mental illness. Despite dementia being a quintessentially primary care mental disease – its prevalence means that the vast majority of care must be delivered in the community – the absence of effective therapies reduces its priority. We know that the life expectancy for those with long-term psychosis is markedly lower than the population, partly due to their sedentary lifestyles and smoking. Yet, family doctors are urged to focus on care for the worried well.

It is difficult to imagine a metric that would validly assess the degree of parity between care for the mind and the body, but one can imagine the values that would be expressed when parity is achieved. These values include continuity, choice, personal care, access to expert general care, compassion and commitment regardless of whether the main problem is psychological or physical.

Further, those who present with the predominant problem in one domain, whether physical, psychological or social, should receive care in the others. Just as a first diagnosis of diabetes has significant mental health implications, so a diagnosis of psychosis has physical implications.

Clearly this utopian vision has resource implications with sufficient time being the most precious. However the most important requirement is a positive culture. We must start by breaking down the isolation of psychiatry from the rest of medicine, building positive role models for medical students. And then we need to take the improved model into each and every consultation.

4.2. PROMOTING MENTAL HEALTH DIGNITY – THE ROLE OF SECONDARY CARE MENTAL HEALTH SERVICES

- Dr. Alberto Minoletti, School of Public Health, University of Chile.

Dignity for persons with mental disorders is exercising citizenship, with a sense of empowerment and control over their lives, and demanding the same rights (e.g. the right to decide where to live, whom to meet, whom to love, where to work, etc.) and take the same responsibilities (e.g. respecting the laws, voting, volunteering, paying taxes, etc.) as other citizens (1). Exercising citizenship helps a person to feel worthy, honored, esteemed, respected, and (by extension) self-respected, attributes that are all important components of good positive mental health. However, all over the world, people with mental disorders and/or psychosocial disabilities not only are deprived of their status as citizens, but experience violations of many civil, cultural, economic, political, and social rights, especially in low-income and middle-income countries (2). Secondary care mental health services and staff cannot be indifferent to these negative factors for the mental health of service users.

Literature suggests a number of ways in which dignity might be promoted or protected in secondary mental health care (3). These include:

- Person-centered care: ensuring that information is more accessible and service users are better informed, developing approaches to involving caregivers, and ensuring that all service users are effectively involved and engaged, and their views made explicit within individual care planning processes.

- Good communication: Hopkins (4) carried out a literature review of service users' expectations of mental health care, concluding that the largest theme under "respect for dignity" was interpersonal relations. Individual attention from healthcare staff is most valued and expected by users, and there was a significant relationship between a member of staff's ability to listen and service users feeling respected.

- Human rights: The first principle of the UN Convention on the Rights of Persons with Disabilities (including mental disability) (5), which had been ratified by 147 countries by July 2014 (6), is "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons with disabilities". The application of this principle to secondary care mental health facilities requires that each person is treated as a human being with due consideration to their prevailing circumstances (7).

The World Health Organization (WHO) has developed an instrument, the WHO QualityRights tool kit (8), based on an extensive international review by people with mental disabilities and their organizations. This instrument provides for a comprehensive assessment of mental health care facilities, in order to plan effective means to ensure that the services promote the users' dignity, autonomy, and right to self-determination, as well as to ensure that the services offered are of good quality, respectful of human rights, and responsive to the users' requirements. One of the critical quality standards for mental health dignity, as defined by the WHO QualityRights tool kit, is the one that stresses that psychosocial rehabilitation and links to support networks and other services are elements of a service user driven recovery plan. This plan, in turn, should contribute to a service user's ability to live independently in the community.

The WHO Mental Health Action Plan (9) also supports the dignity of persons with mental disorders and psychosocial disabilities, through principles and actions that emphasize the importance of empowering and involving them in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation. This is meant to en-

sure that persons with mental disorders and psychosocial disabilities and their organizations are given a formal role and authority to influence the process of designing, planning and implementing secondary mental health care services. The WHO Secretariat, Member States, international development agencies, academic and research institutions, and civil society should develop specific actions to achieve these purposes.

