



Addressing Mental Health from a Global and Local Perspective: A Guide for Employers

The Business Group on Health would like to thank our member companies, as well as the member companies of The Consumer Goods Forum and the Global CMO Network, for their contributions to this product. Also, a special thanks to ComPsych and Dr. Neil Greenberg for their expertise.



CONTENTS

Introduction.....	3
Think Global: Strategies that Multinational Employers Use Worldwide	7
Act Local: How Access, Stigma and Coverage Vary in Key Markets, and Their Impact on Employer Offerings	15
In-Depth by Country:	
China.....	19
France	23
India	27
Italy.....	31
Japan.....	35
Mexico.....	39
South Africa	43
Spain.....	47
United Kingdom	51
United Arab Emirates (U.A.E.)	55
Example Employer Tools and Resources	59
References	71

Introduction

Mental health is a critical issue around the world. It is especially relevant to global employers because of its impact on productivity, well-being and the bottom line. Consider the following numbers:

10%

The estimated percentage of the **global population who experienced a mental health disorder in 2017**,¹ although accurate data in many countries is difficult to obtain due to stigma and poorly defined and understood measurement techniques.

\$1 trillion

The estimated **cost of depression and anxiety to the global economy** (in USD).⁴

1 in 4

The estimated **prevalence of mental health disorders** among the adult population in the U.S. and the U.K.^{2,3}

13%

Percentage of the total **global burden of disease** attributed to untreated mental disorders.⁵

91 million

Workdays lost annually in the U.K. due to mental health disorders.⁵

\$4

According to a World Health Organization-led study, the estimated **return on investment** for every \$1 put into scaled up treatment for common mental health disorders.⁴

While there have been substantial efforts made by some countries and organizations to improve the mental health of populations and employees, a significant amount of work remains, and the response has not yet been proportional to the significant need.

Key challenges remain; namely, access, public and private system coverage and stigma.



- **Access:** Access to mental health professionals depends on the country you live in. The rate of mental health professionals per 100,000 population varies considerably: “In low-income countries, the rate of mental health workers can be as low as 2 per 100,000 population, compared with more than 70 in high-income countries. This is in stark contrast with needs, given that 1 in every 10 person is estimated to need mental health care at any one time.”⁶



- **National health care systems:** The amount of government funding for mental health also depends on where you live. In low- and lower-middle income countries, government expenditure on mental health is less than \$1 (USD) per capita.⁶ Whether mental health disorders are covered by national health insurance or reimbursement schemes also plays a role in quality of care. In countries where mental health care is included in public health insurance the extent of care and how it is provided vary significantly and can be limiting. For example, in some locations, inpatient care and/or medication are the only real options, and psychological therapies either don't exist or are only for the wealthy who have private insurance or can afford to pay out-of-pocket.⁶ The World Health Organization says that more than 80% of people experiencing mental health, neurological and/or substance use disorders do not receive quality and affordable mental health treatment.⁷



- **Policy:** Countries are taking action in various ways in an attempt to change the narrative. These actions include decriminalization of some behaviors such as suicide, advocating for insurance coverage and promoting company stress assessments.
 - In many countries, private and group insurance exclude mental health coverage. Recently some countries, such as India and Malaysia, are looking to make changes by encouraging or requiring insurers to provide coverage for mental health conditions.
 - Other countries, such as India, have taken action to decriminalize suicide.
 - Mexico, Japan and the European Union are examples of geographies that have requirements for employers to assess, and in some cases, address workplace stress.



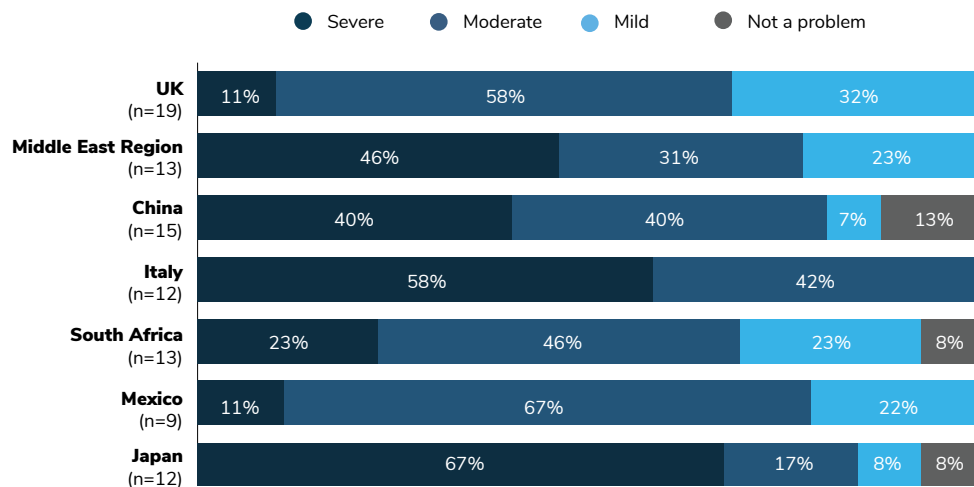
- **Stigma and fear or discrimination keep people from seeking treatment.** The perception of stigma-associated risk and severity of repercussions not only varies by individual, but is significantly influenced by culture and local environment, including the policy and legal framework.

What is Stigma?



Source: Neil Greenberg, M.D., King's College, London

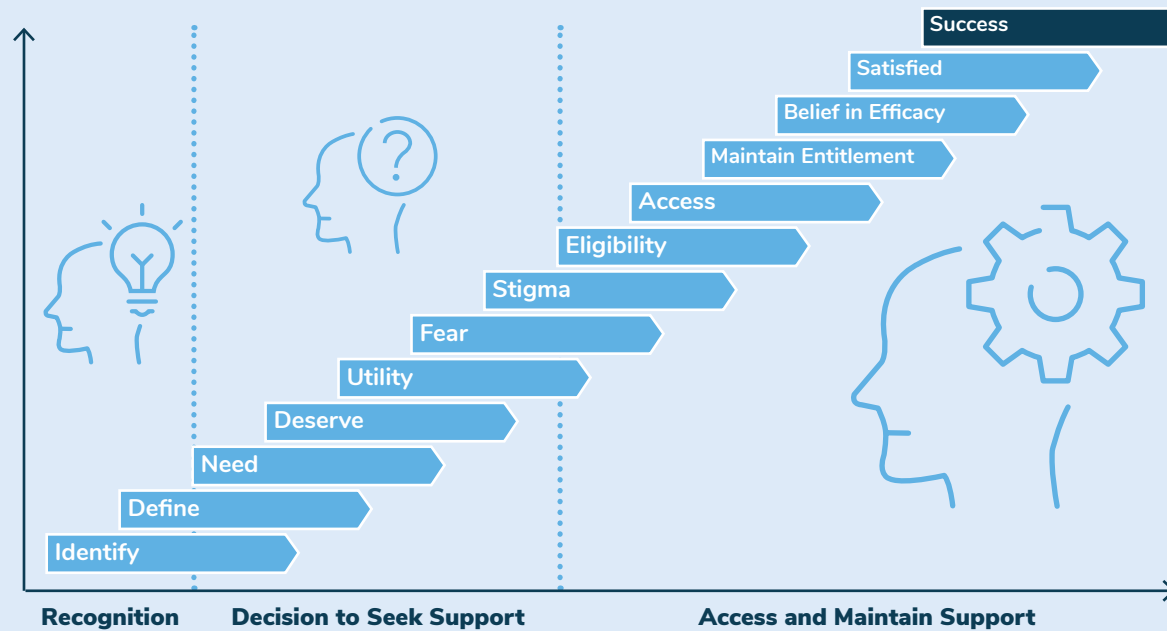
Perception of Mental Health Stigma in Selected Markets, 2019 Business Group on Health Survey



Source: Mental Health Benefits Around the World - Employer Programs and Challenges

Other barriers to getting or maintaining treatment include people not recognizing that they need assistance, not feeling deserving of help because things are not bad enough or not believing they can make changes. Steps along that journey are outlined on the following page.

Journey to Mental Health Support



Source: Neil Greenberg, M.D., King's College, London

Role of the Workplace

Unfortunately, despite many employers' efforts, the workplace remains the place where employees often feel least comfortable discussing their concerns.⁶ Companies have experienced somewhat of an evolution by implementing champions, utilizing testimonials and having leadership involved, but it takes significant dedication and commitment throughout the organization to make sustained change. It's important to recognize that investment in these types of programs is not only beneficial for employees, it is also good for company outcomes.

Nearly two out of three companies worldwide with effective health and productivity programmes in place believe their performance is better than their competitors.⁸ It is therefore in the interest of employers to ensure that employee health and wellness is treated as a priority item, leading to frameworks for action to develop mental health policies – from addressing prevention to early intervention.

