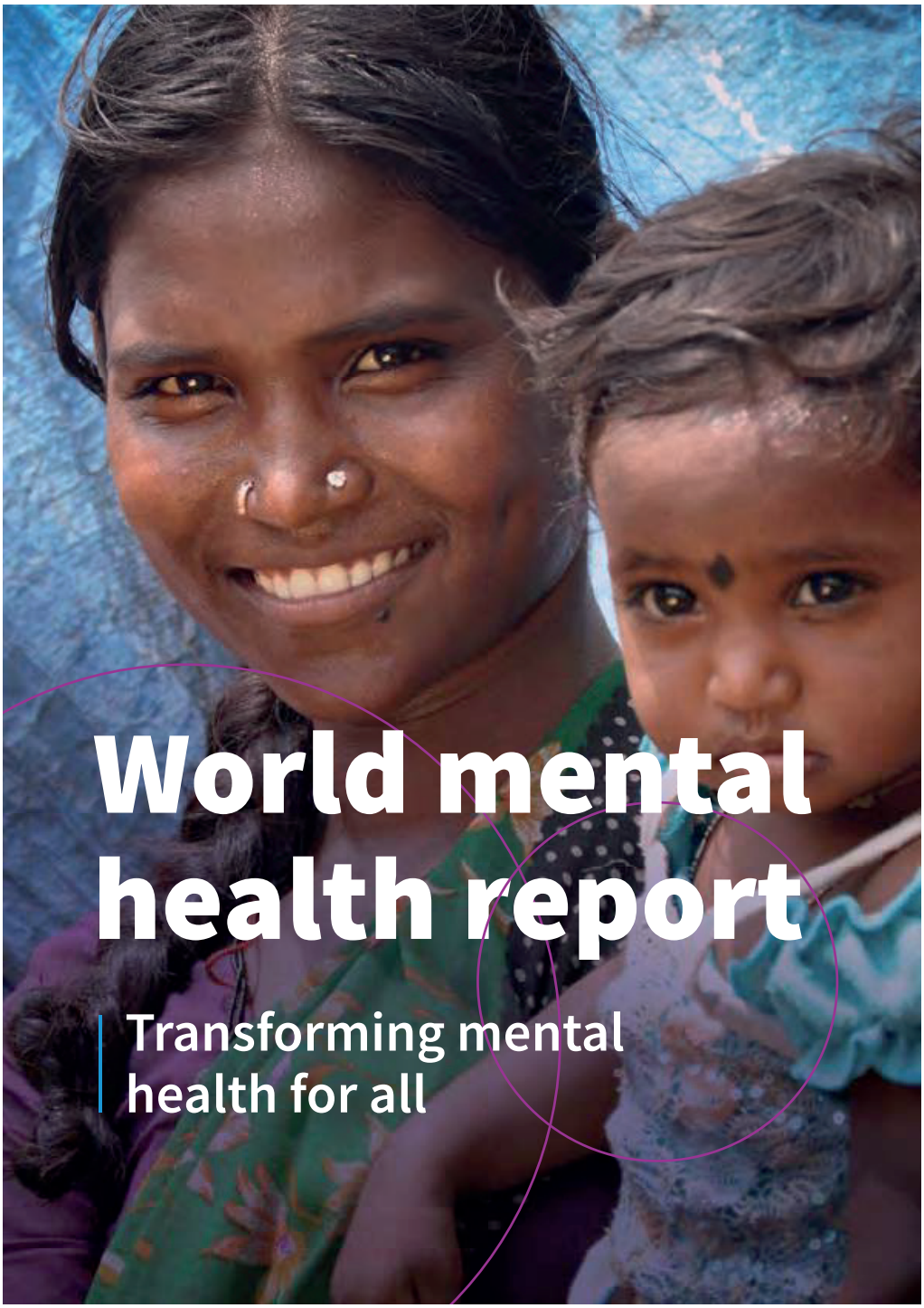


6.2 Selective and indicated prevention

Unlike universal prevention, which aims to shift the risk profile of whole populations, selective and indicated prevention strategies are designed to reduce risk in one or more groups of individuals who are at higher-than-average risk of experiencing mental health conditions.

This includes priority groups as a whole, who are at higher risk of experiencing mental health conditions because of the demographics, local contexts and circumstances in which they find themselves (selective prevention). But it also includes individuals who are at

higher risk because they are already experiencing symptoms of what may be an emerging mental disorder (indicated prevention).

At-risk people may (but do not necessarily) include people living in poverty or with chronic health conditions, people with disabilities, youth exposed to violence or neglect, minority groups, indigenous peoples, refugees, older adults, LGBTIQ+ people, ex-combatants, prisoners and people exposed to humanitarian emergencies. There is large diversity of risks, problems and resources within and across each of these groups.

6.2.1 Supporting at-risk people through selective prevention

The *Comprehensive mental health action plan 2013–2030* is clear that national mental health strategies should include promotion and prevention interventions that specifically respond to locally-identified at-risk people's needs across the lifespan. Priority groups for selective prevention may vary depending on the national or local risk profile.

Selective prevention is often helpful to specific age groups across the life-course. For example, young children and adolescents may benefit from interventions as they go through developmentally sensitive periods (see section 6.3.2 Protecting and promoting child and adolescent mental health).

> *Interventions to expand social contacts and activities are crucial to protecting the mental well-being of older adults.*

Older adults can also be supported through selective prevention. Research suggests that interventions to expand social contacts and increase participation in social activities are crucial to protecting older adults' mental well-being *(345)*.

Another priority group for selective prevention is people experiencing humanitarian emergencies. The forthcoming Mental Health and Psychosocial Support Minimum Service Package (MHPSS MSP) (see Box 6.4 The Mental Health and Psychosocial Support Minimum Service Package (MHPSS MSP)) describes preventive and promotive strategies to broadly support people in these settings, including:

- disseminating information to raise mental health literacy and awareness;
- providing early childhood development and group activities for child well-being;
- supporting pre-existing community initiatives that promote mental health, including re-establishing normal cultural and religious activities, women's groups, youth networks and other interest groups;
- facilitating new community self-help initiatives; and
- supporting caregivers , teachers and other education personnel to promote children's mental health.

6.2.2 Preventing mental health conditions through indicated interventions

Indicated interventions are designed for people who present with signs and symptoms, but who do not meet the criteria for a formal diagnosis of mental disorder.

For people with elevated levels of depressive symptoms, indicated interventions include psychotherapies such as CBT and IPT, both of which have been found to delay or prevent the onset of depression *(347)*. CBT is also an effective indicated intervention for people with anxiety symptoms *(348)*. Given that "subthreshold" depression and anxiety are extremely common, it is particularly important that indicated interventions for this group of

TOOL

BOX 6.4

The Mental Health and Psychosocial Support Minimum Service Package (MHPSS MSP)

The inter-agency MHPSS MSP is a costed package that outlines the minimum MHPSS activities that should be implemented in emergency settings (e.g. due to war or natural disaster) across health, protection, education and other sectors. It aims to ensure humanitarian responses: are better informed by global guidelines; are evidence-based, predictable, equitable; and make more effective use of limited resources. This should lead to improved quality, scale and coordination of MHPSS programming, and substantially better mental health and well-being among affected populations.