Recovery-oriented mental health care facilities include a service user's dignity as one of the core goals with hope, autonomy, personal growth, and ability to change (10). The traditional paternalistic and nihilist perspective towards persons with severe mental disorders has been challenged through an international paradigm shift toward the notion of recovery in the last 25 years (11). The consumer movement has created a demand for recovery-oriented services in many developed countries, which has helped to create an impetus for secondary mental health care facilities to change (12-14).

In conclusion, dignity in persons with mental disorders appears as a crucial aspect of secondary care services delivery, which can be enhanced through person-centered care, good communication between staff and users, and a human rights approach. WHO mental health international initiatives on policies and quality care, as well as mental health services with a recovery culture can strengthen the dignity of users. Learning about dignity in secondary mental health care services from high-income countries should be transferred to low and middle income countries through international cooperation programs.

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4.3. THE WFMH "GREAT PUSH FOR MENTAL HEALTH" INITIATIVE SUPPORTS DIGNITY IN MENTAL HEALTH

- John Copeland, UK.

The underfunding of mental health implies lack of respect for those who experience mental ill-health. Those shown lack of respect have difficulty maintaining dignity—and those who care for them are tempted to display no respect for dignity. The failure starts at the top, with those governments that restrict funding or make little or no budget allocation for mental health. Local organisations do great work with individuals and try to influence governments, but more strident competing forces advocating for spending elsewhere usually prevail.

The WFMH Great Push for Mental Health was set up under four banners, "Unity", "Visibility", "Rights" and "Recovery", so that affected individuals could gain dignity and recognition by joining a movement with many others to achieve government and universal recognition and change.

Unity

Many disparate voices speak for mental illness. This appears to give an appearance of confusion and disagreement. Fragmentation in turn encourages international organisations as well as governments to minimize their chances of finding solutions, and provides a ready excuse for inaction. WFMH has never accepted the idea of lack of "Unity" and has recently demonstrated how untrue it is by asking organisations from around the world what they wanted included in the proposed World Health Organization Mental Health Action Plan. The agreement in the replies was remarkable, and the WHO Mental Health Action Plan now closely reflects that agreement. There is "Unity" on what we want for mental health policy; the WFMH Peoples Charter for Mental Health shows these demands in detail (www.wfmh.org; click on "Initiatives" in the top navigation bar). We know what we want.

Visibility

WFMH's World Mental Health Day has encouraged colorful marches of consumers, family members and service providers, academics and research workers coming together to create "Visibility" by walking in mutual support, demonstrating dignity and recognition.

Rights

In every country in the world the "Rights" of those who are mentally ill continue to be dishonored, sometimes flagrantly, even in those countries regarded as the most advanced, due to ignorance and superstition.

Recovery

Treatment must go beyond the absence of disease towards true "Recovery". How else can dignity be achieved for each individual?

Basic treatments are inexpensive, yet millions are still deprived of them. But there is hope. At last the World Health Assembly has officially requested a WHO Mental Health Action Plan. All WHO Member States have accepted it and the 68th World Health Assembly (2015) is monitoring its progress.
Cynics will remember decisions that were unanimously accepted by other world bodies but where change and universal action have been slow. We will not achieve universal recognition of the need for identification and treatment of mental

illness worldwide without applying continuous pressure on governments and governmental organisations. Many local organisations do wonderful things with small resources, but major change is unlikely without concerted international action by those who care—the consumers themselves, family members, service providers, academics, researchers and advocates, striving together—and international organisations like WFMH. Political influence and power lie in the numbers. When so many people demonstrate they care, recognition becomes universal and with it dignity and recovery become possible.

So far 405 organisations in 86 countries and many individuals are signed up to support the WFMH Great Push for Mental Health and its Five Core Goals. Join us, sign up and support these Goals (to do so, contact jrmcop@btinternet.com).

4.4. PROMOTING MENTAL HEALTH DIGNITY IN PRIMARY CARE THROUGH RECOVERY-ORIENTED PRACTICE

- Professor Tawfik A.M. Khoja, Saudi Arabia

Dignity and mental health care in practice

- Provide person-centred care and support – place the individual and their needs, preferences and aspirations at the centre of care. An ethos of person-centred care upholds the dignity both of people using services and of staff.

- Adopt a recovery approach to mental health – in particular, help people sustain their personal identity and self-respect, which are both closely associated with the concept of dignity.

