World mental health report

Transforming mental health for all

Of course, not all research is done to specifically inform a given policy or with the intention of being directly applied in practice. And it is often the accumulation and replication of data that eventually gets adapted and adopted into policy or into clinical guidelines or recommendations, rather than a single piece of research. Notwithstanding, where research starts with the intention of practical application, there is much that researchers can do to support the translation of knowledge into practice and guide mental health transformation.

They can, for example, ensure that their research reflects local and national realities. Data collected for the *Mental health atlas 2020* shows that less than 5% of health research outputs globally focused on mental health; and most of that was concentrated in high-income countries (see section 3.3.1 The data gap). Addressing global research imbalances and helping to close the data gap is important to ensure LMICs have the information they need to identify and target their own mental health needs and priorities. That means conducting clinical research in LMICs and ensuring a central role for LMIC researchers in designing and managing the research. It also means paying greater attention to mental health systems research, rather than basic or clinical research, to better understand how to transform services so they meet the mental health needs of all those who need care *(252)*.

Researchers can do much more to involve people with lived experience in research design and delivery. People with lived experience and their organizations can facilitate global networks for research collaboration. They can help design and carry out culturally-validated research. And they can help evaluate services to ensure research is credible and genuinely useful to service users and carers *(253)*.

Ensuring that mental health research evidence can be put to use – including by policy-makers, managers, clinicians and mental health planners – is essential *(254)*. Planning research collaboratively with stakeholders, sharing regular updates and findings, assessing potential implications and jointly considering how to use evidence as it emerges, holds enormous potential for translating knowledge into practice, including by conducting implementation science.

5.2 Understanding and commitment

Mental health is underserved for many different reasons. One of the most important is that it tends to be ignored and undervalued – by individuals, families, businesses, communities and countries. The result is that people at all levels of society and government take insufficient action to promote mental health, prevent mental ill-health, or to provide comprehensive, rights-based, quality care to those in need. A deep appreciation of the real value of mental health is not in itself enough to transform mental health; but it is a fundamental step in the right direction.

5.2.1 Strengthening political will and engagement

Transforming mental health cannot be achieved without reallocating limited resources, developing new policies, building new skills, establishing new partnerships and engaging new stakeholders. In doing these things it is common to encounter strong resistance to change, driven, for example, by logistical challenges, vested interests and competing priorities *(237)*. Strong political will and commitment are essential to overcome the barriers.

Political will for an issue typically includes three types of commitment: how widely decision-makers publicly support the issue (expressed commitment); the extent to which policies, plans and programmes are established to implement the stated intent (institutional commitment); and whether or not the necessary funds are allocated (budgetary commitment) (see Fig. 5.1) *(255)*.

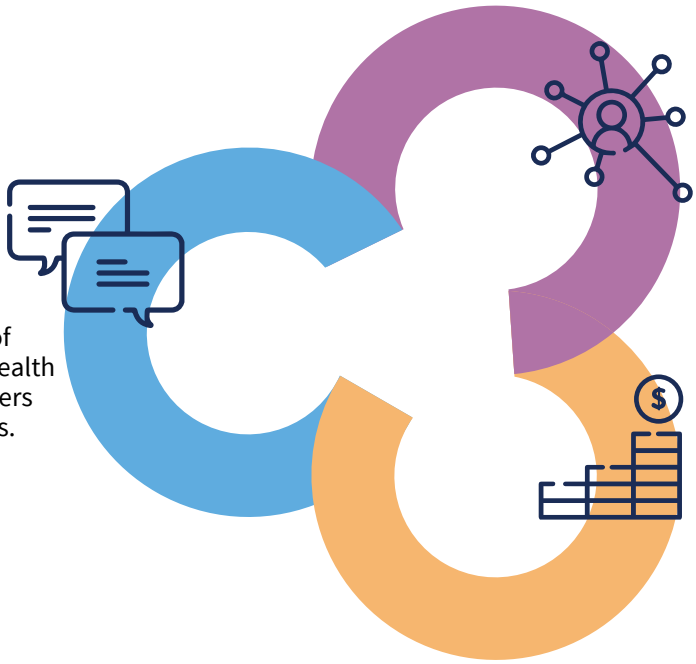
All three types are needed to drive the mental health agenda forward and effect meaningful change. Indeed, a 2007 analysis of LMICs suggested that many of the barriers to improved mental health services could be overcome by generating political will for accessible and humane mental health care *(252)*. Since then, growth in global advocacy and action has focused political attention on the need for quality mental health care and built an appetite for change.