The MHPSS MSP includes preventive, promotive and treatment interventions and covers:

- inter-agency coordination and assessments;
- essential components of MHPSS programmes, including programme design, monitoring and evaluation, staff care and staff competencies;
- MHPSS programme activities, such as orienting humanitarian workers and community members; strengthening self-help and community support; and providing extra support to people impaired by distress or mental health conditions; and
- activities and considerations for specific settings, such as infectious disease outbreaks

Source: WHO, UNICEF, UNHCR and UNFPA *(346)*.

people are inexpensive and scalable. Self-help materials, whether through books or digital programmes, can be particularly useful (see section 5.4.4 Competencies for self-care). And early interventions by trained lay counsellors is another inexpensive and scalable approach to preventing the onset of mental disorders.

For people with signs and symptoms that indicate a high risk for psychosis, specialized early intervention can substantially improve clinical outcomes (see Box 7.14 Services for people with first-episode psychosis) *(349)*.

Indicated prevention effectively offers support to those with the most to gain. It may also deliver significant returns on investment. The economic evidence for early intervention in psychosis indicates that it is cost–effective, and can even save money *(350, 351)*.

Indicated interventions for people with heightened psychological distress during or after an emergency can be particularly useful. This includes facilitator-guided group-based interventions such as WHO Self-Help Plus, which has been used, with varying degrees of success, to prevent onset of mental disorders in refugees and asylum seekers in Türkiye, Uganda, and Western Europe *(352, 353)*.

Enabling multisectoral promotion and prevention: what role for the health sector?

Reshaping the individual, social and structural factors that influence mental health often requires power, experience and expertise that lie beyond the health sector. Housing improvement schemes are typically approved and run by the housing sector. Child protection programmes are managed by social affairs. Occupational health and safety regulations are usually the labour department's responsibility. And school-based programmes for social and emotional learning are delivered through the education sector.

Effective promotion and prevention for mental health is a truly multisectoral venture. The health sector may not be able to implement every strategy or intervention required. But it can contribute significantly by embedding promotion and prevention within health services, especially for at-risk populations. The health sector also has a major role in enabling a society-wide comprehensive and joined-up approach: by advocating, initiating and, where appropriate, facilitating multisectoral collaboration and coordination.

Some of the strategies available for achieving this are outlined below. In all cases, successful multisectoral collaboration requires intelligent and appropriate information sharing, joint planning, strategic design and support, and good delivery. Multisectoral collaboration is more likely to succeed when there is transformative leadership to inspire and make the case for action, to focus efforts, and to drive through the necessary negotiations (see section 5.2.1 Strengthening political will and engagement).

Embed promotion and prevention programmes within health services

The need for a joined-up approach to promotion and prevention actions for mental health applies within the health sector as much as it does beyond it. Strategies to embed promotion and prevention programmes within health services include integrating mental health promotion into perinatal care, nutrition and child health services as well as disease-specific programmes and clinics. Primary care providers play a key part in increasing mental health literacy and advocating healthy choices around diet, exercise and sleep. Primary care providers are also well-placed to introduce people to evidence-based self-help materials for people in distress.

Support mental health promotion and protection in non-health settings

Given that many interventions to promote and protect mental health should be delivered in non-health settings, the health sector has an important role in supporting colleagues across sectors as they design and deploy effective interventions.

This involves working with schools, prisons and women's shelters among others to build competencies and resilience and empower people. It also includes working with businesses to support mental health in the workplace.

Advocate for, and provide expert opinion on, specific plans and policies

By seeking out opportunities to contribute informed opinion, mental health professionals can leverage their expertise through advocacy and thus help ensure that policies, plans and practices around structural factors are supportive of people's mental health.

For example, if a new housing settlement is being planned, mental health experts may comment on the mental health benefits of including sporting and recreational facilities (which can increase participation in community activities), and access to green space (which has benefits for mental well-being). They may further comment on the need for a community mental health centre and group home for people with mental health conditions. And they may liaise with transport sector planning to ensure that people living with mental health conditions in the new settlement can freely access mental health services when they need them.

Include mental health in "health in all policies"

"Health in all policies" is an established approach that seeks to systematically consider the health implications of public policies across sectors. It seeks synergies and aims to avoid harmful health impacts *(354)*. It emphasizes the consequences of social and economic policies on population health and helps strengthen the accountability of policy-makers for health impacts at all levels of decision-making.

Applying this approach to mental health is essential to remodel relevant social and economic policies. By understanding where and how social and structural factors influence mental health, and embedding this in government thinking, broad policy is more likely to enhance mental health, or at the very least avoid harming it.

Establish mechanisms for collaboration

Sometimes, establishing a specific mechanism for multisectoral collaboration offers the most practical option for bringing different stakeholders together for mental health promotion and protection, especially when it comes to addressing the structural factors that influence mental health. Such mechanisms can be set up at different levels of government and with different stakeholders.

Health Promotion Foundations (HPFs), sometimes called National Health Councils or Commissions, are multisectoral organizations established through an Act of Parliament or equivalent to promote health and prevent diseases. They bring together government departments, nongovernmental organization, academics, user groups and others to investigate root causes and plan effective action. Each sector is responsible for delivering its part of the action plan. HPFs are commonly used to combat HIV, TB and NCDs; but they are under-used for mental health.

Joint authorities are similarly established through an Act of Parliament or equivalent. They typically include representatives from the ministry of health as well as high-ranking officials from other ministries, such as social welfare, justice and home affairs. They can be effective ways to enable multisectoral collaboration that tackles the social and structural factors influencing mental health.

Multisectoral task forces or coordination groups are made up of stakeholders from multiple sectors who have been convened to achieve a specific goal, such as preventing suicide or supporting humanitarian responses.

> During the COVID-19 pandemic the number of MHPSS coordination groups established at national level **more than doubled.**

For example, in most large humanitarian emergencies in LMICs, mental health and psychosocial support (MHPSS) is coordinated through a multisectoral working group. MHPSS coordination groups are often co-chaired by stakeholders from both health and social sectors. These groups agree and oversee action across many of the domains that influence mental health – including health, education, social services, food, security, shelter and water and sanitation – in accordance with Inter-Agency Standing Committee guidelines. During the COVID-19 pandemic the number of MHPSS coordination groups established at national level more than doubled from 23 countries in February 2020 to 54 countries 24 months later.

Importantly, while coordination in MHPSS working groups cuts across sectors, accountability typically does not. All sectors agree on an overall action plan and on the division of labour; and then individual sectors are responsible for implementing the specific actions that fall in their domain.

6.3 Selected priorities for action

The *Comprehensive mental health action plan 2013–2030* emphasizes the need for a comprehensive approach to promotion and prevention and commits WHO Member States to develop at least two functioning national, multisectoral prevention and promotion programmes by 2030. Only 52% of WHO Member States currently meet this target *(5)*.

As outlined above, prevention and promotion programmes can focus on numerous topics and populations. In the rest of this chapter, we will zoom in on three key priorities (see Fig. 6.2):

- actions to prevent suicide
- interventions aimed at children and adolescents
- interventions in work settings.

6.3.1 Preventing suicide

The need to prevent suicide is recognized and prioritized at the highest international levels. All UN and WHO Member States have committed – through the SDGs and *Comprehensive mental health action plan 2013–2030* – to reduce the global suicide mortality rate by one third by 2030. The global age standardized rate dropped 10% between 2013 and 2019, which shows that real progress is feasible *(355)*. But much more action is needed to ensure that the global target will be met by 2030. This is especially so because progress varies significantly across countries and regions.