Research shows that respecting an individual's identity and protecting their dignity will help to promote recovery, whereas acts that violate dignity and fail to respect individuals and their stories will lead to further damage. Respecting integrity and dignity is not only an ethical obligation but also 'the means to recovery'.

Personalisation has become a key concept for the future of primary mental health care. It is a means to protect and uphold the dignity of people with mental health problems. However, at present its reach does not go beyond social care.

In mental health care, the 'recovery approach' embodies many of the same principles as personalisation. 'Recovery' has been adopted and re-defined by mental health service users as a personal journey, a means of finding a meaningful life with or without the continued experience of mental health problems and symptoms.

Recovery 'is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness....'

The recovery approach could be promoted and put into action, based on some key organisational challenges:

- Changing the nature of day-to-day interactions and the quality of experience.

- Delivering comprehensive, service-user-led education and training programmes.

- Ensuring organisational commitment, creating the 'culture'.

- Increasing 'personalisation' and choice.

- Changing the way we approach risk assessment and management.

- Supporting staff in their own recovery journey.

- Increasing opportunities for building a life 'beyond illness'.

Recovery-oriented practice

The term recovery does not have one standard definition in mental health. However, there is general agreement among experts that it refers to "living a satisfying, hopeful, and contributing life, even when there are ongoing limitations caused by mental health problems and illnesses."

Recovery-oriented practice, which is based on dignity and respect for the individual, recognizes the possibility of recovery and wellness, maximizes self-determination and self-management of mental health, and helps families understand and support their loved ones.

The recovery approach does not preclude or replace clinical treatment. Medication, for example, can still play a vital role. The difference is that clinicians support patient autonomy by undertaking shared decision-making about the treatment: What does the patient hope to gain by using this medication? Does the patient understand the potential side effects? How will this medication help the patient reach a recovery goal?

Recovery is a multifaceted concept, and the need for operationalization in practice has been identified. However, although guidance on recovery-oriented practice exists, it is from disparate sources and is difficult to apply.

Promoting recovery-oriented practice in mental health services

Recovery has become an increasingly prominent concept in mental health policy internationally. However, there is a lack of guidance regarding organisational transformation towards a recovery orientation.

A key challenge for primary mental health services is this lack of clarity about what constitutes recovery-oriented practice. The conceptual framework contributes to this knowledge gap.

Training can provide an important mechanism for instigating change in promoting recovery-orientated practice. However, the challenge of systemically implementing recovery approaches requires further consideration of the conceptual elements of recovery, its measurement, and maximising and demonstrating organizational commitment.

Promoting recovery-oriented practice can be achieved through the following:

1. Introducing organisational change that is differentiated from the change in the content and structure of services necessary for implementing recovery, yet related to it.

2. Implementing strategies to guide the transformation of primary mental health services toward becoming more recovery-oriented.

3. Using the concept of recovery as an integrating bridge for the content and structure of services.

4. Creating values and policies in the larger cultural and policy environment that are supportive of recovery processes.

5. Introducing substantial changes in treatment philosophies, regulatory policies and monitoring protocols, clinical and support service menus, service relationships, the training and supervision of staff and volunteers.

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SECTION V
TRANSFORMING SERVICES - TIME TO ACT

5.1. DIGNITY AND MENTAL HEALTH – TRANSFORMING THE WORKFORCE

- Gabriel Ivbijaro,[1] Dinesh Bhugra,[2] Vikram Patel,[3] Claire Brooks,[4] Lucja Kolkiewicz,[5] Pierre Thomas.[6]

Introduction

To make dignity and equity in mental health care a reality for many and not just a few requires global consensus and an appropriately trained workforce to provide evidence- based care wherever and whenever it is needed.

The World Health Organization (WHO) Comprehensive Mental Health Action Plan 2013-2020[1] and the movement for universal health coverage[2] are laudable, but despite all WHO Member States endorsing this plan it is likely to remain a dream for many mental health service users globally. There are many reasons for this and shortage of an appropriately trained workforce and a shortage of advocates is one of them.

