GOOD PRACTICES
in Mental Health & Well-being

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Introduction

Mental disorders place a tremendous burden on the well-being and health of European citizens. They are a leading contributor to the burden of disease (DALYs) in the European Union[1], and approximately 38.2% of EU citizens across all age groups are affected by a mental disorder each year. Good mental health is fundamental for the well-being of individuals, and are critical for achieving EU policy objectives related to economic growth, job creation, and quality of life for EU citizens. It can lead to an increase in productivity and subsequently enhance economic growth, social cohesion and prosperity in Member States. Therefore action is required to respond and address the mental health needs of the European population.

The EU Compass for Action on Mental Health and Well-being, a tender commissioned by the Consumers, Health, Agriculture and Food Executive Agency (Chafea), aims to support actions that address challenges in mental health in Europe through monitoring and disseminating activities on mental health in the European Union. The EU Compass builds upon previous mental health and well-being work at EU level such as the Green Paper for Mental Health (2005), the European Pact for Mental Health and Well-being (2008), and the Joint Action for Mental Health and Well-being (2013-2016).

Sharing information on good practices implemented in various settings can help stimulate investment in mental health, and collaborating efforts across EU in designing and implementing such activities in a more effective and efficient manner. This booklet presents examples of good practices in the field of mental health from EU Member States and stakeholders for 2015-2016. Practices submitted to the EU Compass have been evaluated by an external expert panel, in line with a set of quality criteria tailored to evaluating practices in this field. Practices meeting the criteria are presented in this booklet as Good Practices.

[1] H.U. Wittchen, F. Jacobi, J. Rehm, A. Gustavsson, M. Svensson, B. Jönsson, J. Olesen, Allgulander, J. Alonso, C. Faravelli, L. Fratiglioni, P. Jennum, R. Lieb, A. Maercker, J. van Os, M. Preisig, L. Salvador-Carulla, R. Simon, H.-C. Steinhausen. (2011). The size and burden of mental disorders and other disorders of the brain in Europe 2010. European Neuropsychopharmacology 21, 655–679

Methods

Data collection tool and evaluation criteria

Good practices in this booklet have been collected in the basis of a standardized format developed by the EU Compass Consortium, building on previous experience within the EU and in the field of good practices. The format included fourteen questions corresponding to the good practice selection criteria developed by the EU Compass. The development of criteria for the selection of good practices was carried out by the EU Compass Consortium with input from the DG Santé. The criteria categories have been based upon existing good practice criteria developed by the EU Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life-cycle (JA-CHRODIS), and the WHO (2008) 'Guide to Documenting and Sharing "Best Practices" in Health Programs'. Individual criteria within these categories have been tailored for the selection of practices as follows:

1. Comprehensiveness and effectiveness: a) The practice is based on an existing evidence-based intervention, conceptual framework, or approach; b) The results of the practice have been assessed or evaluated through research; c) The outputs and outcomes of the practice are clear and well-defined; and d) The activities of the practice can be seen to build towards the objectives of the practice.

2. Description of practice: a) It is clear which mental health disorder and/or that mental well-being is being addressed by the practice; b) There was a clear description of the key implementers and collaborators; and c) The practice's objectives and activities were clearly specified.

3. Potential of scalability/transferability: a) Facilitators to implementation are well described; b) Barriers to implementation are well described; and c) The practice has been scaled up at national level (80%).

4. Partnerships/intersectoral collaboration: a) The practice involves collaboration between several stakeholders; and b) The practice has been initiated by more than one sector.

5. Community involvement/empowerment: a) The practice involves participation in sectors other than health and social sector; b) The practice addresses empowerment and community involvement of the target population; and c) The practice involves participation of people involved, families, or caregivers.

6. Political commitment and governance: a) The proposed practice has a national level of implementation; b) Main program documentation is publicly available (at least a web link); and c) Funding sources are made available.

Further information on the selection criteria and evaluation process can be provided by the EU Compass team (BHippleWalters@trimbos.nl).

Training, review and selection

An expert panel consisting of eight experts with multi-sectoral backgrounds, reflecting the diversity of EU Member States, was selected by the EU Compass Consortium to carry out a review of the submitted practices. Experts received training during which the background and purpose of the EU Compass was explained, the good practice criteria were presented and discussed, and a trial evaluation took place. Subsequently, experts carried out evaluations of three to six practices each. In total, thirty practices were evaluated. Practices meeting the set threshold have been labeled as Good Practices and have been included in this publication.

Data Collection

The standardized format has been disseminated online along with EU Compass Member State and stakeholder surveys in January 2016. The survey had open access and data collection has been carried out between January and April 2016. Thirty-four practices have been submitted, of which four were empty submissions. The list of contributors, who submitted the practices in this booklet, can be found in *Annex 1*.

Limitations

The information related to good practices presented in this booklet was extracted from the EU Compass Good Practice Surveys 2016. Information has not been checked for accuracy by third parties or through other sources, and solely represents the input obtained from survey respondents, with minor editorial changes.


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Practice 1: Salute allo Specchio (Reflections of Health)

Summary

Salute allo Specchio (Reflections of Health) began in June 2013 and was initiated by the health and social sector. *Salute allo Specchio* is both a research and an action program. The objective of *Salute allo Specchio* is to help women cope with cancer and with the side effects of cancer treatment, providing for a protective environment, and reducing the risk of the onset of psychological distress symptoms and social isolation. It focuses mainly on prevention of anxiety disorders and depression.

Salute allo Specchio is a psychosocial program designed to help women cope with the cosmetic side effects of cancer treatment, which often determine severe changes in one's self-image. It is composed of group sessions during which a team of experts (in oncologic cosmetology, oncologists, psychologists, hospital volunteers) give information about make-up, wigs, skin treatment, and massage. The group setting provides women with the opportunity to share their experience with other women with the same condition. Psycho-educational interventions have been implemented and focus on nutrition, fertility and sexuality, and communication of the diagnosis to children whose parents have cancer. These interventions are carried out by psychologists and physicians (oncologist, nutritionist, gynecologist).