Globally, expressed commitment is significantly stronger than it was a decade ago. Institutional commitment has similarly grown, with 146 countries now reporting stand-alone policies and plans in place for mental health. But still, countries remain reluctant to make change happen and budgetary commitment is rare: only 67 countries reported data on mental health spending in 2020 and those that did still only spent on average 2% of their total health budget on mental health (see section 3.3.2 The governance gap) *(5)*.

Each type of political commitment can be influenced by a range of national and international factors, including national leadership, domestic advocacy, international public health and development agendas, and public opinion. In all countries, identifying and engaging key agencies and stakeholders in the overall process so that there is shared ownership of the vision and its implementation is important.

FIG. 5.1.

Political will is made up of three types of commitment



EXPRESSED COMMITMENT

- Public expressions of support to mental health by government leaders and decision-makers.

INSTITUTIONAL COMMITMENT

- Establishment of the policies, plans and programmes needed to realize the stated intent.

BUDGETARY COMMITMENT

- Allocation of the necessary resources required to implement the response.

Source: Fox et al, 2011 *(255)*.

In low-income countries, where mental health budgets are particularly limited, there is potentially also a catalytic role for external donors in initiating and enabling a transformation in mental health. And political will in source countries as well as recipient ones can have a large influence over whether or not international organizations choose to invest in mental health in LMICs *(256)*.

All over the world, advocacy, evidence and political context can also be hugely influential in fostering political commitment and leadership.

Advocacy movements

Advocacy at all levels – global, regional, national and within communities – is needed to advance mental health policies and practice. And at all levels, there are a growing number of organizations that advocate for better mental health policies, more financing for mental health systems, and an end to stigma and discrimination against people living with mental health conditions.

> *Advocacy at all levels is needed to advance mental health policies and practice.*

Advocacy also increasingly combines different types of stakeholders to achieve change. Ensuring representation from different stakeholders in advocacy movements is important to their success and is recommended by the *Comprehensive mental health action plan 2013–2030*.

WHO has developed guidance and works with a wide variety of organizations to deliver successful mental health advocacy *(257)*. International institutions can be key agents of change in encouraging and supporting policy-makers to improve mental health services, ensure equity in care and promote human rights. Leading figures from these organizations – such as the WHO Director-General and the UN Secretary General – have a critical role as champions for better mental health.

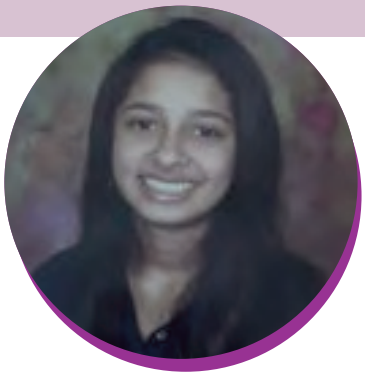
Member States in global decision-making bodies, such as the World Health Assembly or the UN General Assembly, or in coalitions of nations such as the G77, G20 or G7, can be strong advocates among their peers to include mental health in deliberations and to deliver shared commitments to change (as expressed, for example, in the *Comprehensive mental health action plan 2013–2030* or the *UN political declaration on NCDs*). Mental health advocacy by national governments is equally important in influencing the policies and priorities of international organizations such as the World Bank or Global Fund to Fight AIDS, TB and Malaria.

Mental health professionals and people with lived experience of mental health conditions have an important role in advocacy. Mental health professionals can help influence policy-makers and advance progress through peer to peer influencing within and between countries. And participation by people with lived experience is important to help change attitudes and build awareness about mental health conditions, to articulate the value of improved access to effective and humane mental health care, and to provide peer support services, among other things (read Sahar's experience and see Chapter 4, In focus: Engaging and empowering people with lived experience) *(23)*.