There have been many global initiatives to improve health outcomes, including the Alma-Ata Declaration[3] and the Millennium Development Goals.[4] However people with mental ill health and their families continue to feel marginalised. Many citizens of the world know enough about common physical health problems but there remains widespread ignorance about mental health conditions. This affects access to care and ultimately has a negative impact on outcome and dignity.[5]

Case for Change

We know that every year 30% of the population worldwide will suffer from mental disorders and at least 60% of these people will receive no treatment regardless of income.[5] What does this mean in reality? In the USA 31% of people are affected by mental ill health but 67% of them do not receive any treatment,[6] and approximately 40%-50% of people with schizophrenia do not receive any treatment in a given year.[7, 8] Europe is no better; 27% of people in Europe suffer from mental ill health and 74% receive no treatment.[9] This rises to approximately 90% of people in Nigeria and China.[10] Dignity in mental health cannot be achieved when so many people with mental ill health do not have access to the right care. Anthony Lehman puts this starkly by stating: "We can no longer tolerate palliative care for persons with schizophrenia."[11] Neither should we tolerate minimal care for mental health conditions generally.

We need to innovate and develop a work force that has the right skills to provide evidence- based treatment in a dignified way to people who use mental health services. [12, 13, 14, 15, 16, 17, 18, 19]

There will never be enough specialist mental health workers to provide the care needed to cover the whole population. We need to develop new ways of working that lead to better integration and collaboration across sectors. These new ways need to be effective, safe and cost effective in high, medium and low income countries.[20]

One way to develop more mental health workers and improve access to care is by using *skill mix* and *task sharing*. This means that new roles are developed and existing roles are re-defined.

Skill mix describes the range of roles and skills that people working together in a mental health team can offer each patient that they see.[12, 13, 14]

Task sharing (or task shifting) is when activities previously provided by a certain professional group are transferred to other people. These may include non-specialists such as lay workers and family members who can use community platforms and assets such as schools and other public facilities to support the extended primary care role, while also supporting self-care and working as partners in mental health care with mental health specialists. [15, 16, 17, 18, 19]

There has been an over-reliance on technology that results in mental health workers looking at patients in biomedical terms. Many patients find it difficult to navigate impersonal, over-pressured health care systems.[21] The right mix of workers with the right skills and attitude will understand and promote the dignity of those people using mental health services. Medical practice needs to find ways to foster not just physical healing but wellbeing.[22, 23] This is dignity in mental health.

Defining Dignity

When used in mental health the word "dignity" means different things to different people, but whatever definition is used, being respected and valued lies at the core.

Dignity has its origins in medieval Christianity which ascribed dignity to man and not to animals, because man alone was made in God's image. The 18th century philosopher Immanuel Kant stated that to be able to regard one's own existence as having worth, all people must apply that recognition of worth equally to others. By the 21st century Nora Jacobson noted that human dignity is central to human bioethics and consists of two main forms, human and social dignity.[24, 25]

Human dignity and social dignity must be complementary in health delivery as envisaged in the 1948 United Nations Universal Declaration of Human Rights.[26]

Dignity – the people's voice

In order to hear the patient voice the World Dignity Project set out to understand what dignity in mental health means to people by asking patients, caregivers and mental health professionals for their experiences and definitions.

The World Dignity Project reached out to 120 people in 11 countries around the world and their feedback helped us identify three main forms of dignity:

1. Human Dignity (external): Physical care and respect for the individual.
   "I was given a room with a bed and linen plus I had people to talk to. This was in sharp contrast to my first experience of being sectioned…I was locked in an empty room with no bed or linen but just cold cement to sleep on."
   Eddie, Uganda.

2. Self Dignity (internal): Feeling empowered in the treatment process.
   "Dr S consulted…considered how I felt before she did anything…listened to my concerns. I always felt like I was in control of my treatment."

Jenny, UK.

3. Universal Dignity: How society treats those with mental illness.
   "We need unity in order to achieve dignity. We need to be open-minded and welcoming of new ideas. We need to talk about mental health issues in everyday life, in the media and in the government…Above all, we need to show love towards each other and unite for we all live on the same planet."
   Desi, UK.

What people told the World Dignity Project was similar to what many people have already described—that dignity in mental health is about social justice, equality, being respected and being allowed to contribute.[27]

Equity as a Means to Achieving Dignity

Equity and fairness for the patients who need services is vital to ensure that services are accessible, acceptable and approachable. Depending upon resources, different models of care can be delivered. Social justice for persons with mental illness means equity and fairness at a number of levels.