Salute allo Specchio has been complemented by research from the beginning; evidence shows that such a program helps to reduce anxiety and depressive signs and symptoms, improves self-esteem, self-image and quality of life. Concrete results include positive evaluations, for example from women who reported a reduction in isolation and the feeling of being "really taken care of".

www.saluteallospecchio.it; www.hsr.it/salute-allo-specchio/

Responsible organization or person:

Salute allo Specchio Onlus and San Raffaele Hospital

Addressed priority areas

- ☒ **Prevention of depression and promotion of resilience**
- ☐ Provision of more accessible mental health services
- ☐ Provision of community-based mental health services
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☐ Other

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Professionalism of all people involved*
- *An integrated model of medical care, which considers the patient as a person with not only physical, but also psychological and social needs*

What did not work/ barriers to implementation

- *Difficulty in finding economic sources for funding*
- *As long as it is not considered as an integral part of patients' treatment, it will be difficult to implement this kind of program beyond a local level, where a large number of patients could benefit from it.*

This practice was initiated in: Italy

Level of implementation

- ☐ European
- ☐ National
- ☐ Regional
- ☒ **Other: local, San Raffaele Hospital, Milan**

Practice 2: Eating Disorders Centre, Mental Health Department Ferrara, University of Ferrara

Summary

The *Eating Disorders Centre* was started in 2015 and was initiated by the health sector. The *Eating Disorders Centre* focuses on action and on mental health in all policies. The objective of the *Eating Disorders Centre* is the prevention and treatment of eating disorders. Activities include a multidisciplinary approach to eating disorders between psychiatric, psychological, and nutritional disciplines. Concrete results (outputs and outcomes) are the treatment of one hundred outpatients per year and the treatment of fifty new cases per year.

http://www.ausl.fe.it/azienda/dipartimenti/daismdp/staff/m.o.-interaziendale-del-servizio-per-i-disturbi-del-comportamento-alimentare-d.c.a.

Responsible organization or person: University of Ferrara, Stefano Caracciolo

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☐ Provision of more accessible mental health services
- ☒ **Provision of community-based mental health services**
- ☐ Suicide prevention
- ☒ **Mental health in the workplace**
- ☒ **Mental health in schools**
- ☐ Integrated approaches for governance
- ☐ Other

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Support from stakeholders, patients' associations and families*

What did not work/ barriers to implementation

- *Patients' barriers to help-seeking or refusal of treatment, for example by patients with Anorexia Nervosa*

This practice was initiated in: Italy

Level of implementation

- ☐ European
- ☐ National
- ☒ **Regional: Ferrara, Emilia-Romagna, Italy**
- ☐ Other

Practice 3: The Well-being Guild of Entrepreneurs

Summary

The Guild project was carried out between 2008 and 2010, which led to the development of the Guild model. The dissemination of the Guild model in Finland commenced in 2012 and will finish by the end of 2016. *The Guild project* was initiated by the health sector and the labor sector; the model was developed by an NGO. *The Guild project* focuses on the tool/instrument, action, training, and dissemination of the Guild model.

The main objective of *the Guild project* is to support the mental well-being of small and medium-sized entrepreneurs and ensure that they have the skills and resources to take early action in case of onset of mental health problems. In line with the model, veteran entrepreneurs and well-being experts advise entrepreneurs in small and medium-sized companies on sustainable well-being. The core activities are two-fold:

- a two-day course on welfare (applied mental health first aid); and
- the guild's peer group activities, in which expert and peer support were used to develop participants´ self-knowledge, stress management skills, and ability to handle loneliness.

There have been over six hundred entrepreneurs who have taken part in *the Well-being Guild* of entrepreneurs. Two thirds of participants were women and over ninety percent of the participants recommend *Guild* activities to their colleagues. Peer group discussions focused on coping and on problems related to everyday life and work. This has helped entrepreneurs understand their own coping and identify risks related to mental well-being.

Responsible organization or person:
The Finnish Association for Mental Health, Tiina Lumijärvi

Addressed priority areas

- ☒ **Prevention of depression and promotion of resilience**
- ☐ Provision of more accessible mental health services
- ☐ Provision of community-based mental health services
- ☒ **Suicide prevention**
- ☒ **Mental health in the workplace**
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☒ **Other: peer support, mental health first aid**

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Systematic evaluation and feedback from participants enabled the model to be developed based on the needs of entrepreneurs*

What did not work/ barriers to implementation

- *The set-up of self-sustaining peer support groups consisting of entrepreneurs who have participated in the Guild training courses*
- *Time commitment from the entrepreneurs needed for involvement in the peer support groups*
- *Marketing approaches of the training courses and the peer group activities could be improved*

This practice was initiated in: Finland

Level of implementation

- ☐ European
- ☒ **National: Finland**
- ☐ Regional
- ☐ Other

Practice 4: Lifeworks

Summary

Lifeworks started in 2008 and is still ongoing. The program was initiated by the voluntary sector and is a service-delivery approach/method. The objective of *Lifeworks* is to improve mental health and resilience of socially excluded people, including those who are homeless and rough sleepers. Activities focus on individual psychotherapy in accessible places such as hostels, day centers, and other community settings. Concrete results of *Lifeworks* include:

- 70% engagement from rough sleepers and homeless people and >75% attendance;
- >75% positive outcomes, as measured by the South London and Maudsley evidence-based Well-being Measure; and
- an increase in social functioning across all measures of Outcomes Star (for example 44% of people were in training or work placement after six months, compared to 20% of those who were not in the service).