Increasingly these stakeholders are joined by other influential groups including parliamentarians, businesses and media and communications organizations who also advocate for better mental health. More broadly, a growing range of stakeholders are acknowledging mental health as a cross-cutting issue and working to better integrate it in multisectoral services and programmes targeted at, for example, improving physical health, strengthening educational attainment, upholding human rights, and supporting people affected by conflict and disaster.

NARRATIVE

Giving people hope is my greatest pleasure



Sahar's experience

I was 16 when my life was turned upside down by an invisible illness. I spent what should have been my senior year in high school on a couch, too depressed to move, eat, or think, in a maelstrom of internal terror that I hoped would go away. It never did.

I spent years living with an undiagnosed mental illness. All I knew was I was hurting and terrified that people would find out about my mental struggle. I didn't know anyone who was open about having a mental illness. I turned to drugs and alcohol to numb my pain. My life didn't matter to me and I had a suicide attempt.

It has been eleven years since my world fell apart. In that time I have been diagnosed with borderline personality disorder, major depressive disorder, and obsessive compulsive disorder. I have dealt with the perils of addiction. Today I am taking prescribed medication, attending therapy sessions, and putting in the work be mentally healthy.

Over those eleven years I also broke out of my bubble of shame and realized that my illness was a superpower I could use to help others. I cofounded a non-profit organization aimed at bringing awareness to mental health and used my story to create awareness and help others. I am proud to be a mental health advocate. Giving people hope by sharing my story has been the greatest pleasure of my life. Maybe that is what all the heart ache and suffering is for – to help others.

As much as my illness is a superpower I have days where I am crippled by my illness. I am lucky to have an incredible support system that helps me through the darkness. This is not something I take for granted. Many people have no support and no access to good mental health care. They are left to suffer and in some cases perish from something that is treatable.

To move forward we must ensure that mental health care is accessible to all. We must ensure that our kids are taught that it is ok not to be ok and help is just a conversation away. Mental illness is not a death sentence nor a sign of weakness.

My name is Sahar. I am a proud mentally ill teacher, advocate, daughter, niece, friend, aunt, dog-mom, and human, finding my way in the world like everyone else.

Sahar Vasquez, Belize

In all cases, ensuring consensus and clarity in communications is important. Fragmentation in advocacy, where different stakeholders argue against each other to highlight different aspects of mental health, has been identified as a major barrier to progress *(258)*. But overall, there has been a rise in coordinated national and global advocacy campaigns, events, forums and platforms in recent years (for example, see Chapter 4, In focus: Engaging and empowering people with mental health conditions). These can serve as vehicles for strengthening political commitment. For example, World Mental Health Day (celebrated on 10 October each year) is increasingly used all over the world to raise awareness of mental health issues, garner public expressions of commitment from national decision-makers and mobilize efforts in support of mental health *(259)*.

Windows of opportunity

Some political contexts offer particularly favourable opportunities for securing commitment from political leaders and moving the mental health agenda forward. This includes, for example, the launch of a landmark report or international agreement. In 2001, the WHO flagship report on mental health captured the attention of political leaders all over the world and provided the momentum for a number of national and international mental health initiatives to take root and flourish *(237)*.

> *Humanitarian emergencies and natural disasters offer unparalleled platforms for change to develop better care systems for the long term.*

In the Americas, it was the signing of the Caracas Declaration in 1990 that paved the way for mental health reform. The declaration called for mental health to be integrated into primary care, and for the human rights of people with mental health conditions to be protected. It was informed by a combination of epidemiological studies that showed the extent of mental ill-health in the region; but also political and social innovation following the end of several dictatorships. It provided the basis for policy and legislative initiatives and successful and innovative reform in many countries, including Brazil, Chile, Cuba, El Salvador, Guatemala, Nicaragua and Panama, among others *(260)*.

Humanitarian emergencies arising from natural disasters and conflict, despite their tragic nature and adverse effects on mental health, offer unparalleled platforms for change. They represent an obligation and opportunity for countries to invest in mental health. A surge of national and international aid, combined with sudden, focused attention on people's mental health, can galvanize political support and action and create opportunities for developing better care systems for the long term.