Equity is about access to services as well as reduction in unfair and avoidable factors which contribute to inequality. It is a major part of the role of the doctor as an advocate to help promote a fair society by challenging injustices and valuing diversity related to age, sex, religion, sexual orientation etc. This advocacy will help to develop institutions which not only uphold values of equality but also ensure that adequate human and material resources are allocated to the reduction and elimination of disparities and inequalities.

Advocacy can help deal with prejudices and discrimination whether these are related to age, gender, sexual orientation, race and ethnicity, disability, belief, location or social class.

Inequalities are never just. Social determinants of health indicate that poor mental health leads to further social inequalities and create a downward spiral. Outcome based parity and human rights based parity will lead to better outcomes and also improve the quality of life of persons with mental illness.

Making It Happen

Making dignity central to delivering good care and supporting recovery for people with mental health problems and their families requires a workforce that can work in a collaborative way with patients and carers across traditional boundaries and sectors. Although we have talked about delivering dignity in mental health through transforming our mental health workforce, this is not enough. We support the WPA-Lancet Commission in Psychiatry that aims to address the role of the psychiatrist in 21st century mental health care but part of the solution lies in our wider society. Working together we need to emphasise the promotion of self-care through a partnership of patients with mental health specialists and other medical specialists working with the people around us, including families, schools, the criminal justice system and faith communities. This may require laws to be reviewed to ensure that dignity and value-based care are entrenched in every encounter so that it becomes a positive dignity encounter.

For dignity in mental health to become universal we need to promote dignity and ethical values including social justice throughout our whole society, and we need to create a shared understanding of what dignity in mental health looks and feels like.

We applaud the theme of this year's World Mental Health Day and applaud WFMH on its leadership role. We call on the

membership of WFMH to work with its allies and build on the Lille Declaration and World Dignity Project to propose a Commission to better define what Dignity in Mental Health is and should be.[28] This will enable us to agree on standards so that we can benchmark services and better recognise and promote Dignity in Mental Health, working in partnership to achieve it.

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5.2. PROMOTING DIGNITY BY ADDRESSING DIVERSITY AND SOCIAL INCLUSION

- Mental Health Commission of Canada

On behalf of the Mental Health Commission of Canada, I would like to commend the World Federation of Mental Health for its efforts to raise awareness and combat stigma through World Mental Health Day.

It is fitting that this year's theme is "promoting dignity by addressing diversity and social inclusion." While we have made great strides in the right direction, there is still much work to be done.

Canada is many things. Yet, above all, diversity is central to our identity as a nation. As a country that strives to be inclusive, we must ensure our definition of diversity is broad enough to encompass Canadians of all ages, races, genders, backgrounds and beliefs.

Through its unique Health Canada mandate, the MHCC was tasked with creating Canada's first-ever mental health strategy. Key among the strategic directions outlined in this seminal document, *Changing Directions, Changing Lives*, are the promotion of mental health **across the lifespan** and the creation of a system that can meet the needs of **all Canadians**.

In any given year, one in five Canadians will experience a mental health problem or illness, thus affecting Canadians of all walks of life. Any successful system of mental health treatments and supports must reflect the needs of the individual – be they cultural, societal or linguistic.

In an effort to leverage our influence with policy makers, the MHCC is building what we call "A Case for Diversity." Essentially, this project aims to demonstrate the tangible benefits of investing in culturally and linguistically competent services for immigrant, refugee, ethno-cultural and racialized groups.

We know that culture plays a significant role in mental and physical health. Culture informs lifestyle behaviours, health beliefs, attitudes and communications patterns. Addressing these factors accords patients respect and dignity – and, as such, may improve outcomes.

This is especially true of the distinct cultural identity of Canada's first peoples – First Nations, Inuit and Métis cultures. At once distinct from one another, and encompassing considerable diversity within each population, for First Nations, a holistic approach is often expressed through a balance of physical, emotional, mental and spiritual wellness.