FIG. 6.2

Selected priorities for action, and associated strategies, to promote and protect mental health

- Limit access to means
- Interact with media for responsible reporting
- Foster social and emotional learning for adolescents
- Early intervention

- Policies and legislation
- Caregiver support
- School-based programmes
- Community and online environments

- Legislation and regulation
- Organizational strategies
- Manager mental health training
- Interventions for workers

NARRATIVE

Receiving help guided me to inner strength and self-awareness

Enoch's experience

The pain would not stop. In my head, in my mind, in my heart. I did not want to live anymore. I was about to end my life right there and then, and I was moments away from dying. But I survived. My boyfriend had come into the room in that split second and stopped me from what I was about to do. I started sobbing and wailed in rage. I was disappointed in myself that I could not kill myself and felt worse than a failure.

Depression meant failing to me. So to find myself unable to decide what to wear, unable to work, unable to get out of bed was devastating. When the doctor suggested I see a therapist, I scoffed at her. When I eventually went to see a psychologist and was told I was severely depressed, I smirked. I could not stomach the fact that I needed help. To me, that meant I was weak, incompetent.

I used to look down upon those who wanted to kill themselves, for why would anyone give up? I used to think those who mulled about life and the meaning of it were too impractical – that earning money and climbing the corporate ladder would bring stability and happiness. I strived hard to maintain the image I thought society wanted to see. I smiled on the outside, but inside I was empty.

I started recovery slowly, through writing, therapy, playing. I started letting out the emotions I had kept suppressed. I learned to acknowledge them, and not berate myself each time I acted them out. These emotions were all part of me, but I had rejected them previously.

I started to understand that I had a part to play in the stigma against mental health conditions. The moment I understood that depression and anxiety could hit anyone, and it doesn't make us less of a person, was the moment I became open to the fact that I needed others to help me find myself again. Receiving help did not make me weaker. Rather, help guided me to ignite my inner strengths and self-awareness.

Enoch Li, China

In 20 countries, suicide attempts are a criminal offence, punishable by fines and typically one to five years in prison *(356)*. But criminalizing attempted suicide does not stop suicides. Rather, it increases stigma and undermines suicide prevention. It prevents people from seeking life-saving help, and it creates barriers to implementing policies, delivering effective support and to getting accurate knowledge on the size of the problem *(356)*. For countries that still criminalize suicide, a crucial step to advance mental health is to change this legal status.

All countries should develop, implement and evaluate a national strategy for suicide prevention that raises public awareness, de-stigmatizes suicidal thoughts and behaviours, encourages people to seek help, and deploys effective interventions to reduce mortality.

To help countries implement this recommendation, WHO has developed the LIVE LIFE approach to suicide prevention *(357)*. LIVE LIFE focuses on four key prevention interventions with proven efficacy.

- Limiting access to the means of suicide.
- Interacting with the media for responsible reporting on suicide.
- Fostering social and emotional life skills in adolescents.
- Early intervention for anyone affected by suicidal behaviours (read Enoch's experience).

Limit access to the means of suicide

Although there is a complex interplay of factors that lead up to suicide attempts, the path linking an attempt to a death is simpler and depends only on the choice of method and any life-saving response after the attempt *(358)*.

Suicide attempts are often impulsive, involving less than 30 minutes of planning. And the impulse is frequently brief. More than 90% of people who present to health care services after deliberate self-harm do not die from suicide later in life. This suggests that most survivors of a suicide attempt usually do not switch to other, more lethal methods *(359)*. This makes it crucial to reduce the chance that any suicide attempt is fatal.

> Pesticides account for
> **1 in 5 suicides**
> globally.

Accordingly, one of the most straightforward and impactful policy-based interventions is to reduce access to lethal means and improve medical responses after a suicide attempt. This includes making laws and policies to:

- Restrict access to means, including banning highly hazardous pesticides, regulating firearms, installing barriers at potential jump sites such as high rises, bridges or metro platforms, limiting access to ligatures in prisons and hospitals, and restricting the prescription of highly toxic medicines.
- Reduce availability of means, including limiting how much of a hazardous substance someone can buy or easily access, for example by changing the packaging of toxic medicines from bottles to strip packs.
- Reduce lethality of means, including switching to low-risk alternatives, for example by replacing coal gas with natural gas in households, or replacing highly hazardous pesticides with less toxic chemicals or non-chemical approaches to crop protection.
- Improve medical treatment, including increasing the availability and effectiveness of antidotes after acute intoxication and medical management after injury.

Any regulation aiming to reduce access to means of suicide should first focus on the most common and most lethal methods used. This varies from country to country, as well as within countries and across socio-demographic groups.

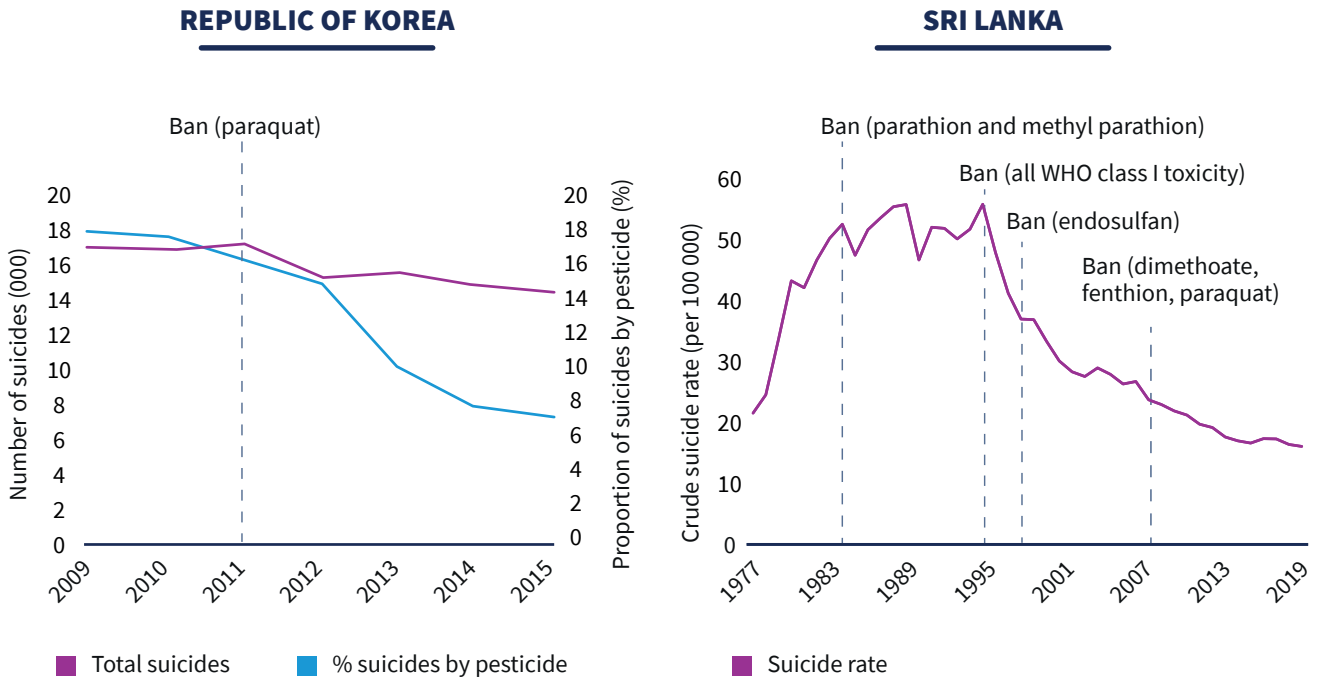
Highly hazardous pesticides

Pesticide self-poisonings account for up to one fifth of all suicides globally and are of particular concern in LMICs, where many people live in rural, agricultural communities with easy access to highly hazardous pesticides. Close to half of all suicides in LMICs in WHO's Western Pacific region have been estimated to be by pesticide poisoning *(360)*.