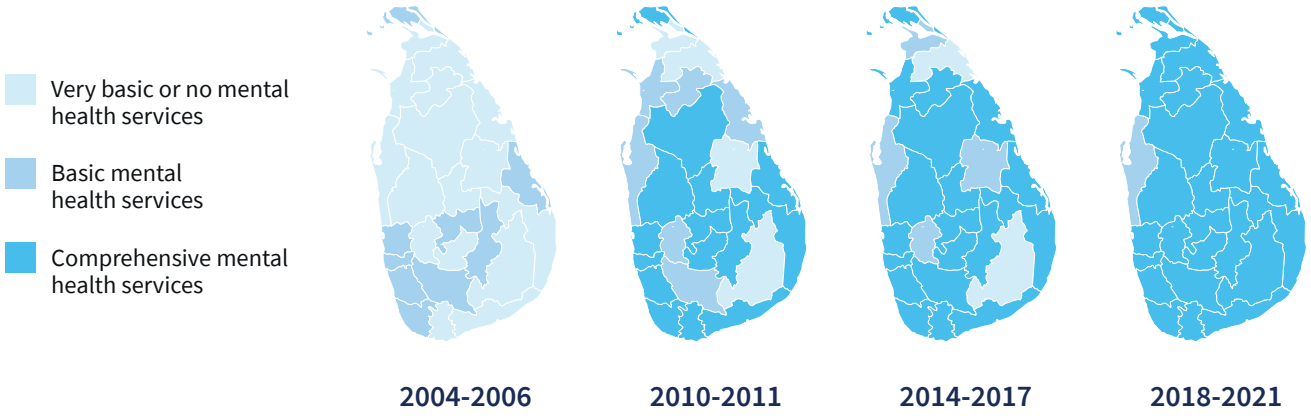
In Syria, for example, before the conflict, there was scarcely any mental health care available outside the psychiatric hospitals in Aleppo and Damascus. Now, thanks to a growing recognition of the need for support, and increasing humanitarian aid, mental health and psychosocial support has been introduced in primary and secondary health facilities, in community and women's centres, and in school-based programmes. Today, despite the ongoing conflict, at least one of every four functioning general health care facilities in Syria has one person trained in mental health, who is supervised and works within a system to provide mental health care.

Many countries have already capitalized on emergency situations to build better mental health systems *(261)*. For example, in Sri Lanka, the impacts of the Asian tsunami in 2004 dramatically increased the political interest in mental health and facilitated the mobilization of immediate resources for emergency mental health care, which then provided a platform for broader national mental health reform. Supported by WHO, the Sri Lankan Ministry of Health worked

with stakeholders to develop a national mental health policy focused on decentralizing care and ensuring the local availability of mental health services in all districts of the country. The plan was implemented through multiple programmes at national and district levels. Today, every district in the country has mental health services infrastructure, compared with a third before the tsunami (see Fig. 5.2).

FIG. 5.2

The expansion of mental health services in Sri Lanka, 2004–2021



SERVICES	2004	2021
Acute inpatient units	10	25
Outpatient clinics at hospitals	10	26
Intermediate care rehabilitation unit	5	21
Alcohol rehabilitation centres	1	11
Outreach clinics	55	287
Child mental health clinics in general hospitals	2	26
Child mental health units	-	2
Mental health helpline	-	1