Yet, to truly address diversity, in all its compelling facets, we must view mental health services through a broader lens. Take Canadian youth, for example. We know that in more than 70 percent of instances, mental health problems begin in childhood or adolescence. We also know that early intervention is key to successful recovery. Putting two and two together, it only makes sense to ensure that youth are actively engaged and empowered to promote mental wellness, identify emerging problems and seek appropriate treatment.

Currently, the MHCC has several youth-focused initiatives. The first is HEADSTRONG, our youth anti-stigma program. HEADSTRONG is geared towards equipping students with the knowledge they need to better understand mental health challenges.

However, meeting the mental health needs of youth must go beyond changing attitudes and behaviours. We must also address the very real system challenges young people face when transitioning from child and youth services into the world

of adult mental health care.

We know that this transition is often difficult to navigate. It is a time when young people are particularly vulnerable to disengaging with the system entirely. That is why the MHCC has partnered with the Children's Hospital of Eastern Ontario (CHEO) in an effort to address policies and practices to better manage mental health and addictions issues during this crucial stage of development - which we refer to as the "emerging adult."

Given that *Changings Directions, Changings Lives, The Mental Health Strategy for Canada* is a blueprint for change in mental health service delivery across the system, acknowledging the special challenges faced by young people must be counter-balanced by recognizing that Canadian seniors also have specific needs, and are vulnerable to social exclusion.

By 2036, nearly one in four Canadians will be a senior. Seniors can be affected by the spectrum of mental health problems, including the co-morbidities that exist between chronic illness and mental health. For example, major depression occurs in a significant number of patients who have experienced acute stroke. To that end, the MHCC has produced Guidelines for Comprehensive Mental Health Services for Older Adults in Canada, which elucidate key recommendations for understanding the diversity among seniors.

In short, Canada must work towards building a system of person-centred care oriented towards recovery – which refers to living a satisfying, hopeful and contributing life, even with ongoing limitations from mental health problems and illnesses.

In so doing, all Canadians will benefit from a sense of dignity and inclusion.

LESSONS LEARNED FROM THE CREATION OF A MENTAL HEALTH STRATEGY

Released in 2012, Canada's first-ever mental health strategy, Changing Directions, Changing Lives, represents the culmination of extensive consultation and discussion. The following are key lessons resulting from that journey, which remain relevant today.

Mapping a Blueprint

Changing Canada's mental health landscape in a substantive and meaningful way involved the ranking of priority areas. The consultative nature of the process was key to the resonance of the Strategy as a whole. This same approach is currently serving as the model for a follow-up document, the Mental Health Action Plan, which will aim to elucidate next steps around furthering the goals in the Strategy, while addressing pressing emerging mental health issues in Canada. In other words, gaining a consensus around which areas are most critical to the achievement of an overarching goal is an essential step.

Broadening the Tent

Changing Directions, Changing Lives, drew on the experiences, knowledge and wisdom of thousands of people across the country. Crucially, those people included individuals with lived experience of mental illness, and their families. Their insights were not peripheral – but rather central – to the creation of the Strategy. In a similar fashion, the Mental Health Action Plan will be informed by broad, national consultations.

Making Sense of it All

Putting forward 26 priorities and 109 recommendations in an accessible, cohesive format involved the definition of clear strategic directions. By presenting these recommendations under the umbrella of six strategic directions, the Strategy ensures that each one contributes to an overall picture of an improved mental health system.

Knowledge Exchange

In many ways, our first strategic direction, "Promoting mental health across the lifespan in homes, schools, and workplaces, and preventing mental illness and suicide wherever possible," could also be interpreted as a key lesson: to broadly share what you have learned. Central to all our messaging is advocating recovery-oriented practices, and upholding the rights of individuals living with mental health problems and illnesses.

In ten short years, Canada has progressed from the sole country in the G-8 without a mental health strategy, to a respected international mental health leader. This sea-change can be attributed, in no small part, to Changing Directions, Changing Lives. It contains the hopes and aspirations of thousands of Canadians, and has had a transformative effect on Canada's mental health landscape.

5.3. DIGNITY AND MENTAL HEALTH CARE IN PRACTICE

- Social Care Institute for Excellence, UK

- Treat people with respect – as individuals and fellow human beings. Avoid labelling people because of their diagnosis or their association with any other group.