It is often difficult for global employers in the corporate office to understand the nuances that take place at the local level. These nuances are particularly important for a sensitive topic like mental health, where misunderstandings and fears are abundant. Therefore, the country framework for issues like mental health cost, access, quality and stigma should allow for a “glocal” approach, or one in which there is a global strategy that is highly locally relevant.

Think Global: Strategies that Multinational Employers Use Worldwide

Local context is incredibly important when it comes to making sure mental health initiatives and strategy are effective at the country, city and site levels. That said, there are programs and resources that, when tweaked, can be effective in most locations.

Below are examples of tools and ideas that global employers are implementing in many geographies around the world. What's more, these efforts are receiving positive feedback from employees and HR partners. Some are targeted to key needs such as awareness, stigma, access or training.

Example Employer Programs



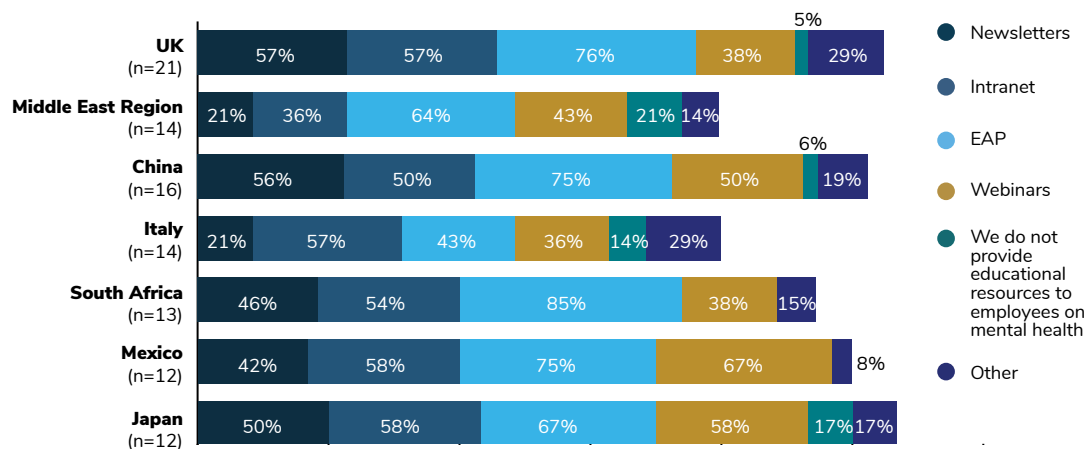
Awareness and Education

There is a lot of misinformation about how mental health conditions start, what causes them and how they are treated. These erroneous ideas range from mental health disorders being thought of as a weakness in some countries to being thought of as witchcraft in others.

Employers can play a significant role in educating the workforce by talking about the following, among other points:

- The various types of mental health conditions and the related signs and symptoms;
- How common mental health conditions are;
- The importance of being mindful about the language used in the workplace in regards to mental health;
- How mental health conditions are likely not caused by a single factor, but can be caused by genetics, life experiences, biological factors, traumatic brain injury, substance use, environment, social factors or other serious medical conditions;⁹
- How people with common mental health conditions are not any more dangerous than any other person and can recover with appropriate treatment and support, and
- The effect of stigma and discrimination on a person's willingness to seek treatment and the overall impact on an individual's mental and physical health.

Communication Channels Used in Selected Markets, 2019 Business Group on Health Survey



Note: Other responses included: Face-to-face seminars/workshops, booklets, using workplace social communication tools, TV screen advertising, associate on-boarding, on-site lecture, in-person mental health training for managers, bi-weekly communications to all managers and employees, on-site campaigns - "Time to talk" coffee events, World mental health day, we will call in experts to give sessions, and conferences.

Source: Mental Health Benefits Around the World - Employer Programs and Challenges



Addressing Stigma

Testimonials and Storytelling: One of the most effective ways to combat stigma is to have people share their stories.

- **Employees' sharing:** In many workplaces, particularly in countries like Canada, the U.K. and the U.S., employees are commonly the ones sharing.
- **Sharing public stories:** In others, where stigma might be even stronger still, employees may not yet be comfortable telling others about their mental health conditions, particularly in certain industries or sites. If that is the case, employers can still utilize existing, publicly available videos, stories or ads from national campaigns, celebrities or even elsewhere in the world (see sample resources below).
- **Executive sponsors:** Consider naming an executive sponsor of mental health. Visible leadership support can go far toward making positive change in an organization.

Remember that communications are always most powerful when they come from someone who "looks like me" or is "someone I want to be."

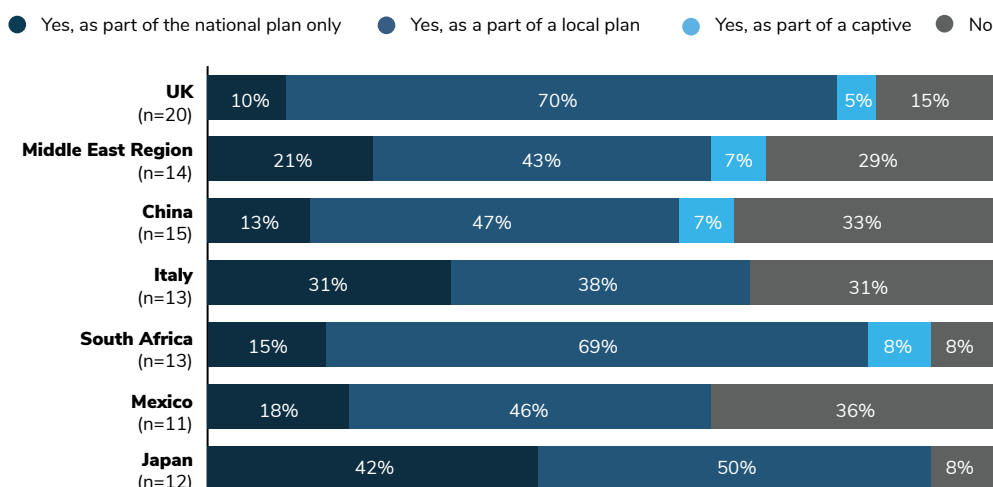


Providing Access

In many countries, there is relatively little convenient, safe and affordable access to mental health clinicians. Inpatient or psychiatrist visits may be covered for serious mental health disorders, and medications may be covered, but counseling is unheard of except for the very rich. Employers can bridge the access gap in a few ways:

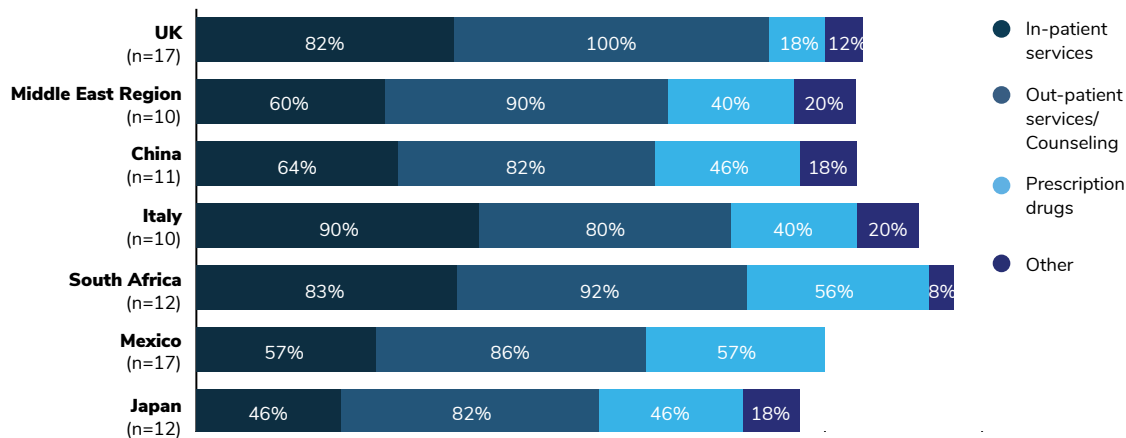
- Offering an employee assistance program (EAP) that is available to all global employees, has an adequate number of allowed visits and is highly promoted to drive utilization.
- Trained and supervised mental health peer mentors and early interveners.
- On-site clinicians (often facilitated through the EAP).
- Virtual therapies or digital solutions (through the health plan, EAP, or standalone).
- Review local health plans to add coverage for mental health where available. Companies often face challenges with local insurances due to limitations either with insurers or as a systemic exclusion in the country's industry. However, there are actions employers can consider:
 - Some countries have announced reforms where they are encouraging insurers to provide coverage for mental health needs. In these markets, companies can try to push the marketplace by having discussions with their local insurers to add the coverage to their plans.
 - Companies with a captive solution can work with their consultant to determine how coverage can be provided.
- Consider including mental health as a part of your company's minimum core benefits strategy.