Banning the sale and use of acutely toxic, highly hazardous pesticides can lead to fewer deaths by suicide. It is a low-cost intervention, which is highly cost–effective in countries with a high burden of pesticide self-poisonings *(222, 361)*. National bans have been linked to a drop in pesticide suicides in Bangladesh, Jordan, Republic of Korea, Sri Lanka and in Taiwan, China (see Fig. 6.3 and Box 6.5 Sri Lanka: banning pesticides to prevent suicide) *(362)*. In the Republic of Korea, a ban on the highly hazardous pesticide paraquat in 2012 resulted in an immediate and clear decline in pesticide self-poisoning suicides and contributed to a marked decline in overall suicide rates across all population groups (see Fig. 6.3). Such declines have not been associated with reductions in agricultural yield *(363)*.

FIG. 6.3

National bans on highly hazardous pesticides and reduction in deaths by suicide



Sources: Korea: WHO, 2017 *(364)*; Sri Lanka: Duleeka Knipe, University of Bristol, unpublished data, April 2022, updated from Knipe, 2017 *(365)*.

CASE STUDY

BOX 6.5

Sri Lanka: banning pesticides to prevent suicide

When Sri Lanka's government drew up the Control of Pesticides Act in 1980, pesticide poisoning accounted for more than two-thirds of all suicides in the country.

In 1984, the Office of the Registrar of Pesticides began using its powers under the new Act to ban highly hazardous pesticides, starting with two organophosphorus insecticides (parathion and methyl parathion). Within ten years, all remaining highly hazardous WHO class I toxicity pesticides had been banned. In 1994, a Presidential Commission was established to draft a national policy and action plan on suicide prevention, and to coordinate action across multiple government agencies, including agriculture. Further bans in 1998 (endosulfan) and 2008 (dimethoate, fenthion and paraquat) boosted the decline. In total Sri Lanka banned 36 highly hazardous pesticides.

By 2016, the annual suicide rate had fallen more than 70% to 14 per 100 000.

The Ministry of Health continues to work on suicide prevention in multiple departments and the overall suicide rate now stands at around 25% of its peak. The national policy, and how it is implemented, is regularly reviewed by a Pesticide Technical and Advisory Committee, which is made up of many stakeholders within government. The committee also regularly engages the pesticide industry to ensure wide buy-in and cooperation.

Together, the bans are estimated to have saved 93 000 lives between 1995 and 2015, at a direct government cost of US$ 43 for each life saved. Thousands of lives continue to be saved every year. Strong cooperation of farmers and agricultural suppliers mean that crops could be effectively grown using alternative pesticides so agricultural output has not been affected.

Sources: Knipe et al, 2017 *(365)*; Jeyaratnam et al, 1982 *(366)*; Pearson et al, 2015 *(367)*.

Interact with the media for responsible reporting of suicide

Media reporting can have a major influence in shaping public opinion and attitudes about suicide. There is evidence that glamourized coverage of high-profile suicide cases or detailed descriptions of attempts can lead to imitation suicides *(368)*. Conversely, stories that include information on where to seek help contribute to suicide prevention *(369)*.

Working with the media for responsible reporting can include collaborations to:

- build capacity of journalists through training or guideline development; or
- regulate coverage of suicide, including identifying and correcting (or deleting) articles that fail to meet established standards.

In Lithuania, for example, journalists and psychologists have worked together to develop a code of ethics for public information to guide suicide reporting in the country. A Suicide Prevention Bureau reviews around 30 reports of suicide or suicide attempts in the online media every working day to ensure compliance with the code. For every article that is found to breach the code, the bureau contacts the editor of the publication and requests a correction *(357)*.

Working with the media can include collaborations at all levels, from regional to local, and all platforms, including television, radio, newspapers and social media.

Foster social and emotional life skills in adolescents

The LIVE LIFE approach recommends implementing WHO and UNICEF's Helping Adolescents Thrive (HAT) guidelines, which advocate social and emotional life skills training in schools alongside a range of other initiatives to promote and protect the mental health of adolescents, including anti-bullying programmes, support on how to stay connected and safe online and offline, gatekeeper training for teachers, mental health literacy initiatives for parents and extra support to high-risk students (see section 6.3.2 Protecting and promoting child and adolescent mental health).

CASE STUDY

BOX 6.6

Guyana: building capacities for suicide prevention

Suicide prevention has been a government priority in Guyana since 2014. Action is directed by two national plans for mental health and suicide; and led by a national Mental Health Unit within the Ministry of Public Health.

Part of this action focuses on scaling up capacities for suicide prevention among primary health care providers. In 2015, the Pan American Health Organization (PAHO) began training these health care workers in identifying and managing risk for suicide and providing appropriate follow-up care. PAHO used a virtual campus to deliver an online course based on the WHO mhGAP-IG to physicians.

Since then, more than 300 health care providers have been trained to assess, manage and follow up common mental health conditions and suicide/self-harm. More than a third of these are doctors working in primary health care.

In addition, gatekeeper training is being planned and implemented to involve informal care providers in suicide prevention. This includes training teachers to recognize mental health issues in children and adolescents, and refer them to appropriate services.

Source: WHO, 2021 *(357)*.

Early intervention for those affected by suicidal behaviours

The fourth priority intervention in the LIVE LIFE approach lies in the early identification, assessment, management and follow up of anyone affected by suicidal behaviours. This includes equipping anyone who is likely to encounter someone at risk – including all health workers and relevant community providers such as teachers – with the competencies to guide people to the support they need. It also includes providing follow up support to anyone who may have been bereaved by suicide.

Early intervention is important across the full spectrum of health services. WHO's mhGAP Intervention Guide (mhGAP-IG) includes tools and training materials to support clinical decision-making and management by non-specialized health workers (see Box 6.6 Guyana: building capacities for suicide prevention) *(244)*.

Community-led services have an important role in supporting people affected by suicidal behaviours through survivors' groups and self-help groups facilitated by survivors with lived experience. Schools and other learning environments also have a role in providing support to those experiencing suicidal thoughts and behaviours by offering guidance on where and how to seek help. And other sectors, such as social welfare, also have a part to play in supporting survivors who may, for example, need help accessing work or benefits.

6.3.2 Protecting and promoting child and adolescent mental health

Infancy, childhood and adolescence are ages of both vulnerability and opportunity in mental health. This is a time when children acquire the cognitive, social and emotional attributes and skills they need to thrive as adults.

Childhood and adolescence is also a time of life when we are highly susceptible to environmental influences. Nurturing caregiving and supportive learning environments can be hugely protective of future mental health. On the other hand, adverse childhood experiences in homes, schools or digital spaces increase the risk of experiencing mental health conditions (see section 2.2 Determinants of mental health).

> *Nurturing caregiving and supportive learning environments can be hugely protective of mental health.*

Informed by WHO's evidence-based guidelines the sections that follow consider the rationale and options for universal promotion and prevention across four platforms *(370, 371)*:

- policies and legislation
- caregiver support
- school-based programmes
- environments outside school.