- Provide person-centred care and support – place the individual and their needs, preferences and aspirations at the centre of care. An ethos of person-centred care upholds the dignity both of people using services and of staff.

- Promote good practice in safeguarding – focus on prevention and make proportionate, person centred responses to abuse.

- Adopt a recovery approach to mental health – in particular, help people sustain their personal identity and self-respect, which are both closely associated with the concept of dignity.

- Promote good communication – this demonstrates respect and maintains an individual's dignity. Good communication means enabling both professionals and service users to communicate. Professionals may be trained in the relevant attitudes and communication skills, but services users may need support with communication, particularly if they lack capacity.

- Tackle discrimination – through individual and local community initiatives, national programmes, policy and legislative measures.

- Engage service users from black and minority ethnic groups – take active steps to engage people and ensure their views are recorded in their care plan.

- Adopt a human rights-based approach to mental health care – ensure that people's human rights are protected at a time when their capacity, autonomy, choice and control may be compromised under mental health legislation. Where someone has been deprived of their liberty under the Mental Health Act, offer them support to deal with any related trauma.

- Preserve autonomy, choice, control and independence – provide person-centred care and enable people to state their needs and preferences in advance of loss of capacity. Methods you can use include advance statements, crisis cards and life story resources for people with dementia.

- Improve the quality of care in inpatient settings – provide patient-centred care that is individualised, comprehensive and continuous; a range of therapeutic resources; a relaxed and secure atmosphere. See for example the Sainsbury Centre for Mental Health (2006).

- Promote a positive organisational ethos – from the top, encourage an ethos of respect and dignity (Carter, 2009). Include taking a person-centred approach to care and a zero tolerance of abuse.

- Provide training, clinical supervision and support – adopt measures to enable staff to examine their own attitudes and to feel supported in their role. This will encourage them to treat others with respect.

- Address environmental risks to dignity – provide single sex wards, privacy in personal care and use of bathroom facilities, clean facilities, adequate space and appropriate staffing levels.

KEY POINTS FROM POLICY AND RESEARCH

- Adults with mental health problems are one of the most socially excluded groups in society (Social Exclusion Unit, 2004).

- Self-respect and self-esteem is central to maintaining mental health and wellbeing (Warner, 2011).

- Current government policy on mental health enshrines the concept of dignity within a strategy based on outcomes. (Department of Health, 2011)

- The Human Rights Insight Project showed that vulnerable groups see being treated with dignity and respect as the single most relevant factor when dealing with workers in the NHS or social services, compared with other principles of human rights (Ministry of Justice, 2008).

- Respecting an individual's identity and protecting their dignity will help to promote recovery, whereas acts that violate dignity and fail to respect an individual and their story can lead to further damage (Jacobson 2009; Kogstad 2009; Warner 2011).

- People in mental health units are less likely to report that staff treats them with dignity and respect than those in primary and secondary care (Ipsos MORI, 2005/6).

- Environmental issues that can threaten dignity in acute wards include overcrowding, poor staffing (levels and quality), the use of mixed sex wards and impoverished or unclean environments (Curtice and Exworthy, 2010).

- Dignity in mental health settings is supported by person centred care, improving inpatient experiences for black and minority ethnic communities, good communication, human rights and safeguarding.

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5.4. CALL TO ACTION

- WFMH

Introduction

The World Federation for Mental Health was founded in 1948, the same year as the United Nations and the World Health Organization. It is the oldest mental health organization in official relations with the World Health Organization, the United Nations health agency, and has a long history of advocacy for improving mental health care, promoting mental health, and educating the public about mental disorders. It established World Mental Health Day (10 October) in 1992 as a way to expand public education, using annual themes and providing specially prepared material.

Why dignity was chosen as the theme for this year

Every human interaction holds the potential to be a dignity encounter and this can either be positive or negative. Sadly, although many people with mental health problems and their families can describe a positive dignity encounter, the majority describes encounters that are negative. This is unacceptable - we cannot be bystanders, we need to do something.

What do we know?

One in four adults will experience mental health difficulties. Over 450 million people globally experience mental disorders each year. Despite the commonly repeated mantra of 'no health without mental health,' people with mental health difficulties continue to face challenges in obtaining the help that they require.