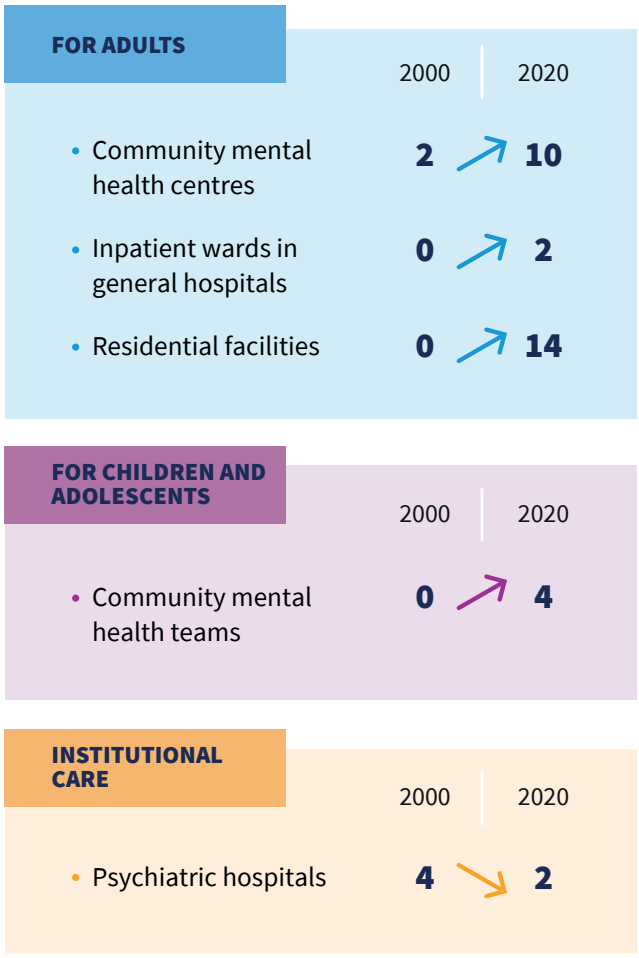
HUMAN RESOURCES	2004	2021
Psychiatrists	36	136
Child psychiatrists	1	10
Forensic psychiatrists	-	2
Medical officers of mental health (MOMH)	40	223
Medical officers with one year diploma in psychiatry	-	47
Psychiatric nurses	-	71
Psychiatric social workers	9	78
Occupational therapists	6	58
Community support officers	-	54
Speech therapists	-	13

Source: Ministry of Health Sri Lanka et al, 2021 *(262)*; Directorate of Mental Health, Sri Lanka, unpublished data, June 2022.

In Albania, the 1999 crisis of refugees from Kosovo[1] created an interest in mental health and an appetite – backed with finances – for mental health reform. A new mental health plan was approved and services were decentralized from a hospital-only and biologically-oriented system of care to a wide range of community-based services (see Fig. 5.3).

FIG. 5.3

Change in mental health facilities in Albania 2000–2020



Source: Ministry of Health, Albania, unpublished data, March 2022.

Most recently, the COVID-19 pandemic has made strengthening mental health systems more urgent all over the world, but especially in LMICs. It has prompted swift and diverse responses through, for example, national COVID-19 response plans for mental health services, implementation of WHO and Inter-agency Standing Committee (IASC) guidance and a WHO Executive Board decision urging Member State action on, and resources for, mental health (see Chapter 2, In focus: COVID-19 and mental health) *(7, 263)*. Building on the growing interest in using new technologies in mental health care over recent years, the pandemic has also spurred development and deployment of a swathe of digital tools and tactics to support mental health in the face of deep uncertainty, stress and change (see In focus: Harnessing digital technologies for mental health).

Whether it is a new report, a change in government, a disaster or a public health emergency, all opportunities must be used to transform mental health.

5.2.2 Building public awareness and interest

Building public awareness and interest is essential to transform and scale mental health care. Mental health is everybody's business. Intrinsic to our quality of life and our potential for prosperity, it is something that all people should value for themselves and others. If the general public does not know about or is not interested in mental health issues, they are less likely to take responsibility for self-care, to seek appropriate help when they aren't well, or to prioritize access to quality mental health care for all (see section 3.4.2 Low levels of health literacy about mental health). Governments are also unlikely to invest in mental health promotion or commit to mental health care reform if the general public is not knowledgeable and interested in mental health issues.

Building public interest in mental health, shifting attitudes and tackling stigma is not easy. But experience shows it is possible, most notably through education, contact and protest anti-stigma strategies such as those outlined in section 4.2.1 Stopping stigma. Approaches based on social contact with people with mental health conditions

[1] The reference to Kosovo in this report should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

NARRATIVE

Knowledge is power

Angelica's experience

In my country there are 17 psychiatrists for 16 million people. The mental health budget is very small and conditions like mine – obsessive compulsive disorder (OCD) – are simply ignored.

For years I thought that maybe I was bewitched, or cursed, or possessed by evil spirits. I had to go through this alone, because of fear of stigmatization. I could not even tell my husband. I was scared my loved ones would desert me. My church could not help. No priest understood what I was going through. There were no support groups in the whole country.