Responsible organization or person: St Mungo's, Peter Cockersell and Lee Murphy

Addressed priority areas

- ☒ **Prevention of depression and promotion of resilience**
- ☒ **Provision of more accessible mental health services**
- ☒ **Provision of community-based mental health services**
- ☒ **Suicide prevention**
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☐ Other

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Taking time (six months) to set up and begin to deliver services*
- *Allowing for word of mouth among the clients to promote the program*

What did not work/ barriers to implementation

- *Main barriers were management lack of understanding, and actions by staff/management that undermined therapeutic relationships*

This practice was initiated in: United Kingdom

Level of implementation

- ☐ European
- ☐ National
- ☒ **Regional: London**
- ☐ Other

Practice 5: Individual Placement and Support for Employment (IPS)

Summary

Individual Placement and Support (IPS) first started in the UK in 1995 at South West London and St George's Mental Health NHS Trust. It has now spread across the UK and is still ongoing. The practice was initiated by the health and social sector and is categorized as a campaign and service delivery method. It focuses on both action and research. The objective of *IPS* is to enable people with severe and/or chronic mental ill health to enter and/or remain in the competitive labor market. *IPS* has been shown to be more effective the more closely it follows these eight principles:

1) it aims to get people into competitive employment;
2) it is open to all those who want to work;
3) it tries to find jobs consistent with people's preferences;
4) it works quickly;
5) it brings employment specialists into clinical teams;
6) employment specialists develop relationships with employers based upon a person's work preferences;
7) it provides time unlimited, individualized support for the person and their employer; and
8) benefits counseling is included.

The concrete results of *IPS* show that more than twice the number of people joined paid employment than with any other methodology, as has been confirmed by numerous randomized control trials.

https://www.centreformentalhealth.org.uk/individual-placement-and-support

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☒ **Provision of more accessible mental health services**
- ☒ **Provision of community-based mental health services**
- ☐ Suicide prevention
- ☒ **Mental health in the workplace**
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☒ **Other: labor market integration**

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Following the 25 point Fidelity Scale with regular reviews of services has been shown to be most effective*

What did not work/ barriers to implementation

- *Services which implement some of the key principles selectively, are less effective*
- *The most challenging principles are integration of employment specialists into clinical teams and establishing relationships with employers*

This practice was initiated in: United Kingdom

Level of implementation

- ☐ European
- ☒ **National: United Kingdom**
- ☐ Regional
- ☐ Other

Practice 6: Stability training (Tasapainovalmennus)

Summary

The *Stability Training* model was developed as a project in 2012-2014 by the Finnish Association for Mental Health and is now part of rehabilitation services of the SOS-Crisis Centre at the Finnish Association for Mental Health. *Stability Training* addresses is a service delivery method. The objective of *Stability Training* is to educate immigrants suffering from traumatic experiences to learn understand, recognize, and manage PTSD and its symptoms. *Stability Training* is a designed to consist of eight meetings. A shorter model, *Stability Training Info,* was developed for immigrants who suffer from changes caused by immigration processes and cultural changes rather than from trauma. This model focuses on the immigration and integration process and consists of one to four groups meetings, which give information and tools to understand and support well-being in difficult life situations.

Participants learn about tools to deal with symptoms through better understanding and body awareness. Out of the total of eight meetings, four meetings focus on psychoeducation, two on practical training with physiotherapist, and one is a lesson given by a physician about medication and open questions around the topic. The short *Stability Training Info*-sessions aim to teach basic knowledge about mental health and well-being through psychoeducation and (educational) materials translated in the language of the participants.

http://www.mielenterveysseura.fi/en/support-and-help/support-and-help-foreigners

Responsible organization or person:
The Finnish Association for Mental Health, SOS-Crisis Centre

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☐ Provision of more accessible mental health services
- ☐ Provision of community-based mental health services
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☒ **Other: mental health of immigrants and refugees**

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Good cooperation with partners who were familiar with the efforts of the SOS-Crisis Centre with immigrant clients. They helped to reach the right clients for the groups.*
- *Good cooperation with interpreters, who have extensive experience with translating mental health vocabulary.*
- *Information: the more information participants received about mental health, the more the stigma around mental health topics decreased. Some participants attended the groups because they had heard about the groups from other people with similar immigration backgrounds.*

What did not work/ barriers to implementation

- *Open groups, for which participants did not have to enroll beforehand, were not successful.*
- *Large groups with more than fifteen participants were too busy and therefore not successful.*

This practice was initiated in: Finland

Level of implementation

- ☐ European
- ☒ **National: Finland**
- ☐ Regional
- ☐ Other

Practice 7: Joint Experiences and Local Mental Health Systems, third edition 2014-2017 (Esperienze Compartecipate e Sistemi Locali di Salute Mentale, 3° edizione 2014-2017)

Summary

The *Joint Experiences and Local Mental Health Systems* program was started in 2014 and was initiated by the cultural sector, the social sector, and the health and social sector. *Joint Experiences* focuses on action and research. The objectives of *Joint Experiences and Local Mental Health Systems* include:

- to develop local knowledge in mental health by activating social and cultural elements in order to better balance the current predominance of the therapeutic approach of services based on global and mainly bio-medical knowledge;
- to develop different initiatives at local level through peer to peer collaboration among users, carers, local governments, and services (Joint Experiences);
- to permanently monitor both the state of each Joint Experience and the relationships among users, carers, local governments and services; and
- to establish an intermediate area between the service and the community as support to the Joint Experiences, which is led democratically by user organizations, relative organizations, services, and local governments.