Prevalence of Covered Mental Health Services by Selected Markets, 2019 Business Group on Health Survey



Source: Mental Health Benefits Around the World - Employer Programs and Challenges

If Yes (Covered Mental Health Services), what does the health plan cover?



Source: Mental Health Benefits Around the World - Employer Programs and Challenges



Peer/Manager Training

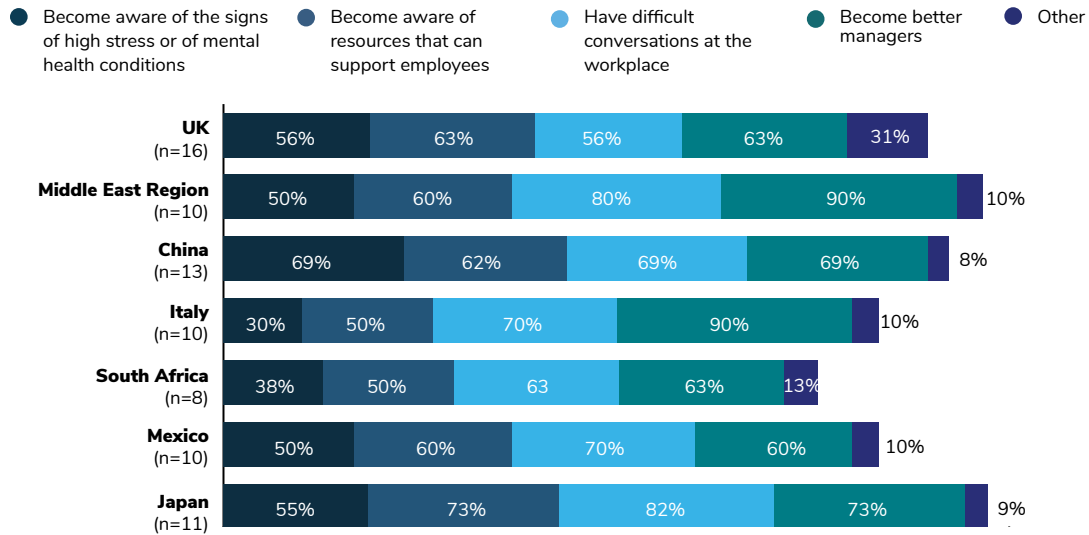
Peers and managers often report being concerned about the mental health of co-workers and supervisees, but they are unsure about how to start the conversation on this sensitive topic. Global employers are implementing various training programs to assist in starting this dialogue, build awareness of the resources available and promote utilization of services.

Considerations include:

- **Internally delivered vs. external vendor:** Some employers choose to develop training programs in-house, while others contract with vendors (including EAP, Mental Health First Aid, TRiM, StRaW, The Working Mind, etc.) or utilize existing NGO programs to train their workforce. This likely depends on available resources and comfort level, as well as the ability to customize by country as needed and understand the company culture.
- **Web-based on-demand vs. classroom-based:** Training can be done in-person in a classroom setting or remotely through the internet. Advantages of web-based training include greater economies of scale and the ability for employees to access it on their own time. Classroom training may be better used for champions, leaders or others who will be more intimately involved in mental health programs in the workplace.
- **Voluntary vs. mandatory:** While many employers are making mental health training voluntary for employees who choose to take it, there has been a push in some countries and companies for mandatory training, particularly among certain populations, like leadership.

Addressing mental health issues can be particularly difficult for managers who are hesitant to say anything that might run afoul of privacy laws or internal policies, so having clear direction to guide them and resources to point to can be extremely helpful.

Peer/Manager Training Offerings in Selected Markets, 2019 Business Group on Health Survey



Note: Other responded included: Understand the EAP role.

Source: Mental Health Benefits Around the World - Employer Programs and Challenges

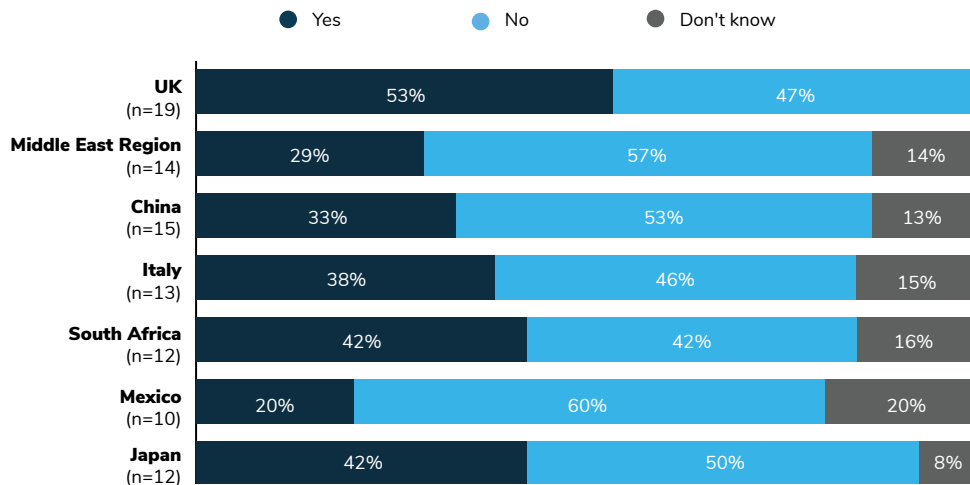


Workplace Champions

Similar to well-being champions, mental health champions typically volunteer to address stigma and misinformation about mental health issues, as well as spread the word about available benefits and programs at their worksite.

This can be done both informally, through sharing with peers, and formally, through workshops, webinars, World Mental Health Day campaigns and more.

Workplace Champion/Volunteer Offerings in Selected Markets, 2019 Business Group on Health Survey



Source: Mental Health Benefits Around the World - Employer Programs and Challenges

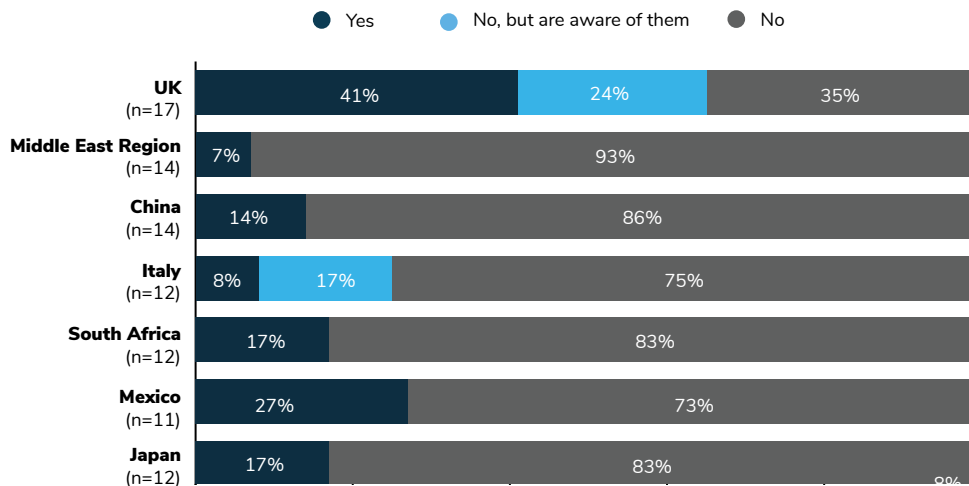
GlaxoSmithKline offers modular style e-learning in 13 languages to all its managers. The training includes videos from subject matter experts as well as interactive scenarios where managers can decide how they would respond during that incident. Topics include how to spot the signs of mental health conditions, how to open a dialogue on mental health, what resources are available for support and what to do if an employee becomes distressed. The training can be completed flexibly as a manager's schedule allows.



Leveraging National Campaigns

In many countries, there are already national campaigns and NGOs addressing mental health in the workplace. Some of these have training tools, employer pledges, testimonials and other resources available. Rather than starting from scratch, partnering with or utilizing tools from these organizations can give global employers head starts in a resource-constrained environment. It also allows the company to promote an already established brand and message – one employees may already be seeing in TV commercials, billboards or celebrity endorsements. The local nature of these programs ensures that company efforts are already culturally relevant and resonate with the local population.