I finally found out about OCD online. Even then it took me nearly a year to get the courage to visit a health care worker. I remember once telling a friend that the government was letting people with OCD down because no one was talking about it. They replied that we only have ourselves to blame: we need to speak up.

In 2018 I set up a nongovernmental organization called Zimbabwe OCD Trust to raise awareness of and provide support to people with OCD. I started a support group. We used to meet face-to-face once a month before COVID-19; now we meet online. I gave talks on the radio and at local events. Our work was featured in newspapers and magazines. People started to notice me, they started listening to what I was saying and then they started coming forward and inviting me to talk about this highly stigmatized disorder.

Knowledge is power. Just knowing that their distress was caused by a mental health condition and not some evil spirit was a relief to most people. I am not a psychiatrist, so once someone is comfortable talking about their disorder I ask them to seek professional help.

I feel that this is just the beginning of my work in raising awareness of OCD, ending stigma towards it and supporting people with lived experience to be treated as equal partners in this world.

Angelica Mkorongo, Zimbabwe

CASE STUDY

BOX 5.6

VISHRAM: a community initiative to reduce suicides in rural India

The Vidarbha Stress and Health Program (VISHRAM) was a community-based programme run over 18 months in 2014 and 2015. It was designed to address the mental health risk factors for suicide in the rural Amravati district of Vidarbha, central India. By the end of the project, the prevalence of suicidal thoughts among VISHRAM's target population had halved, and the prevalence of depression had fallen by 22%. There was also a six-fold increase in the percentage of people seeking mental health care.

VISHRAM used a tiered model of collaborative care, in which community health workers provided the first point of contact. They visited households and held small meetings to increase awareness of mental health conditions and the services available to treat them. They also helped identify people with symptoms of depression, persuading them to talk to a lay counsellor for psychological first aid; or, for people with more severe symptoms, to visit an outreach clinic and see a psychiatrist.

As a legacy of VISHRAM, each of the 30 villages involved in the programme has a community health worker who is trained to detect depression, provide frontline support and refer people to the public health system for further management. The increased awareness among community members also triggered 26 village councils to pass resolutions to the State Government demanding mental health services.

Source: Shidhaye et al, 2017 *(264)*.

are particularly effective. People with lived experience, including in peer-led organizations, can be important agents of change. They can increase awareness and acceptance among the general public and so build health literacy in mental health (read Angelica's experience).

In practice, awareness-building programmes can vary widely from country to country, reflecting differences in culture, context and resources available. In many cases they are embedded in other community-based mental health services and infrastructure designed to increase the demand for care (see Box 5.6 VISHRAM: a community initiative to reduce suicides in rural India).

Improving awareness and help-seeking is a key requirement to scale up much needed mental health care. If people do not know that some of their mental health difficulties can be addressed by locally available services, they will not seek care.

Awareness building also includes proactive case detection. Research in rural Nepal showed that community volunteers trained to use a vignette and picture based case detection tool can identify people with mental health conditions and so inform them about available care *(265)*. The Nepal study found that proactive community case detection led to nearly 50% more people starting mental health care compared with general awareness-raising and self-referral.

Harnessing digital technologies for mental health

Digital technologies – from websites and online platforms to smartphones and mobile applications – have long been able to help people achieve better mental health *(266)*. But until recently it has mostly been people in higher-income countries using them. Now, these technologies are becoming more available and affordable in many countries and settings, and they are increasingly being harnessed to improve mental health, especially in remote areas where people are more likely to have access to a mobile phone than mental health care.

This trend was amplified during the COVID-19 pandemic as service users and providers searched for ways to deliver and access mental health care amid social restrictions.

Of course, digital technologies for mental health are not without their risks. In all cases, digital interventions should be guided by ethical principles and implemented in line with professional codes of conduct. Key areas of concern are: privacy, data protection, safety and accountability *(267)*. Availability and fairness are also important issues, especially as many people – especially those with fewer resources – may not be able to access digital technologies (see section 3.3.3 The resources gap: a digital divide).

And digital technologies more broadly can adversely impact mental health. Various studies suggest that exposure to social media in particular has been linked with mental health conditions in young people (although there are caveats due to methodological limitations in the research). Time spent online, types of activities and addictive use have all been associated with depression, anxiety and psychological distress in adolescents.