Activities of *Joint Experiences and Local Mental Health Systems* focus on a questionnaire for mapping the Joint Experiences in Tuscany, data collection, data processing and discussion with the core group, and production of a web profile for each Joint Experience. Furthermore, meetings are held with all stakeholders for revision of the questionnaire and the project; a conference is held to launch a permanent online mechanism to update the Joint Experiences regarding both their internal functioning and the relationship with their local mental health system. Concrete results (outputs and outcomes) of the practice include the direct involvement of user and carer organizations in the field of action-research and the development of local knowledge beyond the biomedical knowledge.

http://www.mhe-sme.org/fileadmin/Position_papers/BBP_Resource_Update_2.pdf

Responsible organization or person: Pino Pini

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☐ Provision of more accessible mental health services
- ☒ **Provision of community-based mental health services**
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☒ **Integrated approaches for governance**
- ☐ Other

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *The close and longstanding alliances among several mental health associations in Tuscany, including collaboration with a research center.*

What did not work/ barriers to implementation

- *Resistance from services that do not believe in projects focused on social and cultural aspects of care.*
- *Services which tended to concentrate on scientific approaches/knowledge did not work.*

This practice was initiated in: Italy

Level of implementation

- ☐ European
- ☐ National
- ☒ **Regional: Tuscany, Italy**
- ☐ Other

Practice 8: The Professionally Guided Peer Support Groups for Bereaved by Suicide (Ammatillisesti Ohjatut Vertaistukiryhmät Läheisensä Menettäneille)

Summary

The Professionally Guided Peer Support Groups were started in 1995. The *Peer Support Groups* were initiated by the health and social sector and are a tool/instrument, training method, and service delivery approach/method. The objective of the *Peer Support Groups* is to strengthen the group members' resilience and teach different ways to cope in difficult life situations. Other objectives of the program are to strengthen social well-being and to prevent suicide attempts among this high risk group. The main methods used in the groups are thematic discussions guided by professionals. These thematic discussions form a continuum from processing the experiences of participants, dealing with the various feelings caused by the life situation, to strengthening resilience and coping. The groups are arranged as intensive courses around Finland (three to five days) or as weekly meetings (fifteen meetings) in the crisis center in Helsinki or in other cities.

During the last group session and three months later, participants are asked to evaluate the content and functionality of the support group and the professional leaders. Results have been excellent for years; the mean of Likert scale answers is continuously more than 4 out of 5. Participants indicate that most positive changes during their process were due to peer support in the group.

http://www.mielenterveysseura.fi/fi/tukea-ja-apua/vertaistukiryhm%C3%A4t

Responsible organization or person:

The Finnish Association for Mental Health, SOS-Crisis Centre, Reija Narumo

Addressed priority areas

- ☒ **Prevention of depression and promotion of resilience**
- ☐ Provision of more accessible mental health services
- ☐ Provision of community-based mental health services
- ☒ **Suicide prevention**
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☐ Other

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *The structure and processes of this model are solid and their functionality has been tested for years.*
- *All participants are interviewed before the group in order to construct functional peer support and to ensure that participants could benefit from participation.*

What did not work/ barriers to implementation

- *Finding enough participants; participants in the groups are surprised that they have not heard of these groups before. The demand for the support groups is constant.*

This practice was initiated in: Finland

Level of implementation

- ☐ European
- ☒ **National: Finland**
- ☐ Regional
- ☐ Other

Practice 9: Peer2Peer Vocational Training Course

Summary

The first *Peer2Peer t*raining course was organized in October 2014 and was initiated by the labor sector. The program is a tool or instrument which focuses on action, service delivery, and training. *Peer2Peer* is a new and innovative course designed to prepare people who experienced mental health problems to be employed in peer support roles and support others in their recovery. It will not only provide them with the knowledge, skills and experience required to be in a peer support role but will also contribute to the creation of a recognized employment and career pathway. The activities that form part of *Peer2Peer* include:

- developing an Alpha version of the teaching pack;
- piloting the teaching pack;
- improving the Alpha version and production of a Beta version informed by the results and assessment of the pilot courses; and
- disseminating the teaching pack and making it available to organizations interested in promoting peer support.

The concrete results of *Peer2Peer* are a *Peer2Peer* website (http://p2p.intras.es/index.php), training course (http://p2p.intras.es/images/manual/EN/P2P%20vocational%20Training%20Course.pdf), and documentary film (https://vimeo.com/144476270). *Peer2Peer* has resulted in training 135 people and in employing 22 trainees as volunteers or employees after the course.

http://p2p.intras.es/index.php

Responsible organization or person: Fundación INTRAS

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☒ **Provision of more accessible mental health services**
- ☒ **Provision of community-based mental health services**
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☒ **Other: provision of employment opportunities**

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Increasing the number of sessions, if needed, which enables certain sessions to be divided in two sessions.*
- *Organizing a preparatory session in which students meet each other, receive more information about the course, and determine how they will manage their wellness during the course.*
- *Starting each session with the opportunity for students to share their most important lesson from the previous session.*
- *Being mindful of group dynamics in the session and seeking to use approaches which build confidence in group discussions and trust between students.*

What did not work/ barriers to implementation

- *A manual for trainers could be developed, which could include sections that could be used to form a student manual.*
- *Students' feedback regarding the pilot course included the desire to have a manual for reading in their own time and possibly for doing individual exercises.*

This practice was initiated in: Spain

Level of implementation

- ☒ **European**
- ☐ National
- ☐ Regional
- ☐ Other

Practice 10: Housing First Portugal (Casas Primeiro Portugal)

Summary

Housing First was started in 2009 and was initiated by the health and social sector. *Housing First* is a service delivery approach or method. The objective of *Housing First* is to provide integrated housing in the community for long-term homeless people with severe mental illness, in some cases combined with substance abuse. Activities of *Housing First* include intensive and direct support to the person in the household and the integration in local services in all areas, such as health, mental health, social welfare, and judicial services (if applicable). A concrete result of *Housing First* is that 89% of the people involved retain their housing option.

http://www.aeips.pt/

Responsible organization or person:

AEIPS (Associação para o Estudo e Integração Psicossocial)

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☒ **Provision of more accessible mental health services**
- ☐ Provision of community-based mental health services
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☒ **Other: housing and community support for homeless people with severe mental illness**

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *A specialized team in community intervention*
- *Financial resources to make more housing available*
- *Interactions with local welfare organizations*

What did not work/ barriers toimplementation

- *Instability of funding efforts*

This practice was initiated in: Portugal

Level of implementation

- ☐ European
- ☒ **National: Portugal**
- ☐ Regional
- ☐ Other

Practice 11: Mobile Crisis Work: help at home in difficult life situations

Summary

The pilot project of *Mobile Crisis Work* took place in the city of Tampere, Finland, from October 2014 to December 2015. In 2016 the practice will be disseminated to another local area through training; its transferability will be tested. *Mobile Crisis Work* was initiated by the health and social sector and focuses on both service delivery and training.

The objective of *Mobile Crisis Work* is to develop an age sensitive mobile crisis aid practice for older adults, which can be transferred from one local crisis center to another by providing training and training material. The activities of the pilot project include one to five aid visits to each client and group activities for older adults. In difficult life situations, *Mobile Crisis Work* has resulted in promoting the feeling of well-being and supporting peripatetic assistance work activities.

Responsible organization or person:

The Finnish Association for Mental Health, Mirakle project

Addressed priority areas

- ☒ **Prevention of depression and promotion of resilience**
- ☒ **Provision of more accessible mental health services**
- ☐ Provision of community-based mental health services
- ☒ **Suicide prevention**
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☒ **Other: aid in difficult life situations**

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *For service providers it is important to recognize the diversity of older people. One-on-one conversations, which were provided by the crisis assistance, can facilitate this.*

What did not work/ barriers to implementation

- *The one-year pilot project in Tampere was too short for establishing proper cooperation with municipal services.*
- *For older adults processing takes more time and very often more than five visits were needed.*
- *Because of safety and coping issues, working in a team or in pairs would be preferred over working alone.*

This practice was initiated in: Finland

Level of implementation

- ☐ European
- ☐ National
- ☒ **Regional: Tampere, Helsinki, Vaasa, Turku, etc.**
- ☐ Other

Practice 12: Recovery: a person-centered approach in health and social services

Summary

Recovery was initiated by the health and social sector and by the social sector and is a service-delivery approach or method. The objective of the local recovery strategy in Arhus is to create person-centered services for people with mental health problems. As part of that overall objective, the strategy seeks to create strong orientation towards individual persons, to involve users and relevant stakeholders, to enable the user to live a self-determined life, and to stimulate the person's potential for development.

Recovery made new and significant demands on the way social services were organized in the City of Aarhus as well as on staff qualifications. Activities of *Recovery* concentrate on redesigning services to focus on recovery. The activities include an initial evaluation in which the user and a team of professionals summarize the situation and draft a realistic action plan, which may include medical and/or psychiatric treatment, education, employment and social initiatives. Other activities are user support by a personal coordinator and provision of services by various agencies brought together in one organization, named 'local psychiatry'. Additionally, peer support is available. Redesigning services to focus on recovery has produced positive results in Aarhus, relating to the improvement of users' quality of life and satisfaction with services. Following this evaluation, recovery was embedded more widely across the directorate of social services.

http://www.aarhus.dk/sitecore/content/Subsites/recoverydk/Home

Responsible organization or person: Marianne Cohen

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☒ **Provision of more accessible mental health services**
- ☒ **Provision of community-based mental health services**
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☐ Other

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Evaluation of current practices*
- *Testing new practices*
- *Status and dissemination strategy*
- *Implementation of new practices*

What did not work/ barriers to implementation

- *Stigma associated with poor mental health is a barrier to effective treatment and support, social inclusion, and ultimately an improved quality of life. Action should therefore be taken to improve knowledge of mental health problems and change perceptions by making mental health a political priority. These actions need to target not only the general public but also health and social professionals and people with mental health problems themselves.*

This practice was initiated in: Denmark

Level of implementation

- ☐ European
- ☐ National
- ☐ Regional
- ☒ **Other: local, city of Aarhus**

Practice 13: Education: a key tool for recovery and fight against stigma

Summary

Education was started in 2008 with preparation; in 2009, the first course took place. A total of five courses take place in Madrid between 2009 and 2017. The program was initiated by the health sector; by the NGO Fundación Mundo Bipolar and Universidad Autónoma de Madrid. *Education* focuses on action, research, and training.

The course is aimed at people with psychosocial disabilities and mental health problems with the model of recovery and empowerment. It consists of four parts. During the first part, people with psychosocial disabilities attend the 'specific course', a 28 hour-long multidisciplinary program . This program focuses on human rights, stigma and discrimination, self-management tools, psychological aspects, and lifestyle. The second part involves a train the trainer course. In the third part, students give presentations at schools about mental health problems and about their own experience in a positive light. The fourth part is the evaluation and dissemination. As a result of *Education,* an increasing number of experts by experience can be seen in Spain, some of which become teachers. Other results are a reduction in crisis situations and hospitalizations.