Employers Reporting Partnerships with Local Campaigns or NGOs in Selected Markets, 2019 Business Group on Health Survey



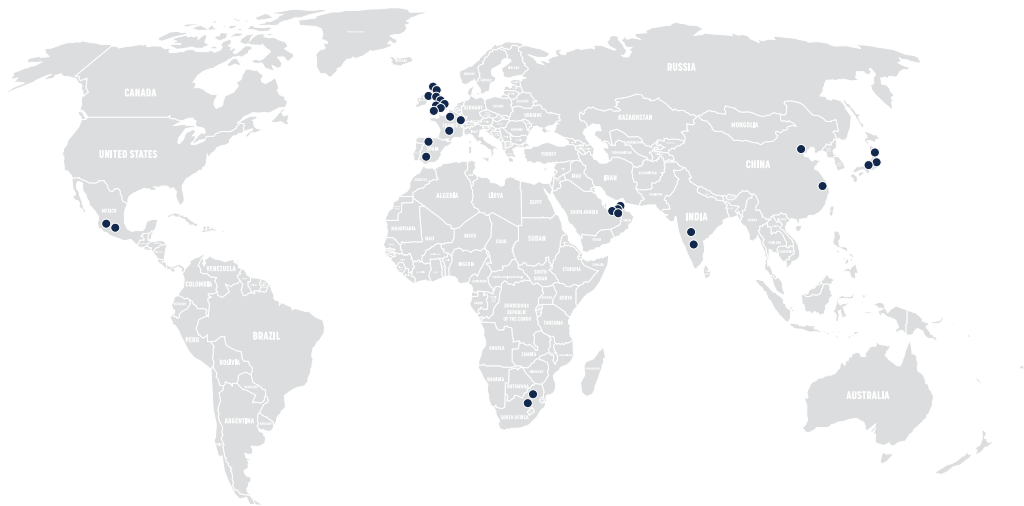
Note: Other responses included: UK - Time to Talk, NHS Taking Therapies - Berkshire service, mental health awareness week and world mental health day, and, Mind Workplace Well-being Index.

Source: [Mental Health Benefits Around the World - Employer Programs and Challenges](#)

12 Addressing Mental Health from a Global and Local Perspective: A Guide for Employers

This Guide should not be reproduced or quoted without permission from Business Group on Health. © 2020 Business Group on Health

Known NGO's Referenced in this Guide's In-Depth Countries



Improving Workplace Culture

It's no secret that in our 24/7 environment, people are working longer hours than ever. In some countries bullying and harassment are significant problems that contribute to mental health issues and suicide. Taking measures to train leaders to be more effective, to build a healthy workplace and to address negative behaviors may assist in preventing people from developing mental health conditions as well as supporting those who are already dealing with them.



Utilizing Relevant Legislation

Many countries in the European Union (EU), Asia and Latin America have legislation in place requiring that employers assess for psychosocial risk factors and/or address organizational risks. Examples include the EU's workplace- related stress regulations, Japan's stress test requirements and Mexico's new stress test checklist. These can be effective ways to lay the groundwork for an overall mental health strategy and to make the business case to leaders and managers that stress reduction and mental health are both important and essential in their locations. Many companies work with their occupational health teams to ensure that these requirements become an integral part of the company's mental health and well-being strategy.



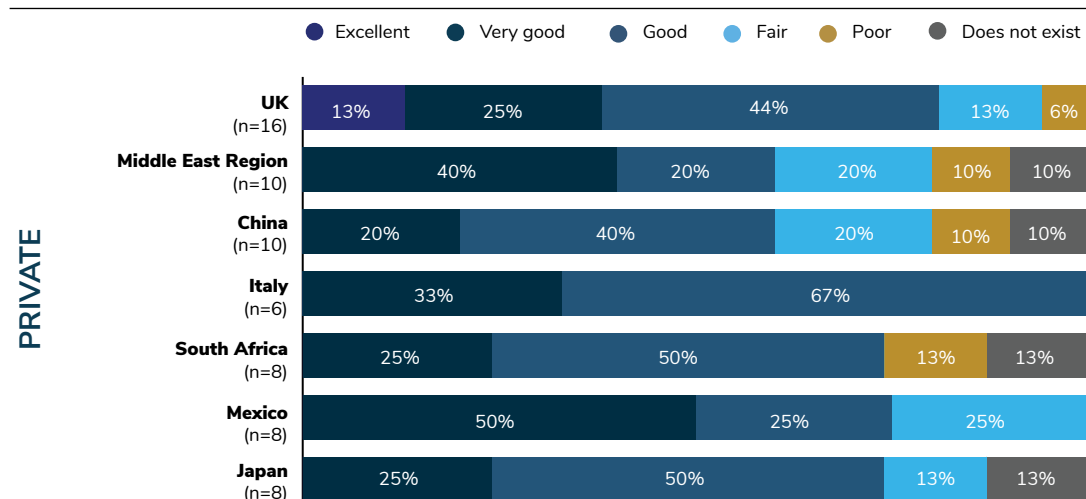
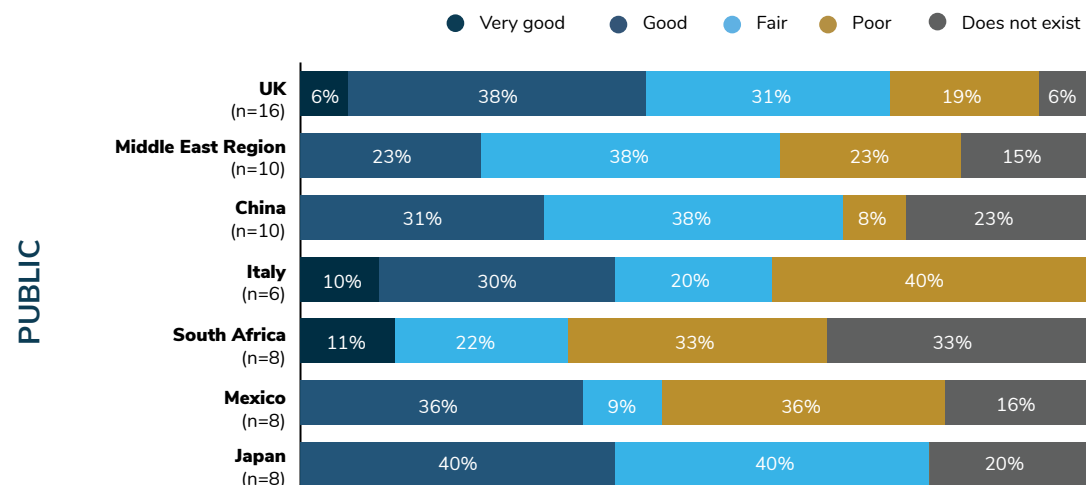
Measurement

Employers should be sure to assess the impact of their mental health programs on their global workforce's well-being as well as on their company's business outcomes. This means regularly assessing key performance indicators and calculating return- on- investment or value- on- investment scores. Putting in place mechanisms to measure performance can enable organizations to achieve desired program impact, improve adoption rates, and enhance decision-making.¹⁰ Potential measures include health care claims, disability rates, presenteeism, absenteeism, turnover, employee feedback, engagement, customer satisfaction and increased productivity in the form of greater revenue or decreased costs.



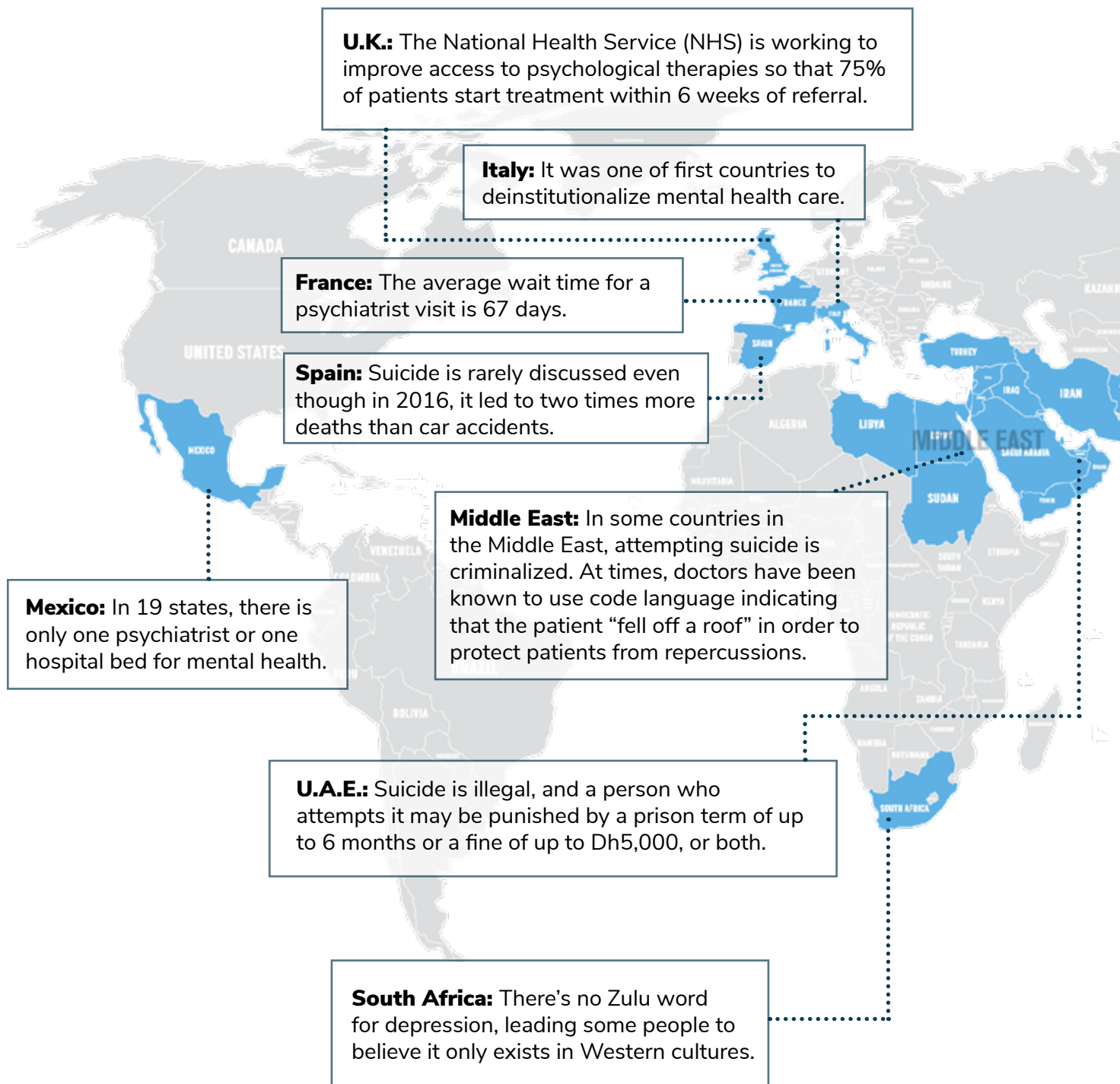
Act Local: How Access, Stigma and Coverage Vary in Key Markets, and Their Impact on Employer Offerings