Policies and legislation

International frameworks such as the UN Convention on the Rights of the Child (CRC) commit all countries to promote and protect child and adolescent mental health. The CRPD complements the CRC and includes an article on protecting the rights of children with disabilities, including psychosocial disabilities. Together, they support access to care and social inclusion for children with mental health conditions.

National policies, plans and laws that align with these human rights instruments are critical to developing appropriate systems of mental health care for young people. Yet in 2020, fewer than half of WHO Member States reported having a plan or strategy for child and adolescent mental health *(5)*.

For young children, laws and policies that support caregivers in providing nurturing care

NARRATIVE

This illness stole precious moments from me and my girls

Olivia's experience

Before becoming a mum I thought motherhood would be, yes, tiring and overwhelming at times, but mostly I expected it to be a period of joy and happiness. Not once did I think it would in fact be one of the darkest times of my life.

Both my girls were born prematurely and after giving birth to my eldest I immediately started to experience symptoms of psychosis. I felt deeply depressed and anxious, was plagued with irrational beliefs and fears, and had severe panic attacks. My symptoms went unrecognized by myself and undiagnosed by the medical staff taking care of me.

My first psychotic episode took place a few months later. I'd settled my daughter down in her nursery and then experienced the most terrifying of visions. I saw demons flying around our house, saying they were here to kill my daughter. I began living with what I came to call my "dark stranger": a shadowy figure who would appear unexpectedly telling me I was in danger and that my daughter would be better off without me. I became filled with terror. I didn't want to see family and friends and felt like I was trapped in my own horror film. My symptoms were not cared for correctly, and I experienced them again during my second pregnancy and for several months after. My recovery was slow and at times challenging and debilitating.

I've had to come to terms with the fact that this illness stole precious moments from me and my girls that I will never get back. But this realization and my acceptance of it has been my drive to help other women in the same situation. I passionately believe that every woman going into motherhood should be educated on how to take care of their mental health. All women should be informed of the symptoms and know where to get support if they need it.

Since recovering I have published a book about my experiences. I also set up The Letters of Light Project: a peer-to-peer initiative that sends handwritten letters of support from women with lived experience of maternal mental health issues to women who are receiving maternal mental health care around the world. And I have been part of the editorial team for the *World mental health report: transforming mental health for all*. These are all projects I am incredibly proud of. And I get to share them with my daughters so they know that suffering with a mental health condition is not a weakness or a source of shame. People with lived experience are courageous people whose insight and experiences are invaluable for progressing mental health care worldwide.

Olivia Gascoigne Siegl, United Kingdom

are especially important *(18)*. For adolescents, laws and policies can also be important to reduce common risk behaviours such as self-harm, substance use and risky sexual behaviours *(372)*.

Multiple sectors have a role in creating enabling policy and legislative environments for child and adolescent mental health. For example, health policies set the standards for mental health services and provide universal coverage. Social welfare policies protect families against economic and social adversity. And education policies secure access to learning opportunities.

Caregiver support

Caregivers have a crucial role in promoting and protecting their children's mental health by providing nurturing care throughout childhood and adolescence.

Supporting caregiver health and well-being

Even before we are born our parents' mental health can impact our own. Poor nutrition, exposure to drugs or toxins, maternal infections or stress and birth complications can all adversely affect fetal development and put a child's later mental health at risk *(373)*. Pregnant women with untreated depression or anxiety are more likely to have birth complications or die during pregnancy, and to have a low-birthweight baby *(374)*.

> *After birth and beyond, many caregivers experience psychological distress.*

After birth and beyond, many caregivers experience psychological distress. Especially when this distress amounts to depression or psychosis, there can be serious consequences for both caregivers and their children (read Olivia's experience). For example, depression and anxiety can impair a mother's ability to bond with her baby.

Preventive interventions that support caregiver mental health both before and after birth can make considerable contributions to preventing mental health conditions in children *(375)*. One meta-analysis has suggested that, when these interventions reach caregivers who are already experiencing a mental health condition, they could reduce the risk of mental health conditions in their children by 40% *(376)*.

Reducing caregiver stress and supporting caregiver well-being – including through home visiting interventions – is particularly valuable during pregnancy and early infancy *(377)*. Maternal mental health care should be integrated into early childhood health and development services because of the indirect benefits on caregiving and child development outcomes *(370)*.

Continuing support for caregiver well-being also has the potential to positively influence the development and mental health outcomes of older children and adolescents. WHO and UNICEF's HAT initiative to promote mental well-being and prevent mental health conditions among adolescents emphasizes the importance of intervening with caregivers who are more likely to experience difficulties that could adversely affect their parenting *(372)*. This includes caregivers who live in humanitarian settings, are victims or survivors of violence or who have a mental health condition or chronic physical illness.

All caregivers who live in stressful circumstances can benefit from extra support. In 2020 the Parenting for Lifelong Health programme developed the COVID-19 Parenting Resources to reduce caregiver stress and lessen the risk of violence against children during the pandemic *(378)*. Through tip sheets, interactive text messages, online parent support groups, phone-based counselling and more, the resources use a strategic approach to deliver messages to support caregivers and children during the pandemic. More than 210 million people accessed these resources during the first two years of the pandemic.

Skills for caregiving

Parenting programmes focus on equipping caregivers with the skills they need to provide nurturing care and a safe and stable environment for their children. Programmes for caregivers of newborns often focus on breastfeeding support, which helps establish a sense of attachment and comfort that contributes to mental health *(379)*.

Programmes for young children's caregivers tend to focus on responsive care and learning, including preschool enrolment *(370)*. Experience from around the world suggests that parenting programmes during early childhood can effectively reduce coercive parenting, improve children's problem-solving behaviour and social functioning at home and school, and help prevent behavioural problems, many of which have their onset in preschool periods *(380)*.

Programmes for adolescents' caregivers may focus on *(372)*:

- Support to promote nurturing family environments, including support to increase caregivers' involvement in parenting and ability to provide appropriate structure and supervision.
- Skills to strengthen caregiver–adolescent communication and relationships.
- Skills to strengthen positive parenting and protect adolescents from exposure to violence, including skills for setting limits and rules, promoting praise and positive reinforcements and reducing harsh punishment.
- Knowledge to increase caregivers' understanding of mental health and adolescent development, including the psychological, social, physical and sexual changes that happen during adolescence.
- Support for family social networks and community connectiveness.

Caregivers of children with developmental delays and disabilities may benefit from specific support because they are likely to experience high levels of distress. Experience shows that participating in parenting programmes such as WHO's Caregiver Skills Training (CST) can empower these caregivers to foster their children's learning, social communication and adaptive behaviour *(381, 382)*.

Pregnant adolescents and adolescent caregivers can also benefit from parenting programmes that, for example, build awareness of the mental health challenges they may face and link them to crucial support and services *(372)*.

School-based programmes

Schools are one of the most important settings for mental health promotion and protection among children and adolescents. They can be places that nurture well-being, equipping students with the knowledge, skills, competencies and lifestyles they need to thrive. For children whose home environment is not safe and nurturing, school can be a crucial safety net supporting basic social, emotional, and physical needs. But schools can also be places that undermine well-being, for example by exposing students to bullying, racism, discrimination, peer pressure and excessive stress about academic performance.