Addressed priority areas

- ☒ **Prevention of depression and promotion of resilience**
- ☐ Provision of more accessible mental health services
- ☐ Provision of community-based mental health services
- ☒ **Suicide prevention**
- ☐ Mental health in the workplace
- ☒ **Mental health in schools**
- ☐ Integrated approaches for governance
- ☒ **Other: fight against stigma and discrimination, rights of people with psychosocial disabilities, and peer to peer support/training**

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Good atmosphere among the students, attention of the teachers, questions solved by teachers, and a good interchange of opinions and views*
- *Development of a final document elaborated by the class about empowerment and recovery*
- *Talks at schools by trained users are beneficial for the users themselves, school students and teachers*
- *Peer to peer support and training*

What did not work/ barriers to implementation

- *Lack of funding to pay users for talks at schools or for printing school materials*

This practice was initiated in: Spain

Level of implementation

- ☐ European
- ☐ National
- ☒ **Regional: two regions**
- ☐ Other

Practice 14: Psychologically Informed Environments (PIE)

Summary

Psychologically Informed Environments (PIE) is an ongoing practice, which was started in 2011 and continues to be developed at multiple sites. The practice was initiated by the health and social sector as well as by the voluntary sector. *PIE* is a tool/method and focuses on service delivery, action, and training. The objective of *PIE* is to create an environment of services for homeless people that fosters recovery from trauma and other mental health problems, as well as enabling people to develop resilience and to lead their own direction and movement out of social exclusion. The activities that form part of the implementation focus on:

- a psychological framework for services;
- reflective practice;
- client participation;
- social spaces;
- managing relationships; and
- clinical support for social support services.

The concrete results of *PIE* are a reduction in abandonments and evictions and an Increase in positive move-ons from homelessness institutions. There is a reduction in incidents, including violence, self-harm and suicide, and emergency hospitalization. Finally, the practice has resulted in a reduction in re-hospitalization of people with severe and enduring mental illness.

Responsible organization or person: Peter Cockersell; Robin Johnson

Addressed priority areas

- ☒ **Prevention of depression and promotion of resilience**
- ☐ Provision of more accessible mental health services
- ☐ Provision of community-based mental health services
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☒ **Other: mental health and well-being for homeless people**

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Training provided by clinicians and people with lived experience*
- *Reflective practice*
- *High level of management support and buy-in*

What did not work/ barriers to implementation

- *The indifference of middle and senior management*
- *Staff who initially thought they 'already do that' but didn't really understand the differences brought about by the new program*

This practice was initiated in: United Kingdom

Level of implementation

- ☐ European
- ☒ **National: United Kingdom**
- ☐ Regional
- ☐ Other

Practice 15: Promotion of Community Based Mental Health Services

Summary

The contribution to the work of the World Health Organization (WHO) on the promotion of *Community-Based Mental Health Services (CBMHS)* started in 1998 and is still ongoing. The World Health Organization Collaborating Centre (WHOCC) has been designated by WHO/EURO as the co-leading institution supporting the transformation of mental health services with WHOCC Trieste, Italy in collaboration with various international networks (IMHCN International Mental Health Collaborating Network*).* The program was initiated by the health sector and focuses on training and mental health in all policies.

The objective of the promotion of *CBMHS* is to organize onsite trainings and visits to CBMHS with WHO selected participants from French-speaking countries who are in the process of reforming their services with WHO technical assistance. Every year since 2000, approximately one hundred policy makers, user and carer-representatives, and professionals, both at the national and international levels, attend relevant training courses and visit CBMHS. They participate in national and international exchanges of research and innovative treatment and recovery-oriented care systems, which include the involvement of service users in their implementation. WHOCC (Lille, France) has provided technical assistance in France and to countries wishing to develop CBMHS and recovery oriented services.

http://www.ccomssantementalelillefrance.org/?q=promotion-community-based-mental-health-services

Responsible organization or person: World Health Organization Collaborating Centre for Research and Training in Mental Health (Lille, France) and EPSM Lille Métropole

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☒ **Provision of more accessible mental health services**
- ☒ **Provision of community-based mental health services**
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☐ Other

Lessons learned as identified by contributors

What worked well/facilitators to implementation

- *Full participation of citizens as well as of mental health service users in enhancing the quality of mental health services*
- *Promotion of city integrated and community oriented psychiatric wards*
- *Fight against stigma for people with mental disorders and the promotion of mental health*

This practice was initiated in: France

Level of implementation

- ☐ European
- ☐ National
- ☐ Regional
- ☒ **Other: six towns East of Lille**

Practice 16: The LGBTIreland Report: national study of the mental health and well-being of lesbian, gay, bisexual, transgender and intersex people in Ireland

Summary

The LGBTIreland Report was published on 22 March 2016. The report was initiated by the health sector and focuses on research. *The LGBTIreland* study had two modules each with different objectives. The objectives of module one were to examine mental well-being and mental health issues among LGBTI people in Ireland, with specific emphasis on the adolescent and young adult cohort and to explore the impact of 'minority stress' on LGBTI mental health, including experiences of coming out and experiences of discrimination in the context of school/college/work. Module two assessed Irish public attitudes towards LGBTI people. The second module's objective was to measure attitudes towards LGBTI people in a nationally representative sample of the Irish public.

The study findings and recommendations emanating from these findings will guide the National Office for Suicide Prevention in targeting LGBTI people under the national suicide reduction strategy 'Connecting for Life', where LGBTI people are named as one of the groups most vulnerable to suicide in Ireland. Concrete results of *LGBTIreland* are up-to-date national data on LGBTI mental health, and rates and incidences of mental distress, mental disorder and self-harm/suicidality.

http://www.glen.ie/attachments/The_LGBTIreland_Report.pdf

Responsible organization or person: The National Office for Suicide Prevention

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☐ Provision of more accessible mental health services
- ☐ Provision of community-based mental health services
- ☒ **Suicide prevention**
- ☐ Mental health in the workplace
- ☒ **Mental health in schools**
- ☐ Integrated approaches for governance
- ☒ **Other: LGBTI mental health**

This practice was initiated in: Ireland

Level of implementation

- ☐ European
- ☒ **National: Ireland**
- ☐ Regional
- ☐ Other

Practice 17: Regional Mental Health Plan of Andalucia

Summary

The Regional Mental Health Plan was in place from 2008 to 2012. The program was initiated by the health and social sector and focuses on action, policy, service delivery, and mental health in all policies. *The Regional Mental Health Plan* has the following six objectives:

- quality improvement;
- equality (reduction of inequalities including gender inequalities, protection of the most vulnerable and respect for cultural identities);
- efficiency (mental health promotion, mental illness prevention, improvement of treatment for patients and families);
- user and family involvement;
- promoting professional career training and research; and
- support the organization's human capital.