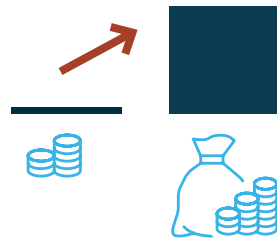
Employee Perceptions of Public and Private Mental Health Services in Selected Markets (per employer response), 2019 Business Group on Health Survey



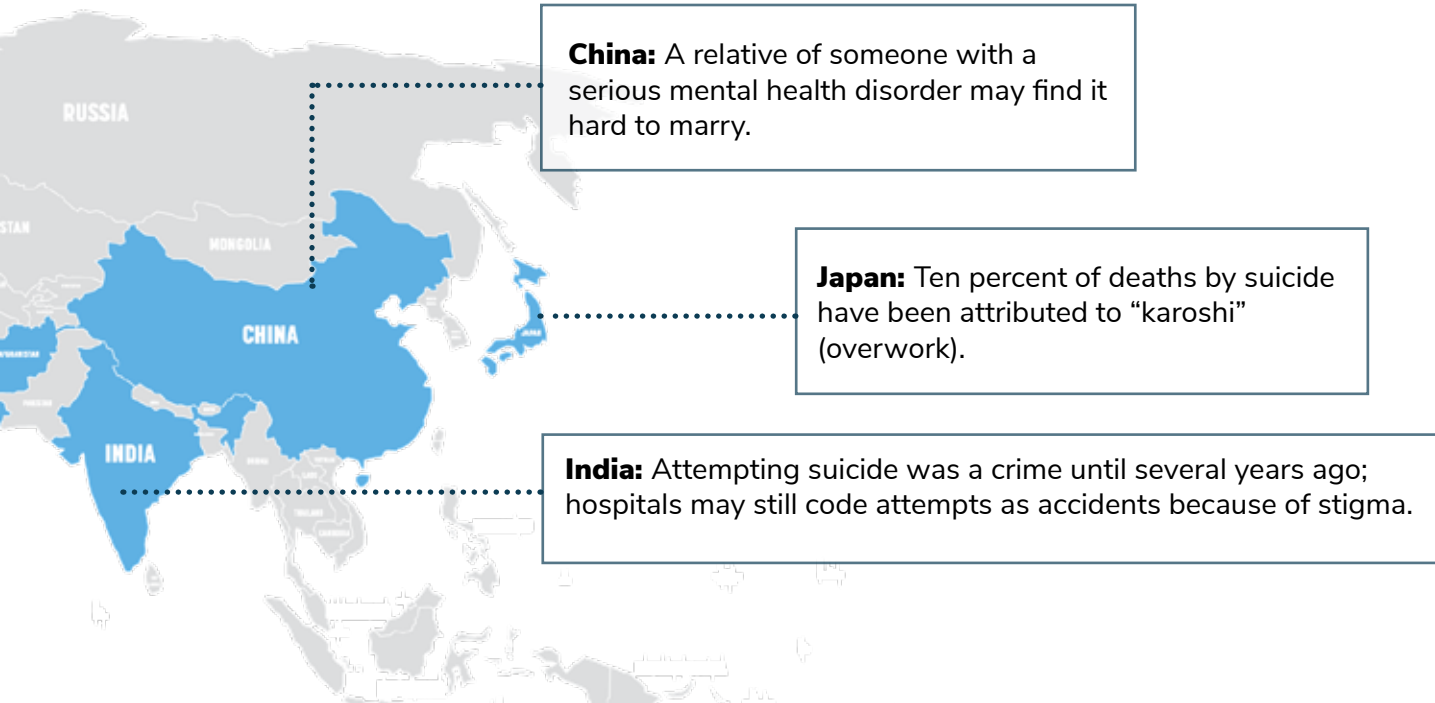
Source: Mental Health Benefits Around the World - Employer Programs and Challenges

The following information has been compiled from interviews with local experts as well as from publicly available sources. See the References section for more details.

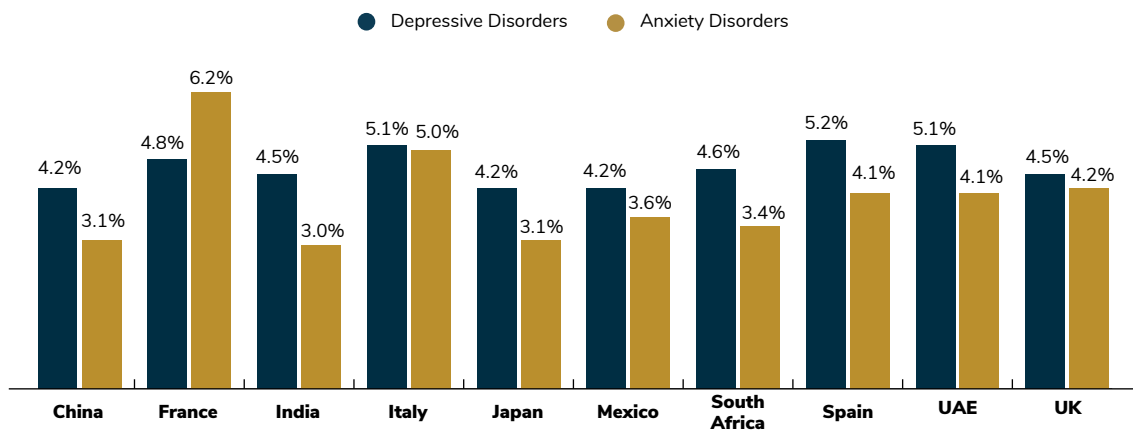




The treatment rate for serious mental disorders in **high-income countries** is about **17x** that of **low-income countries**.^{11,12}



Prevalence of Depressive and Anxiety Disorders in Selected Markets of Focus for Global Employers



Source: Depression and Other Common Mental Disorders: Global Health Estimates. Geneva: World Health Organization; 2017.