Stigma and discrimination are significant barriers to obtaining good mental health care and to accessing the everyday social activities that keep us mentally well. Stigma interferes with people's full participation in society and deprives them of their dignity.

People with mental health difficulties, their families, caregivers, governments, NGO's (non-governmental organizations), professionals of all kinds and the associations that represent them would like all encounters to result in a positive dignity experience. To make dignity in mental health a reality requires every member of society to work together and make mental health visible, not something to be ashamed of.

We all need a voice

The voice of people with mental health difficulties needs to be heard. Every voice, every opinion matters...

What are people saying?

"My second time of being sectioned, I was in England. I was given a room with a bed and linen plus I had people to talk to. This was in sharp contrast to my first experience of being sectioned to a Psychiatric Hospital in Uganda. While in Uganda I was locked in an empty room with no bed or linen but just cold cement to sleep on."
- Eddie

"It is very painful to see even people you expect to handle you with care turn out to shout at you, mock at you, torture and tie you up with ropes and chains in isolated place as though you committed a crime to succumb to mental illness. You are perceived to be cursed, demon possessed, bewitched for doing wrong and outcast never fit to live in society. It is a terrible burden to carry, no one ever feels relieved until life comes to an end. You feel it is only God that understands what you are going through and by his mercy you can get what to eat, where to sleep, who can speak to you warmly and welcome you with

a loving heart and helping hands ...It Is all about a loving heart, empathetic, caring spirit and helping hands that can support, reflect and signify dignity in mental Health."
- Kabale

"The social worker for the ward, a woman I had scarcely known or paid any attention to in the past, came to me as I was leaving and assured me that she would do whatever she could to help my husband's care. She gave me a hug and said she felt for what we were going through. She didn't need to do it, but her kindness at that time made all the difference."
- Sharon

Role for people who live with mental health issues

People who live with mental health issues can learn that their story has power, the power to create change. By learning to use their voices they and others will understand dignity in life, in opportunities, in treatment, and in their communities. Dignity arises from having hope for a full and contributing life. It teaches what respect looks like and more importantly, what it doesn't look like.

People who live with mental health issues have the right to expect to live a contributing life. They must be encouraged to have hopes and dreams and must be informants in showing communities and especially health and welfare providers how to treat people such as themselves with respect and dignity.

People who live with mental health issues must take their rightful place in society, carrying themselves with the dignity and respect that all people deserve. No longer should they think of themselves as less than others because of our illness. They must raise their heads and our eyes and treat themselves with dignity and respect.

Role for government

We call on all governments to rise up to the 1948 United Nations Declaration of Human Rights to ensure that their legislation is consistent with these values.
We call on government mental health leads to make a public statement to mark World Mental Health Day 2015 and declare their intention to ensure mental and physical health parity.

Role for society

We can measure the moral values of our global society by how we treat vulnerable individuals. People with a mental illness are an integral part of our global family. They deserve our respect and compassion as they cope with their disease. We need more education, research and services to combat the stigma that has been associated with mental illness for centuries.

Role for non-governmental organizations (NGOs)

NGOs should collaborate, to amplify the effectiveness of their advocacy efforts.

All NGOs should try to contact their Government Health Departments at least once a year to advocate for more spending on mental health care.

Role for colleges and other institutions

We call on all academic and professional colleges and other academic institutions to mark World Mental Health Day 2015 by fighting for mental and physical health parity to provide dignity and by actively promoting mental health visibility in their day-to-day business.

Role for families

Caregivers of persons with a mental illness bear a tremendous burden. Societal resources are often meager or absent. Policies need to be developed to support caregivers, financially and emotionally. We need to view the role of the caregiver as highly valuable for effective treatment and positive outcomes for persons experiencing a mental illness. They are indeed the unsung heroes in the fight against mental illness and should be accorded our highest praise and respect.

Global action

World Mental Health Day is our opportunity to show our solidarity with people who live with mental illness and their families and to make ourselves visible to fight stigma.

Show some positive action for mental health from 10th September 2015 to 10th December 2015. This can include organizing a physical activity to highlight the importance of dignity in mental health, an artistic activity such as a concert or art exhibition and awareness raising event in your local shopping center or town center and share your experiences with us.

Symptoms are not a barrier to recovery, but attitude is....



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