Extensive screen time and frequent use of digital technology may possibly heighten attention-deficit symptoms, disrupt sleep, and hinder brain development *(268, 269)*. They can lead to technology addiction and social isolation. Gaming disorder, which is a new condition in ICD-11, is an increasing concern *(270)*. It is more common among men than women and it can result in marked distress and significant impairment in personal, family, social, educational or occupational functioning.

Overall, digital technologies have the potential to contribute substantially to national efforts to achieve universal mental health coverage. They reduce travel time and expense. They provide flexibility to fit around people's daily schedules. And their anonymity can help avoid barriers created by stigma. Indeed, the evidence for digital approaches supporting mental health is compelling, with self-help approaches and telemedicine in particular showing strong benefits, including in middle-income countries *(271)*.

The sections that follow describe five areas of great promise, where digital technologies are already being used to effectively improve the availability, reach and quality of mental health care (we have not considered their use in mental health information systems).

The examples provided are far from exhaustive: this is a fast-evolving field and new approaches and applications are constantly emerging.

Digital technologies to inform and educate the public

Having information about mental health and how to deal with one's own mental health can be extremely useful to people experiencing psychological distress or living with a mental health condition; or indeed to anyone who simply wants to improve their well-being.

WHO online resources. WHO provides extensive digital resources to the public through various media including videos, booklets, manuals and webpages *(272)*. Key topics include: managing stress, mental health during COVID-19, dealing with depression, and preventing suicide.

Global experts by experience. The Global Mental Health Peer Network publishes podcasts, interviews, academic papers and online articles to share information aimed at empowering people with lived experience *(273)*. By sharing recovery stories, the network hopes to help break down stigma and remind others that recovery is possible.

Health literacy in China. In response to a rise in mental health problems during the COVID-19 pandemic, mental health professionals and health authorities in China developed a range of online mental health education and awareness programmes *(274)*. These include using social media to provide information to medical staff and the public; and free e-books to educate people about COVID-19 prevention, control, and mental health.

Digital technologies to train health care workers

Across multiple settings, WHO and other institutions use e-learning courses with remote support and supervision to train health care workers in various aspects of mental health care, including clinical management, rights-based care (see Box 4.4 WHO QualityRights), and delivering psychological interventions (see Box 5.12 EQUIP: assessing and building competencies for psychological interventions).

WHO Academy. Using a mix of online, in-person and blended learning programmes, the WHO Academy plans to expand access to learning for health workers, managers, public health officials, educators, researchers and policy-makers around the world. When it opens, it will offer training on all aspects of global health, including mental health. The academy will offer multilingual, personalized programmes featuring innovations such as artificial intelligence and virtual reality technology. All courses will be suitable for low-bandwidth settings. Both mhGAP and QualityRights core training packages for primary health care workers will be available through the new academy.

EMPOWER. EMPOWER is an online, interactive training programme that teaches supervised community health workers to deliver mental health interventions for different conditions. It is being simultaneously developed in India and the United States. The programme is digitizing the content of existing, evidence-based, psychosocial treatments that have been shown to be effective when delivered by non-specialists. Online learning will involve digital leaning, a remote coach, peer supervision moderated by an expert and competency assessment *(275)*.

Virtual Campus for Public Health (VCPH). VCPH is the learning platform of the Pan American Health Organization (PAHO) *(276)*. Through the VCPH, health practitioners can access online courses and interactive materials on a variety of public health topics, including

public mental health topics such as prevention of self-harm and suicide, mental health and psychosocial support in humanitarian emergencies, and stigma reduction. The platform includes content in four languages, contributed from 21 countries across the Americas. The VCPH has supported public health training since 2008 and now has more than a million people enrolled in its courses *(277)*.

Digital technologies to support non-specialist providers

Digital tools can help non-specialist providers to assess mental health conditions and provide treatment.