China

There is a severe shortage of mental health professionals in China. A look at the numbers:

- **4x** : Concentration of psychiatrists is four times lower than the global average.
- **100 patients:** Anecdotal reports say that psychiatrists see up to 100 patients per day; they use assistants to write prescriptions while they move quickly from person to person, spending little time with a minimal amount of privacy.¹⁴
- **Regional impacts:** Resources in the country are uneven. In general, the eastern and central regions are more developed and account for 40%-50% of all medical care in the country. The western regions of the country lack sufficient health care,¹⁵ including mental health treatment. Huge needs in the treatment of the mentally ill have led to an increase of unregistered and inadequately trained psychologists who are unable to provide proper diagnosis and treatment to the patients.¹⁶ As a result, an estimated 90% of people with mental health disorders have never sought treatment,¹⁷ and some do get worse instead of better.¹⁶

Stigma

Stigma surrounding mental health conditions is extremely high in China. For some, this stigma creates fear of getting help even when treatment is available.¹⁴

- Some think that people with psychiatric conditions are possessed by evil spirits.
- Many see mental disorders as a sign of weakness.¹⁸
- Many regard them as socially contagious:¹⁸

Snapshot of the Health System Landscape¹³



Mental hospital beds:
24.29 per 100,000
population



Total mental health workers:
8.75 per 100,000
population



National health insurance or reimbursement scheme includes the care and treatment of persons with major mental disorders (defined as psychosis, bipolar disorder, depression)



No government-adopted or national policy for suicide prevention strategy

- A relative of someone with a serious disorder may find it hard to marry.¹⁸
- “Even many medical students worry that those working with psychiatric patients risk catching their disease,” says Xu Ni of It Gets Brighter, a mental-health NGO in Beijing.¹⁸
- The government has put some policies and programs in place to address mental health issues in recent years.¹⁹
 - Legislation: First mental health law in 2013.¹³
 - Law only allows hospitalization against an individual’s will if that person is a danger to themselves or others.¹⁹

Access and Treatment

Insurance: Public insurance does cover mental health treatment, including diagnosis, treatment and rehabilitation, in hospitals. Persons with less severe mental health conditions are treated in the community, although mental health is not integrated with primary care. Both outpatient and inpatient mental health services are covered by insurance, with benefits subject to lower copayment rates. In 2014, there were 34 million mental health patient visits to special psychiatric hospitals, and on average, one psychiatrist treated 4.8 patients per day.²⁰

EAP: Employee assistance program (EAP) providers say that throughout much of Asia, overwork and work stress are top presenting concerns among clients.²¹ The term for “death by overwork” in China is *guolaosi*.²¹ Approximately 1,600 deaths per day are attributed to overwork.²²

Perhaps as a result of occupational stress and long hours, work/life issues, burnout, sleep and conflict resolution are popular topics among EAP providers in the Asia Pacific region.²¹

Recommendations for Employers in China

- Create a culture of well-being by addressing psychosocial risks like extremely long working hours and occupational stress. Work with managers to identify these risks and develop solutions that mitigate them.
- Use burnout, stress, parenting, conflict resolution and similar topics as entry points for a mental health strategy/employee assistance program. These topics might be more familiar, relevant and less threatening to a Chinese workforce.
- At the same time, don’t be afraid to mention terms like mental health or depression. Not doing so can reinforce stigma. The workplace has an important role to play in educating employees on what mental health conditions are and what they aren’t.
- Understand the importance of “saving face” and social/business connections in Chinese culture and how these concerns might impact the willingness of employees

to speak publicly or even privately about their need for mental health services or other resources.

- Consider educating family members. Research shows that employees in China may be more likely to discuss their problems with relatives than professionals, so education that reaches them will likely have a high impact.²³
- Implement an employee assistance program if it doesn't currently exist and promote/reinforce EAP if it does. While many employers believe that EAP doesn't work in Asian countries, employers who have been successful there say that with familiarity and communication, utilization can be greatly increased.
- Review your health plans for coverage of mental health conditions and discuss with local staff and brokers how well the coverage actually works for employees who attempt to access services.

For more information about how global employers are offering well-being programs and which vendors are commonly used in China, see [Benefits and Well-being Benchmarking Survey Results: China](#).

NGOs/National Campaigns in China

Note: These resources are provided for informational purposes only. This list should not be considered complete or represent any organizational recommendation.

Lifeline Shanghai
CandleX



“Corporations may offer ‘emotional resilience’ training, but rarely are mental health or the symptoms of depression or anxiety mentioned, for fear that employees may feel ashamed. In fact, a few years ago, one company the author spoke to about conducting training for employees insisted on changing the title of the workshop to ‘stress management’ and not to mention ‘mental health’ at all in order to avoid embarrassment!

These concerns, while valid, are perhaps exaggerated, and attitudes are slowly shifting. In our recent experience of delivering mental health training and workshops to organisations in China, the reality on the ground is different. We are met with curiosity and a desire to understand mental health beyond what one needs to do simply to ‘stay well!’”

Erla Magnúsdóttir, Special Advisor to Bearapy and founder and country head of BasicNeeds China, an international NGO for mental health in developing countries.²³



France

Funding

Over three-fourths of total health expenditure in France is publicly funded, primarily through social health insurance (SHI).²⁴

- SHI covers all legal residents and is financed by income-based contributions from employers and taxpayers.²⁴
- SHI partially covers mental health care, including visits with general practitioners and psychiatrists.²⁴
- Voluntary health insurance (VHI) covers copays and additional costs that aren't covered by SHI, including psychotherapy and counseling.²⁴

Snapshot of the Health System Landscape¹³



Mental hospital beds:
6.98 per 100,000
population

**General hospital
psychiatric unit beds:**
22.34 per 100,000
population



**Total mental health
workers:**
173.63 per 100,000
population



**Government mental
health spend as % of total
health spend**



The **majority** of persons
**pay nothing (fully
insured)** for mental health
services at the point of
service.



National health insurance
or reimbursement scheme
includes the care and
treatment of persons
with major mental
disorders (defined as
psychosis, bipolar disorder,
depression)*



Government-adopted or
national policy for suicide
prevention strategy

*According to data submitted to the World Health Organization (2017)

Access and Treatment

The mental health care system in France is overburdened and supply has not kept up with demand. Around the end of the last century, the French government closed many psychiatric hospitals without providing for sufficient community care. Cost and wait times also limit access. There are limited telemental health services available that aren't widely utilized yet but are growing.²⁵

Challenges in the system include:

- **Need for services:** Demand is “exploding,” with 2 million consultations per year and an additional 300,000 patients in the last decade.²⁶
- **Financing:** Therapies for certain conditions are reimbursed at a low rate, making treatment too expensive for many families.
- **Long wait times:** The average wait time for a psychiatrist visit is 67 days (21 in general psychiatry and 116 in child and youth psychiatry),²⁶ but psychiatrists report that at times people have to wait up to a year for appointments, leading to late diagnosis and impacting a person's chances of recovery.²⁷
- **High suicide rates:** These are relatively high compared to the rest of the world (17th highest as of 2019).²⁸

In January 2019, 100 French psychiatrists sent a letter to the French health ministry expressing serious concerns over the amount of funding and resources available for mental health services in the country.²⁷ Also in that month, the French health minister Agnès Buzyn promised an additional €40 million to improve mental health and psychiatric services after 300 nurses, doctors and relatives of mental health patients protested for two days in Paris. The additional money was meant for mental health training, suicide prevention and services for children.²⁹

Stigma

EAP providers report that compared to other nearby countries like Spain and Italy, the program – and mental health in general – is more widely recognized and familiar. It's common to hear national campaigns about mental health awareness or suicide prevention on the radio or television, for example. There is less concern about confidentiality than in some other locations, and mental health disorders and suicide, although still stigmatized, aren't quite as taboo comparatively.²⁵

Recommendations for Employers in France

- Put a suicide prevention plan in place and directly address the topic at workplace trainings and in materials. Provide crisis line numbers and resources, like on-site clinicians, for employees at risk.
- Ensure that EAP services are available for employees and dependents who need community-based mental health care that may not be readily available in certain locations. Also, consider offering telemental health care or on-site therapy in places where demand may outpace supply.
- Leverage the psychosocial risk stress law in order to get programs in place that may address mental health issues and stress.
- Utilize existing national campaigns and promotions in the workplace.

“

“1 out of 3 French would be embarrassed to share a meal or work next to a person suffering from psychiatric disorders, and 75% consider that psychiatric patients are dangerous for themselves or for others.”

Laure Millet, Healthcare Policy Officer, Institut Montaigne

NGOs/National Campaigns in France

Note: These resources are provided for informational purposes only. This list should not be considered complete or represent any organizational recommendation.

Psycom
Fondation de France
Santé Mentale France





India

Snapshot of the Health System Landscape¹³

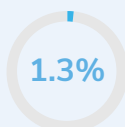


Mental hospital beds:
1.43 per 100,000
population

**General hospital
psychiatric unit beds:**
.56 per 100,000
population



**Total mental health
workers:**
1.93 per 100,000
population



**Government mental
health spend as % of total
health spend**



The **majority** of persons
pay mostly or entirely out
of pocket for services and
medicines.



25% of the inpatient
population stays for 1-5
years. Over one-fourth are
involuntarily committed.



National health insurance
or reimbursement scheme
includes the care and
treatment of persons
with major mental
disorders (defined as
psychosis, bipolar disorder,
depression).*



No government-adopted
or national policy for
suicide prevention strategy

*According to data submitted to the World Health Organization (2017)



“The impression [in India] is that those who are strong cannot weep; they do not feel sad. Only weak people can report feeling sad.”

Dr. Ashwani Kumar, Director and Psychiatrist at Santulan

Stigma

Stigma against mental health conditions is high in India. Examples include:

- Suicide and mental health conditions are still viewed by many as a sign of weakness or a symptom of a disease.³¹
- Attempting suicide was still a crime until several years ago, when the parliament proposed a law to decriminalize most attempts. Now, the government is mandated to provide care and treatment to individuals attempting suicide due to extreme stress or mental health disorders.³²
 - Still, many hospitals underreport suicides and code them as accidents.