To be effective, each intervention in a school-based promotion and prevention programme requires active engagement and support from students, teachers, caregivers and communities. To develop a positive school climate, a whole-school health-promoting approach is needed *(372)*. In turn, such an approach supports better health and educational outcomes and influences health behaviours, to the benefit of students, school personnel and the broader community *(383)*.

TOOL

BOX 6.7

A school mental health training package for the Eastern Mediterranean

WHO's Regional Office for the Eastern Mediterranean (EMRO) has developed a training package for educators to better understand the importance of mental health in a school setting and implement strategies to promote, protect and restore mental health among their students.

Still in the early stages of implementation, the EMRO package includes training manuals and materials to help scale up the number of "mental health promoting schools" that are able to:

- support their children's social and emotional development;
- promote mental health and well-being at all levels;
- provide age-appropriate behavioural management strategies; and
- identify and address early signs and symptoms of mental health conditions.

Source: EMRO, 2021 *(384)*.

A key component of a health-promoting school is a safe and supportive school social and emotional environment. This can be nurtured by training educators (see Box 6.7 A school mental health training package for the Eastern Mediterranean). In all cases, school-based prevention and promotion programmes should be linked with other mental health and social services, which may be provided on- or off-site (see section 7.4.1 Mental health care in non-health settings: Early detection and intervention in schools).

Social and emotional learning programmes

School-based programmes for social and emotional learning are linked to mental health benefits in countries at all income levels *(385)*. They can be delivered for all school ages and are well proven to improve students' emotional well-being, social functioning and academic performance. They are also associated with a reduced risk of depression, anxiety and stress; and prevention of suicide, harmful substance use, antisocial behaviour and health-risking sexual practices (see section 6.3.1 Preventing suicide: foster social and emotional life skills in adolescents) *(386)*.

WHO and UNICEF's HAT initiative advocates a broad approach to school-based social and emotional learning that uses a mix of interventions to build mental health awareness, strengthen emotional, cognitive, and social skills, and engage in physical activity (see Table 6.3) *(372, 387)*.

TABLE 6.3

Psychosocial interventions for social and emotional learning

LEARNING GOAL		INTERVENTION
Emotional	Emotion regulation	Techniques to improve one's ability to manage and respond to emotions effectively
	Stress management	Techniques to control levels of stress, especially chronic stress, that interferes with everyday functioning
	Mindfulness	Activities to enhance abilities to pay attention purposefully, in the present and without judgment
Cognitive	Problem solving	Techniques to identify and act on a solution to a challenge or difficult problem
	Drug and alcohol knowledge	Education about the use of drugs and alcohol, and their effects
Social	Interpersonal skills	Improving skills to develop or improve close, strong and positive relationships with others
	Assertiveness	Improving skills to communicate one's viewpoint, needs or wishes clearly and respectfully
Physical	Physical activity	Opportunities to engage in sports or physical activity, either individually or in teams

Source: adapted from WHO and UNICEF, 2021 *(372)*.

NARRATIVE

Bullying was the perfect soil for my depression to grow

Benny's experience

My first experience of racist bullying was when I was in second grade. My neighbourhood peers saw me and yelled at me to go back to China. I was only eight years of age and already felt unwelcome and unsafe in my closest environment.

I had active asthma and my parents were very protective of my health. I was mocked as a mama's boy; the weak asthma kid. I used to cry to cope with the bullying, rejection and frustration. By the time I was an adolescent, I had become very sensitive. I tried to be more assertive and bold in stating what I thought and felt. But I was being bullied more than ever. I had started having physical health issues and came from a different religious background to many of my peers. The passive aggressive gestures and microaggressions toward my religious identity became a soft method for their bullying.

These experiences made me very aware of the fact that people can be very ignorant and hateful towards diversity and conditions they know nothing about. They made me wonder why people cannot accept others for identities they have no power to choose, why they inflict suffering toward others, and what happiness and harmony should look like. I had nobody to ask these questions to, leading to a greater sense of alienation.

I constantly felt like I was less than those who hated me; and that I had to prove I could do better than all of them. This long-term and multi-layered impact of bullying also made me feel lonely and worthless. It became the perfect soil for my depression to grow. It took years for me to realize that bullying had disrupted my way of relating to myself and others.

Benny, Indonesia

Universal school-based social and emotional learning programmes can be embedded into the usual school curriculum and delivered by teachers. For example, a Canadian Mental Health Curriculum has been adapted for use in classrooms in Malawi, Nicaragua and the United Republic of Tanzania, where it has shown self-reported improvements in mental health literacy and help-seeking as well as reduced negative attitudes *(388, 389, 390)*.

Such programmes are not only effective but can bring good economic returns *(222)*. One investment case for the Philippines calculated that the return on investment (including productivity gains and the social value of health) of universal school-based social and emotional learning programmes was 14.8 to 1 over 20 years *(132)*.

Anti-bullying interventions

Within any school-based promotion and prevention programme, anti-bullying interventions are especially important.

Bullying can take many forms: physical, verbal and psychological. Nearly one in three adolescents are estimated to be victims of bullying in the past 30 days *(391)*. People who are bullied as a child are more likely to experience emotional distress and mental health conditions and to have problems adjusting to school *(392)*. Bullying can also result in isolation, low self-esteem and self-harm (read Benny's experience).

> *Anyone involved in bullying – those who bully or are bullied – are more likely to get depression and anxiety.*

Childhood bullies themselves are more likely to have academic problems in the short term and are more likely to engage in harmful substance use, antisocial behaviour and interpersonal violence later in life *(392)*. Anyone involved in bullying – those who bully and/or are bullied – are more likely to experience a mental health condition *(393, 394)*.

School-based anti-bullying programmes focus on addressing factors in the school that foster bullying behaviour. They can be implemented in different ways, from parental and peer support interventions to staff and student awareness-raising and social and emotional skill building. Overall, school-based anti-bullying programmes have been found to be effective in reducing bullying by approximately 20% *(395)*. Analysis suggests that the most successful interventions use a multi-level, whole-school approach that includes implementing an anti-bullying policy and classroom rules (including accountability mechanisms), providing information for parents, involving peers and enabling cooperative group work.

In addition to reducing bullying rates, anti-bullying programmes can reduce subsequent aggression and emotional problems in adolescents *(396)*. They may even have an impact on psychosis rates, given the link between bullying and psychotic experiences *(397)*.

Environments outside school

Beyond school, children and adolescents spend a lot of time in communities and, these days, in online environments. Moreover, there are millions of children and adolescents out of school. It is important to ensure that environments outside school are safe and healthy and that they enhance mental health outcomes and facilitate access to resources and support.

Adolescents who live in safe, well-resourced neighbourhoods or participate in extracurricular social, physical, creative or playful activities such as youth clubs, sports teams or arts groups have improved mental well-being compared with those who do not. Conversely, adolescents who live in communities with high levels of adversity or conflict are more likely to have poorer mental health. So any intervention that successfully addresses violence and other adversity in the community can be considered promotive. So too can interventions such as safe spaces that support opportunities for children and adolescents to play *(398)*.

There is much concern around children's use of the Internet and social media *(4)*. Around the world, children and adolescents have different experiences in accessing and using the Internet, with different risks and benefits. Some young people have little or no access to digital technologies and the internet; some have recurrent but irregular access; some have regular access but are limited in their use of them by personal or caregiver concerns; and some have regular access with no support or barriers to use *(399)*.