Electronic mhGAP Intervention Guide (e-mhGAP-IG). The original mhGAP-IG provides clinical protocols to support non-specialist providers in assessing and managing priority mental health conditions. The mobile tool offers the same materials, reformulated for use with a smart phone and available in several languages.

e-health in Afghanistan. In Afghanistan, an e-health initiative in Badakhshan province supported community health workers and facility-based health care providers through a tailor-made mobile application *(278)*. Like the e-mhGAP-IG, the Afghan application included interactive mhGAP-based guidelines for screening and management. It could also register mental health service users in the community and provided a platform for teleconsultation. Preliminary evaluation suggested remote communities had enhanced access to care, stigma was reduced, and the quality of health services improved.

Digital technologies for remote care

Tele-mental health is a way of putting service users and mental health professionals in touch remotely. Sessions held through videoconferencing, online messaging or by telephone enable the professional to make evaluations, provide therapy (individual, group or family therapy), prescribe medication, educate about mental health and support self-management. Research shows that psychological treatment through videoconferencing can be particularly useful in treating depression and anxiety *(279)*.

Tele-mental health can also involve mental health professionals supporting pharmacists to deliver prescriptions or primary care providers to deliver consultations, either live or using a record-and-forward format in which information is pre-recorded and sent for review. Or it can involve providing advice and guidance remotely.

In remote rural areas, tele-mental health may be more convenient for logistical purposes. During the COVID-19 pandemic it was the only practical option available for most people (see Chapter 2, In focus: COVID-19 and mental health). People often prefer tele-mental health because it avoids the stigma of attending a physical consultation and the time and cost of travel to the appointment.

Counselling through chat in China. During the COVID-19 pandemic, mental health professionals in medical institutions, universities and academic societies across all regions of China established online 24-hour psychological counselling services through free messaging applications *(274)*.

e-prescriptions in the Philippines. In the Philippines, doctors used teleconsultations to liaise with pharmacies and issue e-prescriptions as a way of improving access to prescription medication during COVID-19 lockdowns *(280)*.

Digital technologies for self-help

Self-help interventions have a strong evidence base, especially for depression and anxiety *(281)*. But when it comes to digital self-help for mental health, there are thousands of online and mobile applications available and only a few have been well tested and evaluated. Examples of well evaluated tools include Step-by-Step

(read Nour's experience and see Box 7.7 Step-by-Step: guided self-help for depression in Lebanon).

Smartphones for stress management. In Viet Nam, a smartphone-based stress management programme has been found to improve work engagement among hospital nurses. The programme was developed in consultation with Vietnamese nurses to consider their work cultures and stressors and was provided in two formats: one where any module could be picked by the user; and one where the modules had to be followed in sequential order. The fixed-order programme, which included CBT-based stress management skill training, was found to significantly improve work engagement at three-month follow up; but its effectiveness did not endure at seven-month follow up *(282)*.

WHO Alcohol e-Health. WHO Alcohol e-Health is an evidence-based interactive self-help tool for people seeking to reduce or discontinue their use of alcohol. Alcohol e-health has been tested in Belarus, Brazil, India and Mexico, where it was found to reduce harmful or hazardous alcohol use within six months, suggesting that this could be an important model for other LMICs to follow *(283)*.

NARRATIVE

I can actually feel a difference

Nour's experience

Since birth, I have suffered with brittle bone disease. When I was young I went to a school that cares about integrating children with special needs and I did not feel different, although outside school I was subjected to bullying that bothered me and made me cry a lot.

Then, in my last year of school, my family moved. My new school did not even meet the lowest standards to support people with my condition. I started skipping school a lot and after years of being at the top of my class, my grades started to drop. When I failed my exams I experienced a great shock and I developed a constant fear of failing. I started having more psychological disturbances but did not have the awareness to express myself or to ask help from anyone.

I tried therapy but I couldn't always afford the fees. Then I found Step-by-Step on social media. Step-by-Step is a free, online mental health programme that gives me a space to express my emotions and tools to help me overcome the problems I face. At first I felt that the tools were not that helpful, but using them again and again I can actually feel a difference.

Today I can express my mood when I need to and I use tools like breathing and grounding exercises to help me decrease my psychological pain. Through Step-by-Step I have learned to get things done even when I'm feeling down and powerless, by splitting them up into simple tasks. Step-by-Step is also helping me strengthen my social relationships. I feel that I belong to a circle of support. And I have gained skills that make me think more positively and gratefully.

Nour Awad, Lebanon