The different actions of the program cross-cut through a wide range of sectors and activities and involved:

- promoting socio-emotional well-being of children and adolescents in school settings;
- promoting health assets in adult women through a socio-educational group strategy in the field of primary care;
- developing a guide to self-help resources for depression and anxiety;
- promoting active participation of users and relatives in the implementation of the mental health plan and mental health services;
- supporting and strengthening cooperation between public services;
- promoting peer support programs within mental health services;
- awareness-raising and training on human rights and mental health in the context of the UN Convention on the Rights of Persons with Disabilities;
- working on integration programs for people with mental health problems; and
- fighting stigma and discrimination.

http://www.juntadeandalucia.es/servicioandaluzdesalud/saludmental

Responsible organization or person: Rafael del Pino López

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☒ **Provision of more accessible mental health services**
- ☒ **Provision of community-based mental health services**
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☒ **Mental health in schools**
- ☒ **Integrated approaches for governance**
- ☐ Other

Lessons learned as identified by contributors

What did not work/barriers to implementation

- *Limited resources (e.g. budgets and staff)*
- *Considerably increased needs due to economic circumstances*

This practice was initiated in: Spain

Level of implementation

- ☐ European
- ☒ **Regional: region of Andalucia**
- ☐ National
- ☐ Other

Practice 18: Mental Health First Aid in Finland

Summary

There are two *Mental Health First Aid (MHFA)* education programs in Finland, both of which started in 2007. The program was initiated by the health sector, the health and social sector, the education sector and the labor sector. *MHFA's* focus is on e-mental health and training.

MHFA is aimed at all adult citizens in Finland and focuses on a wide range of mental health issues and well-being. Three hundred and fifty *MHFA* instructors have been educated in Finland, who train citizens in groups of eight to twenty people. Instructors work, for example, in different associations, communities and schools. Furthermore, there is a training course for professionals who are working with children and adolescents. Other concrete results include producing several videos and e-material and writing three books in both Finnish and Swedish.

Responsible organization or person:

Finnish Association for Mental Health, Ritva Karila-Hietala

Addressed priority areas

- ☒ **Prevention of depression and promotion of resilience**
- ☐ Provision of more accessible mental health services
- ☐ Provision of community-based mental health services
- ☒ **Suicide prevention**
- ☒ **Mental health in the workplace**
- ☒ **Mental health in schools**
- ☐ Integrated approaches for governance
- ☒ **Other: reducing stigma towards mental health disorders**

Lessons learned as identified by contributors

What worked well/facilitators to implementation

- *Training of instructors: participants of the MHFA-courses were enthusiastic and they provided positive feedback*

This practice was initiated in: Finland

Level of implementation

- ☐ European
- ☒ **National: Finland**
- ☐ Regional
- ☐ Other

Practice 19: Technical Assistance to Relevant French Speaking Countries in Implementing their Mental Health Local Councils in Coordination with WHO

Summary

The program *Technical Assistance* began in 2005 and is still ongoing. It was initiated by the health and social sector and at the local policy level. The program focuses on policy, especially on including mental health in all policies. The WHOCC launched the program to support the development and reinforcement of mental health local councils (Conseils Locaux de Santé Mentale) with initial support of the Interministerial Delegation for the City (DIV) and the Agency for Social Cohesion and Equal Opportunities (ACSE) for 2007-2012. The program was renewed in 2014-2016 by the ACSE and the General Delegation of Health (DGS). The main activities include organizing consistent levels of support and integration of care, enabling the understanding of mental disorders, and facilitating users' navigation of the system by organizing access to health care for all and fighting against stigma surrounding mental disorders. A concrete result of the program is the creation of two hundred local councils.

http://www.ccomssantementalelillefrance.org/?q=technical-assistance

Responsible organization or person: World Health Organization Collaborating Centre for Research and Training in Mental Health (Lille, France)

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☒ **Provision of more accessible mental health services**
- ☒ **Provision of community-based mental health services**
- ☒ **Suicide prevention**
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☒ **Integrated approaches for governance**
- ☐ Other

This practice was initiated in: France

Level of implementation

- ☐ European
- ☒ **National: France**
- ☐ Regional
- ☐ Other

Practice 20: Observatory of Perinatal Clinical Psychology (Osservatorio Psicologia Clinica Perinatale)

Summary

The Observatory of Perinatal Clinical Psychology was started in 2004 and is still ongoing. The program addresses the prevention of depression and promotion of resilience in the mother and father and focuses on the relationships with their baby. The practice was initiated by the health and social sector and concentrates on action, training, research, and a tool/instrument. The aims and activities of *the Observatory of Perinatal Clinical Psychology* include:

- research about perinatal clinical psychology;
- prevention of depression in the mother and father and focus on the relationships with their baby;
- organizing a prevention program for families at risk;
- screening of families at risk;
- organization of post graduate courses in perinatal clinical psychology in the University of Brescia aimed at birth attendants such as midwives, and psychologists and social workers; and
- promotion of resilience in the mother and father and focus on the relationships with their baby with clinical psychological interventions using Video Intervention Therapy (VIT)

http://www.unibs.it/dipartimenti/scienze-cliniche-e-sperimentali/osservatori-e-laboratori/osservatorio-psicologia-clinica-perinatale-profssa-l-cena

Responsible organization or person: Loredana Cena

Addressed priority areas

- ☒ **Prevention of depression and promotion of resilience**
- ☐ Provision of more accessible mental health services
- ☐ Provision of community-based mental health services
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☐ Other