While stigma is still a major barrier to treatment, it has been decreasing among certain populations, particularly millennials and those who are more educated. Professional bodies, NGOs and national campaigns are making significant efforts to educate the public about mental health disorders, explaining that they are conditions that can be treated instead of an inherent flaw. Psychologists in many universities and schools have become compulsory, and most young people think it's acceptable to talk to a clinician or your friend about the problems you're facing. However, there are still huge gaps between the onset of mental disorders and when people actually get treatment.³¹

“

A huge treatment gap exists for common mental disorders, the highest being 86.3% for alcohol use disorders. Treatment gaps for major depression and neurosis were identified to be 85.2% and 83.2%, respectively. Among the various factors thought to have an impact on treatment gap, affordability of care was identified as one critical factor influencing treatment utilization.

Bijal AS, Kumar CN, Manjunatha N, Gowda M, Basavaraju V, Math SB, *Indian Journal of Psychiatry*³⁰

Access and Treatment

EAP and on-site services: EAPs are widespread among employers in India, but according to providers, utilization rates for counseling services tend to be fairly low, somewhere around 2%.

- Utilization for other services, such as educational materials, stress reduction programs, manager trainings and health check questionnaires, is higher.

- Another trend that has helped drive utilization is on-site counseling. This has been particularly popular among younger employees who have experience seeing a counselor at their educational institutions, as well as at 24/7 shift companies, where people can't get away for appointments during typical work hours.³¹

Insurance: Cost is a major factor in undertreatment. Data shows that the prevalence of mental health conditions is higher in lower-income households, where the median out-of-pocket expenditures per month are INR 1000–1500.³⁰

- Traditionally, mental health conditions haven't been covered by health insurance.
- As part of the Mental Healthcare Act (2017), insurance companies have been advised to find ways to include coverage for people with mental health disorders "equal to physical illnesses" in their insurance offerings.^{30,31}
 - This still means that only inpatient care may be included in insurance coverage, as currently all outpatient care is excluded from insurance plans, but if an insurer carves out physical illnesses, the company may carve out mental health illnesses as well.
 - The jury is still out about how the law is being interpreted, the cost impact and how the insurance landscape may change.³³



“There is a growing burden of mental health disorders in India; however, the existing mental health professionals can provide for only 29% of the needs, leading to a treatment gap of 70%. One of the solutions to overcome this supply side barrier is the use of information and communication technology such as Tele-Psychiatry to deliver some healthcare tasks via video-conferencing.”

Centre for Global Mental Health

Recommendations for Employers in India

- Leverage existing celebrity interviews and NGO campaigns to get the word out in the workplace.
- Leverage policy by following up with current and potential insurer(s) about how they plan to cover mental health conditions in the future given the recent Insurance Regulatory and Development Authority (IRDA) direction.

- Consider offering an on-site counselor(s) and/or digital health solutions, particularly in areas where there are access issues, long commutes and/or employees who work long hours and cannot get away during the traditional workday.
- Engage leaders to help promote the importance of positive mental health and how using employer-sponsored resources can help. This approach may address the stigma that still often comes along with mental health conditions in India.

For more information about how global employers are offering well-being programs and which vendors are commonly used in India, see [Benefits and Well-being Benchmarking Survey Results: India](#).

NGOs/National Campaigns in India

Note: These resources are provided for informational purposes only. This list should not be considered complete or represent any organizational recommendation.

The Live Love Laugh Foundation
Arogya World

Italy

Access and Treatment

The National Health Service provides all health care free of charge to Italian citizens.³⁴

- Italy was among the first countries to deinstitutionalize mental health care and has a relatively low number of psychiatric beds for its population compared to similar nations.³⁵
- Care is provided by the National Health Service in the community. There are no specific psychiatric hospitals in the country.^{36,37}
- Multidisciplinary teams of psychiatrists, psychologists, nurses, social workers, educators and occupational therapists within local health units coordinate prevention, care and rehabilitation efforts.

Snapshot of the Health System Landscape¹³



Mental hospital beds:
8.96 per 100,000
population



**Government mental
health spend as % of total
health spend**



National health insurance
or reimbursement scheme
includes the care and
treatment of persons
with major mental
disorders (defined as
psychosis, bipolar disorder,
depression).*



**Total mental health
workers:**
55.72 per 100,000
population



The **majority** of persons
**pay nothing (fully
insured)** for mental health
services at the point of
service.



Government-adopted or
national policy for suicide
prevention strategy

*According to data submitted to the World Health Organization (2017)

- Generally mental health care is not part of primary care except in a few regions of the country, where primary care doctors have treated uncomplicated cases of milder mental health conditions.³⁷
- Because the provision of mental health care takes place at the regional and local levels, there are marked differences in access and quality across the country.³⁸

Stigma

Studies show that most of the barriers to treatment come from the demand side and are specifically related to attitudinal factors, such as negative health beliefs, fear about adverse effects of treatment and fear of stigma.³⁸ The Italian government has made concerted efforts to fight the stigma that often comes with mental health conditions through national, regional and local campaigns.³⁴ Still, many people are reluctant to use a counseling service or talk to a psychiatrist.²⁵ Another significant barrier is related to low perceived need for services, at least among those with less severe conditions.³⁸

Religion is an important part of the lives of many Italians, and religious advisors are consulted more often for mental health conditions than they may be in similar countries. “The use of religious advisors indicates both the preeminent role of religion in Italy and a certain reluctance to label one’s issues as mental problems.”³⁸



“For the eighth consecutive year, NHS funding has remained unchanged, which in the face of rising costs leads to an effective reduction of about 15%. A survey led by the Italian Society of Psychiatry found that in the past decade staff allocated to community services faced a reduction of about 50%, with a rate of professionals per 1500 inhabitants going down from 0.8 to 0.4. In many regions, mental health funds have fallen far below the minimum threshold of 5%, in some cases reaching at comparable rates to developing countries.

At the same time, the spectre of needs expanded and diversified, under the combined effect of greater psychosocial vulnerability (e.g., second-generation migrants, the growing population of poor people in the cities, the effect of early use of substances) and the availability of costly technical interventions that are credited with scientific evidence (e.g., psychotherapies in personality disorders, behavioural therapy in autism...). These are problems that afflict all contemporary societies, but that in Italy more than elsewhere seem to creak the plant that 40 years ago was set up with the NHS and with DI [deinstitutionalization] in psychiatry.”

Fioritti A, 2018, in Epidemiology and Psychiatric Sciences

Recommendations for Employers in Italy

- Make the case for EAP to local HR by selling improvements to productivity, manager training and helping employees work more efficiently instead of pushing only for a mental health benefit, particularly in Spain and Italy.
- Utilize EAP services for HR/ manager training on how to identify signs of stress, mental health conditions, low motivation, difficult workers, and other concerns and then make referrals.
- Address mental health stigma through a variety of campaigns that may include testimonials if employees are willing to share. Consider partnering with faith leaders to discuss the importance of positive mental health.
- Emphasize the confidential nature of mental health services, particularly those that are employer sponsored.
- Increase familiarity with mental health/EAP treatment providers by bringing them on site or using training hours for lunch and learns and/or webinars.



Japan

Stigma

Mental health conditions are still very stigmatized in Japan. Those with mental health disorders are often thought of as “sick.”

- In multinational companies, the topic is more commonly discussed, and trainings on the topic are frequently provided.
- The government and NGOs are making efforts to promote mental health awareness.

Snapshot of the Health System Landscape¹³

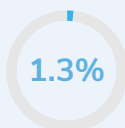


Mental hospital beds:
196.63 per 100,000
population

**General hospital
psychiatric unit beds:**
66.15 per 100,000
population



**Total mental health
workers:**
146.19 per 100,000
population



**Government mental
health spend as % of total
health spend**



The **majority** of persons
pay at least 20% toward
the cost of mental health
services / psychotropic
medicine.



12% of the inpatient
population stays for more
than a year.



National health insurance
or reimbursement scheme
includes the care and
treatment of persons
with major mental
disorders (defined as
psychosis, bipolar disorder,
depression).*



Government-adopted or
national policy for suicide
prevention strategy

*According to data submitted to the World Health Organization (2017)

- In urban areas, there are advertisements in trains, hotlines available and campaigns that take place, but in rural or less populated areas, there are fewer resources and less familiarity with mental health disorders in general.
- The government is also promoting the dangers of poor mental health in the workplace, particularly since suicide is a significant problem among the working population.^{39,40}
 - Japan ranks third among OECD countries for deaths by suicide, and 10% of these have been attributed to work-related factors, one of which is *karoshi*, the Japanese word for death by overwork.⁴⁰

Organizational and Individual Stress

An annual “stress check” was implemented in Japan in 2015 for companies with more than 50 employees.^{39,40} Questions include an assessment of one’s own stress level as well as items about support from managers, evaluations from HR, trust of the company and more.³⁹ It isn’t mandatory that employees complete the Stress Check, but they are encouraged to do so to increase awareness about their own mental health state and promote self-care. Employees receive their results immediately. The company doctor can review individual results and encourage highly stressed employees to receive a medical consultation. If necessary, the company doctor will coordinate with human resources so that working conditions can be improved, or may refer to EAP for problems outside of the workplace.³⁹

The stress check also includes an organizational assessment, which compares the company’s stress level to the national average.