For those who can access the Internet, online environments can be an important source of entertainment, social support and learning. This has been especially true during the COVID-19 pandemic, with the Internet providing a platform for attending classes and socializing with friends, as well as information on how to cope with COVID-19 related stressors (see Box 6.8 My hero is you: a children's book for COVID-19). Of course, many children had no Internet access during the pandemic, or only limited access that made online learning and socializing very difficult.

TOOL

BOX 6.8

My hero is you: a children's book for COVID-19

My hero is you: how kids can fight COVID-19 is a book for school-aged children explaining how they can protect themselves, their families and their friends from COVID-19 and how to manage difficult emotions when confronted with rapidly changing reality.

The book was made available in 2020, in more than 140 languages and numerous adaptations, including animated video, theatre, activity books and audio formats. It came with a guide for parents on how to read the book with their children, explaining how adults can create safe spaces for children to openly share their feelings, including their fears and worries, about COVID-19 and frustrations at their changed daily lives.

A sequel, *My hero is you 2021: how kids can hope with COVID-19* addressed children's changing concerns during the second year of the pandemic and is available in 28 languages, showing the continued interest in countries to provide children with information on coping with COVID-19 related stressors.

Sources: IASC, 2020 *(400)*; IASC, 2021 *(401)*.

NARRATIVE

A toxic work environment left me unable to function

Larry's experience

I loved my work but I grew to hate it as I was working in a toxic environment. A lengthy and unpleasant matter at work was sending my mind reeling into panic attacks, anxiety, and depression. My doctor said I had moderate to severe depression. I maintained a façade of happiness but I would hide in my office in tears, trying unsuccessfully to maintain some level of self-control. I took time off.

On my first return to work, I was utterly overwhelmed and took more time off. On my second return, organizational changes made in my absence meant I started to dread my weekly work meetings. It made me ill just thinking about it. I was unable to function at work for several days.

I felt like a target. My normal duties were being eroded and the authority of my role was diminished without any consultation. I reached out to my professional association and human resources for help, but no action was taken to support me.

Exasperated, feeling cornered, and unable to function in my role I resigned. Following my resignation my personal feelings blazed chaotically between mental anguish, lack of control, isolation, fear, sorrow, intimidation, disbelief, frustration, disappointment, extreme worry for the well-being of my former team, anger about the impact on my 20-year career and, periodically, relief.

The happiness, optimism, and trust in others that used to define me are still mostly absent. I work on those. This was the single most tumultuous experience in my life, but I have no regret as I chose to put my personal sanity and mental health first. In the end, I learned a great deal about myself and what is important to me. This opportunity for self-reflection is the unseen benefit.

Larry White, Canada

When young people spend time online and on social media they can also be exposed to mental health risks such as cyberbullying, cyberstalking, grooming, developmentally inappropriate content, misinformation and unhealthy role models. Social media use can also interfere with sleep *(402)*. And social media breeds social comparison, with adolescents frequently thinking they compare poorly with others *(403)*. So while social media helps many adolescents make connections and explore new ideas and information, it also undermines self-esteem and body image.

The impact of Internet use on mental health, cognitive development and social connectedness – both positive and negative – remains a topic of concern and is a priority for investigation.

Meanwhile, three interventions in particular are considered promising in promoting safe and healthy engagement online for adolescents *(372)*:

- Adolescent training programmes to strengthen skills in how to use the Internet responsibly and safely and to reduce online-related risks such as cyberbullying and victimization.
- Parenting programmes to train caregivers on how to promote their adolescent's safe use of the Internet, including setting rules, monitoring use and encouraging responsible engagement.
- Technological tools to promote online safety by enabling negative content to be filtered and blocked, including caregiver controls, self-regulation tools, language screening software, and reporting systems.

6.3.3 Promoting and protecting mental health at work

Workplaces can be places of both opportunity and risk for mental health. On the one hand, workplaces that promote good mental health and reduce work stress not only enhance mental and physical health but are also likely to reduce absenteeism, improve work performance and productivity, boost staff morale and motivation, and minimize tension and conflict between colleagues. So action to protect and promote mental health in the workplace can be cost–effective *(404)*.

Workplaces can be places of both opportunity and risk for mental health.

On the other hand, unemployment, discrimination in accessing or carrying out work, and poor working conditions can all be a source of excessive stress, heightening the risk of developing new mental health conditions or exacerbating existing ones *(20)*. Such negative working environments and experiences are the very opposite of what is needed for staff to do their work (read Larry's experience).

Some workers, such as health, humanitarian or emergency workers, are more likely to be exposed to adverse experiences at work. This is partly because of the nature of their work (for example, exposure to potentially traumatic events) but also because of the way their job may be designed (for example, high workload, long hours, shift work or work at unsociable hours). This adversity puts workers at risk of negative impacts to their mental health *(405, 406)*. The COVID-19 pandemic has highlighted the heavy workloads carried by health workers, and the potential consequences for their mental health (see Chapter 2, In focus: COVID-19 and mental health). Yet such burdens and consequences were known to risk depression and suicidal behaviours even before the pandemic *(405, 407)*.

Most initiatives for work-related mental health focus on the formal employment sector. Yet the informal economy – where there are no formal regulations, work is precarious, and workers lack access to social protections – accounts for more than 60% of all global employment, and more than 69% of employment in LMICs *(408)*. These workers face threats to their mental and physical health through lack of structural support or recognition for their work and often also face poor working conditions and societal discrimination, all of which may also impede use of mental health services.

The *Comprehensive mental health action plan 2013–2030* emphasizes the need for countries to promote safe, supportive and decent working conditions for all, including informal workers. It further recommends that countries address discrimination in the workplace and promote full access to work participation for people with mental health conditions. Despite this commitment, work-related promotion and

prevention programmes for mental health were among the least frequently reported by countries (35%) in the *Mental health atlas 2020 (5)*.

In 2022, following extensive evidence reviews, WHO will publish the first ever global guidelines on mental health and work. These will highlight the importance of key strategies for preventing mental ill-health including:

- organizational interventions
- manager mental health training
- interventions for workers.

In each case, legislation and regulations are important to ensure these strategies – and others to support workers with mental health conditions – are effectively implemented. While the upcoming guidelines are based on the latest evidence available, there is still much to learn about what works, and for who, when it comes to supporting mental health at work. Strong collaboration between employers and academia is important to gather evidence on the effectiveness of different approaches *(409)*. Interacting with, and listening to, workers to get their perspectives on what they need is just as important.

Legislation and regulation

At national and international levels, legislation and regulation encourage and enforce action to promote and protect mental health at work. For example, the International Labour Organization (ILO) Convention on Occupational Safety and Health (No. 155) and its Recommendation (No 164) call on countries to protect workers' physical and mental health by developing and implementing national policies in occupational safety and health. The convention provides an impetus for employers to integrate mental health into their own workplace policies and is thus a key enabler of organizational interventions (see Organizational interventions).

Other international conventions similarly enable organizational interventions to support people living with mental health conditions. Article 27 of the CRPD for example calls for the protection of rights of persons with disabilities in recruitment, hiring, employment and career advancement through accommodations at work (*410*).

Workplaces can be reticent to hire people with mental health conditions on the misguided assumption that they require more resources, more supervision, have less initiative, cannot deal with customers, or that there are trust issues *(411)*. Laws that compel non-discriminatory practices for all workers can help to uphold people's rights. But changing stigmatizing attitudes requires complementary action, for example to address misconceptions about mental health conditions and increase employers' understanding about how to make reasonable adjustments to recruit and support prospective workers with mental health conditions.