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Multidisciplinary health and social care professionals: psychologists, obstetricians, gynecologists, neonatologists, pediatricians, child neuropsychiatrists, social and health operators, and educators*

What did not work/ barriers to implementation

- *Limited budget*

This practice was initiated in: Italy

Level of implementation

- ☐ European
- ☒ **National: Italy**
- ☐ Regional
- ☐ Other

Practice 21: Memory and Cognition Consultation (MCC) Program

Summary

Memory and Cognition Consultation (MCC) was started in 2013. The program was initiated by the health sector and the main focus is on action. *MCC* is a pioneering, multidisciplinary program in Portugal, which aims to optimize early diagnosis of memory and cognition disorders. It involves systematic treatment with a wide range of staff from different specialties; the patient, the caregiver, the family, and primary care. *MCC* has the primary objective of improving the diagnosis and treatment of dementia, as well as improving the quality of life of patients and caregivers. Thus, the program aims to:

- early diagnosis and treatment of disturbances of memory and cognition, promoting the quality of life of patients and their caregivers;
- decrease the number of readmissions, timely interventions in ambulatory care, and provide support to the caregiver;
- promote knowledge of the caregiver and patient about the disease and its implications;
- improve coordination between the various services and technical stakeholders in patient care, including primary care and other community institutions;
- increase the number of patients covered by the MCC, emphasizing the multidisciplinary intervention;
- reduce hospital costs by coordinated and systematic intervention of the multidisciplinary team;
- increase the level of satisfaction of the patient and caregiver, improving available information and support to caregivers;
- decrease caregiver burden; and
- promote the dissemination of the project in the scientific community, fostering a better characterization and approach of dementia of the MCC in order to facilitate replication in other institutions.

The activities of *MCC* include an initial assessment by a multidisciplinary team of specialists, which is followed by a discussion of the team regarding the initial assessment and the patient's integration criteria in cognitive rehabilitation, psychoeducation, and support groups. During a monthly meeting, diagnostic questions, treatment plan, the need for additional support, and neuro-radiological tests are discussed. When the clinical benefit does not justify maintaining *MCC,* the patient is discharged and caregivers are referred to a subprogram of nursing consultation. Concrete results of *MCC* can be seen in a clear improvement of early diagnosis and organization of the treatment plan. Furthermore, the project resulted in improved knowledge of patients and caregivers about the disease and its evolution.

Responsible organization or person: Jorge Bouça and António Jorge

Addressed priority areas

- ☐ Prevention of depression and promotion of resilience
- ☒ **Provision of more accessible mental health services**
- ☒ **Provision of community-based mental health services**
- ☐ Suicide prevention
- ☐ Mental health in the workplace
- ☐ Mental health in schools
- ☐ Integrated approaches for governance
- ☐ Other

This practice was initiated in: Portugal

Level of implementation

- ☐ European
- ☐ National
- ☒ **Regional: Vila Nova de Gaia, Portugal**
- ☐ Other

Lessons learned as identified by contributors

What worked well/ facilitators to implementation

- *Collaboration with primary health care is important because it allows the patient to be referred for further evaluation, counseling, and therapy by the multidisciplinary team, with subsequent reintegration and care by the medical assistant.*
- *The possibility of multidisciplinary assessment, with early diagnosis and treatment.*
- *Support groups for caregivers, providing useful information, social support and improving their quality of life.*
- *Cooperation with neuroradiology, which comprises a fixed team, focused on diagnosing and characterization of pathology.*

What did not work/ barriers to implementation

- *Insufficient resources to start cognitive stimulation and the implementation of home visits.*
- *Limited area of action; it would be beneficial to expand the network to all health centers in order to include the entire geographical area.*
- *Furthermore, it is important to start training community teams for recognition of early signs of this disease.*

Annex 1: Contributors

Name of Practice	Name of Contributors
Eating Disorders Centre, Mental Health Department Ferrara, University of Ferrara	Stefano Caracciolo
The Well-being Guild of Entrepreneurs	Tiina Lumijärvi
Lifeworks	Peter Cockersell
Individual Placement and Support for Employment (IPS)	Bob Grove
Stability training (Tasapainovalmennus)	Suvi Piironen
Joint Experiences and Local Mental Health Systems, third edition 2014-2017 (Esperienze Compartecipate e Sistemi Locali di Salute Mentale, 3° edizione 2014-2017)	Pino Pini
The Professionally Guided Peer Support Groups for Bereaved by Suicide (Ammatillisesti Ohjatut Vertaistukiryhmät Läheisensä Menettäneille)	Reija Narumo
Peer2Peer Vocational Training Course	Sara Marcos Ispierto
Salute allo Specchio (Reflections of Health)	Valentina Di Mattei
Housing First Portugal (Casas Primeiro Portugal)	Maria Vargas-Moniz
Mobile Crisis Work: help at home in difficult life situations	Sonja Maununaho
Recovery: a person-centered approach in health and social services	Kim Nikolaj Japing
Memory and Cognition Consultation (MCC) Program	Sara Pereira

Education: a key tool for recovery and fight against stigma	Guadalupe Morales Cano
Psychologically Informed Environments (PIE)	Peter Cockersell
Promotion of Community Based Mental Health Services	Alain Dannet
The LGBTIreland Report: national study of the mental health and well-being of lesbian, gay, bisexual, transgender and intersex people in Ireland	Odhran Allen
Regional Mental Health Plan of Andalucia	Kim Nikolaj Japing
Mental Health First Aid in Finland	Ritva Karila-Hietala
Technical Assistance to Relevant French Speaking Countries in Implementing their Mental Health Local Councils in Coordination with WHO	Alain Dannet
Observatory of Perinatal Clinical Psychology (Osservatorio Psicologia Clinica Perinatale)	Loredana Cena Antonio Imbasciati