At the national level, a diverse range of employment laws and policies can be used to establish an enabling environment for protecting workers' mental health (see Box 6.9 Promoting mental health in workplaces in the Philippines). This includes regulations on violence and harassment as well as laws and policies on minimum wage, equality, health, safety, parental leave and flexible working.

CASE STUDY

BOX 6.9

Promoting mental health in workplaces in the Philippines

In 2020, the Department for Labor and Employment in the Philippines issued new guidelines for all employers in the private sector to implement a mental health workplace policy and programme.

The guidelines are enshrined in law through various acts of government and apply to all workplaces and establishments in the formal sector, including those that deploy Filipino migrant workers overseas.

The new guidelines make it mandatory for all employers to establish and implement a mental health workplace policy and programme that:

- raises awareness about mental health in the workplace
- prevents stigma and discrimination
- promotes a healthy lifestyle and work-life balance
- supports workers with mental health conditions and facilitates access to mental health services.

The guidelines are clear that mental health workplace policies and programmes should be co-developed by management and workers' representatives, and regularly monitored and evaluated. All employers must submit annual reviews of their policies and programmes to the Department of Labor and Employment. And those that do not comply with the new guidelines may be fined.

Source: Department of Labor and Employment, 2020 *(412)*.

Organizational interventions

Organizational strategies to promote and protect mental health in the workplace cover interventions that reshape working conditions to reduce workers' exposure to mental health risks. These psychosocial risks may be related to the nature of the work undertaken, the physical, social or cultural characteristics of the workplace, or opportunities for career development, among other things (see Table 6.4) *(413)*. These are risks known to adversely impact mental health outcomes. For example, high job demands, low job control, job insecurity, low relational and procedural justice, bullying and low social support in the workplace are associated with a greater likelihood of developing mental health problems *(20)*.

Violence and harassment at work, in particular, violate human rights and can cause long-lasting harm to mental health *(414)*. Violence and harassment are often enabled by structural factors (for example, gender biases) that foster a negative workplace culture.

Removing or mitigating risks to mental health at work can in part be achieved by integrating mental health into an organization's workplace policies on occupational safety and health (see Box 6.10 SOLVE: integrating mental health into workplace policies). This action helps to ensure that employers meet the requirements of national and international labour standards (see Legislation and regulation).

TABLE 6.4

Examples of risks to mental health at work

POTENTIAL RISK	EXAMPLES
Job content / task design	• Lack of variety in the work • Under-use of skills or under-skilled for work • Insecure or informal working
Workload and work pace	• Heavy workload
Work schedule	• Long work hours • Shift working • Inflexible hours
Job control	• Lack of control over workload • Limited participation in decision-making about one's own work
Environment and equipment	• Poor physical working conditions
Organizational culture and function	• Poor communication • Unclear organizational objectives • Limited opportunities for personal development • Workplace culture that enables violence, harassment, discrimination or bullying
Interpersonal relationships at work	• Limited support from supervisors or colleagues • Violence, harassment and bullying
Discrimination	• Any discrimination based on identifying factors such as race, ethnicity, sexual orientation, gender identity, religion or age • Discrimination against indigenous peoples, migrants and people with disabilities, including psychosocial disabilities
Role in organization	• Unclear job role within the organization or team
Career development	• Under promotion or over promotion • Job insecurity • Poor pay
Home-work interface	• Conflicting demands between work and non-work life

Source: ILO, 2016 *(415)*.

TOOL

BOX 6.10

SOLVE: integrating mental health into workplace policies on occupational safety and health

The SOLVE training package, developed by ILO, provides practical guidance for managers, supervisors and others on how to integrate mental health into their organizations' workplace policies and practices on occupational safety and health.

Designed to support the ILO Occupational Safety and Health Convention (No. 155), the SOLVE training package covers three main targets for policy design and action:

- psychosocial health, including stress, psychological and physical violence, and economic stressors;
- potential addictions, including tobacco, alcohol and drug consumption; and
- lifestyle habits, including diet, exercise and healthy sleep.

SOLVE aims to provide participants with the knowledge and skills they need to integrate each of these topics into their own occupational safety and health policies. To that end it uses a social dialogue approach, involving employers, workers, governments, public services and nongovernmental organization.

Sources: ILO, 2012 *(416)*; Probst et al, 2008 *(417)*.

Specific organizational interventions for mental health include *(418, 419)*:

- providing flexible working arrangements;
- involving workers in decision-making, for example on their job design, through participatory approaches; and
- modifying workloads or work schedules to promote and enable a healthy work-life balance.

Organizational interventions designed to support people living with mental health conditions may also include facilitating the provision of reasonable accommodations, so that workers are supported to access or continue work. In many cases, supported employment programmes may be needed to create opportunities for competitive work for those at disproportionate risk of exclusion, including people living with severe mental health conditions. In all cases, organizations can help foster participation in work activities by providing adapted working conditions to match the capacities and needs of workers with mental health conditions. This may include allowing flexible hours of work, extra time to complete tasks and time off when needed to seek mental health care *(420)*. It may include access to private spaces such as somewhere to store medication or somewhere to rest when necessary. And it may include ensuring supportive relationships with managers and redesigning jobs, for example to avoid interacting with clients if the worker finds this unduly stressful.

Efforts to adapt working conditions may also be beneficial for people returning from absence associated with mental health conditions. If the worker agrees, other stakeholders (such as mental health care providers) may also have a role in supporting their return to work.

Anti-stigma action is critical to ensure workers experiencing difficulties with their mental health feel supported and able to ask for extra support if they need it, without fear of repercussions or judgement. Indeed, reducing stigma at work is vital to the success of efforts to support mental health at work.

Manager mental health training

Mental health training for managers and supervisors is about strengthening knowledge, skills, attitudes and behaviours so that managers may better support their workers' mental health needs *(421)*.

Training may focus on supporting managers' specific mental health needs, for example looking at how to regulate emotions in response to work stressors. Or it may focus on helping managers identify and reduce work-related risk factors for their supervisees, for example by finding ways to manage workloads during busy periods.

Training can also include developing knowledge about mental health and learning how to identify and support supervisees that may be experiencing emotional distress. In these cases, the intention is not for managers to become mental health care providers. Rather it is about enabling appropriate awareness and response, for example using active listening skills and, where appropriate, referring people to sources of support within or beyond the workplace.

Interventions for workers

Interventions for workers often focus on increasing coping capacity to manage stressors. This includes stress management training using mindfulness-based or cognitive-behavioural approaches as well as strategies to promote leisure-based physical activity (see section 5.4.4 Competencies for self-care). Increasing the amount of social support available for employees can also help individuals cope with a stressful situation by mobilizing group problem-solving and positive team functioning.

> *Stress management interventions should be delivered along with organizational interventions that address psychosocial risks and manager training.*

The evidence supporting stress management approaches for workers is clear *(422)*. The ease with which stress management options can be delivered to a workforce render them popular and appealing. But to ensure a holistic approach to workers' mental health, these interventions should be delivered as part of a comprehensive package of interventions that also includes organizational interventions that address psychosocial risks and manager training. This is because a single focus on interventions for individuals can generate a sense of personal blame for people experiencing understandable stress responses to difficult work circumstances.