- Local experts say that most multinationals who have EAPs score better than the national average, likely because they are already being proactive and working to improve health and well-being throughout the company.
- Companies can compare their current year score to those from the last 3 years to see if organizational change has impacted the results.
- After the organizational assessment is completed, as well as any other employee/satisfaction surveys, employers take stock of where they need to make changes, often in tandem with their hygiene committee.
 - For example, there may be seminars related to sleep, exercise, or self-care, as well as training for managers.
- Assessment results can be broken down by division, so that individual interventions and feedback can be personalized to a certain extent. Overall, experts say that effective implementation of the changes really depends on the organization.³⁹
- Harassment in particular has been a hot topic in Japan, as employees feel pressured to work long hours.
 - Legislation that mandates that employers take strict action and preventive measures against workplace harassment was passed earlier this year and will go into effect in April 2020 for large companies.⁴¹



“The traditional Japanese virtue is to stand up to adversity. Unlike in U.S., therefore, accepting counseling as treatment is not common practice. Medical experts say that care is instead skewed toward over-medication with anti-depressants. Furthermore, once admitted into hospital for mental health disorders, patients are often kept in longer than elsewhere, exacerbating worries about missing work. The health services need urgently to address these concerns.”

Nobuko Kobayash, partner with A.T. Kearney, courtesy of Nikkei Asian Review⁴⁰

Access and Treatment

Virtual tools and on-site counselors are becoming more common among global employers, but access to mental health treatment outside of EAP is a challenge in Japan. Psychotherapy and counseling are not covered by medical insurance. People can pay out of pocket, but it is expensive. Psychological tests and therapies, pharmaceuticals and rehabilitative activities are covered with 30% coinsurance.⁴² Most people seeking therapy would hesitate to go to mental health clinics by themselves because of stigma, so finding a provider to refer to individuals who need longer-term care can be difficult. Common reasons for accessing EAP are work-related issues/overwork and workplace harassment.³⁹



A 2019 government report found that “a third of about 1,000 women who received treatment for mental health disorders over a seven-year period attributed their ill health to sexual harassment, assault, bullying or the abuse of power by superiors at work.

A “unique characteristic” of the Japanese workplace is the tendency by senior members of staff to shout at lower-ranked employees, just as they were shouted at by their superiors in the past. They may consider it to be merely delivering instructions, Naito said, but elsewhere it would be classified as verbal abuse and younger workers are upset or offended by this approach.”

Julian Ryall, This Week in Asia⁴³

Recommendations for Employers in Japan

- Leverage the workplace stress check in order to understand how the organization is changing over time and where additional changes could be made.
- Experts say that mindfulness often works well as an entry point in Japan. This can be the start of a larger mental health strategy.
- Utilize EAP and/or on-site counselors to increase access in a country where therapy is expensive and not covered by insurance, and where employees work long hours and may have difficulty getting away during the workday.
- There is upcoming legislation that limits overtime. Utilize this to change the workplace culture surrounding harassment, bullying and overwork.

For more information about how global employers are offering well-being programs and which vendors are commonly used in Japan, see [Benefits and Well-being Benchmarking Survey Results: Japan](#).

NGOs/National Campaigns in Japan

Note: These resources are provided for informational purposes only. This list should not be considered complete or represent any organizational recommendation.

[Befrienders](#)

[TELL Lifeline](#)

[Japanese Association of Mental Health Services](#)

Mexico

Access and Treatment

Like many other countries, Mexico's mental health system is overburdened. Consider the following:

- Only 2% of Mexico's health budget is spent on mental health, and 88% of that goes to psychiatric hospitals, which have been said to have a recent history of neglect and abuse.^{44,45}
- Only about one in five Mexicans who need mental health treatment receive it, and the time it takes to get care typically ranges from about 4 to 20 years.⁴⁶
- Access to care is significantly worse in rural areas than it is in cities. There are very few clinics or mental health professionals in these areas, and people living in poverty may not even know what a psychologist is.^{46,47}

Snapshot of the Health System Landscape¹³



Mental hospital beds:
3.06 per 100,000
population

**General hospital
psychiatric unit beds:**
0.03 per 100,000
population



**Total mental health
workers:**
4.40 per 100,000
population



The **majority** of persons
pay at least 20% toward
the cost of mental health
services / psychotropic
medicine.



15% of the inpatient
population stays for more
than a year.



National health insurance
or reimbursement scheme
includes the care and
treatment of persons
with major mental
disorders (defined as
psychosis, bipolar disorder,
depression).*



No government-adopted
or national policy for
suicide prevention strategy

*According to data submitted to the World Health Organization (2017)

- There are 19 states in Mexico where there is only one psychiatrist or one bed in a hospital for mental health.^{46,47}
- Generally, health insurance companies in Mexico do not cover mental health, except when it is related to trauma.^{46,47}
 - People must either go to the national health service or private facilities. The cost can range from 300-1500 pesos for private facilities. Services in government facilities are free but the wait can range from 3 to 7 months.⁴⁷

While EAP usage has been generally low for day-to-day issues,⁴⁶ mental health experts in Mexico say that they have seen greatly increased utilization in the last year and a half. Frequent presenting issues include family concerns, depression and violence, with mental health and legal/financial problems making up the two largest categories of usage.⁴⁷ Suicide rates have been rising, particularly in areas that see a lot of conflict.^{47,48} Historically, people have been reluctant to go to clinical providers because of stigma and discrimination, particularly due to the strong religious nature of the country,⁴⁶ but now more people are open to going to psychiatrists and psychologists. Still, the cost is too high and the supply is too low.⁴⁷ Employers who have brought in on-site providers have seen success in increasing utilization and access to care.⁴⁶

Organizational Stress

In regards to employees, in recent years, the Mexican government has made a concerted effort to assist those who are dealing with mental health conditions and significant stress in the workplace by implementing the Mexican Standard Norm NOM-035-STPS-2018, *Psychosocial risk factors at work - Identification, analysis and prevention*.⁴⁹

According to lawyers from Baker McKenzie, “compliance with the Official Standard Norm is mandatory for all workplaces within Mexican territory. However, its implementation depends on the number of employees at each workplace. The following are the most relevant employer obligations arising from the NOM:

- Implementation and diffusion of a psychosocial risk prevention policy considering the prevention of the above-mentioned factors, prevention of violence at work and the promotion of a favorable organizational environment at the workplace.
- Development of a mechanism that allows employees to raise complaints against practices that oppose a favorable organizational environment and to report acts of violence at the work centers.
- Identification of employees who suffered any type of traumatic events for work-related reasons, ensuring that they can be taken care of by the medical personnel of the workplace or by a social security or private institution.
- Conduct medical and psychological evaluations of employees who experienced violence at the work centers and/or have psychosocial risk factors.”⁴⁹

This act requires that employers identify psychosocial risk factors in the workplace, defined as “factors that can cause anxiety disorders, nonorganic sleep-wake cycles, and severe and adaptive stress derived from the nature of job functions, the type of workday, and/or exposure to severe traumatic events, including acts of labor violence, to the employee for the work carried out.”⁵⁰

“

There are a number of work-related and social issues at play for our workforce in Mexico that can lead to mental health conditions: stress because of potential closures, a poor economy, violence and long working hours.

A global employer

Recommendations for Employers in Mexico

- Leverage the new psychosocial risk mandate to drive positive change instead of just “checking the box.”
- Since EAP is often one of the only real access points for employees, ensure that it stays top of mind by constantly communicating the various ways in which it can be used for mental health counseling, manager training, work/life issues, etc. People generally only respond to “just in time” communications.
- Ensure that employees are aware that anything they say to an EAP provider is confidential and will not be shared with their employer.
- Work with managers and leadership to address the high levels of workplace stress that may contribute to mental health conditions. Also understand how other social determinants of health, such as violence, finances and grief, may be impacting the well-being of the workforce.^{47,51}

For more information about how global employers are offering well-being programs and which vendors are commonly used in Mexico, see [Benefits and Well-being Benchmarking Survey Results: Mexico](#).

NGOs/National Campaigns in Mexico

Note: These resources are provided for informational purposes only. This list should not be considered complete or represent any organizational recommendation.

International Medical Corps
Vive Con Vida



South Africa

Access and Treatment

About 75% of South Africans with mental health disorders go untreated.⁵² Like many countries in Africa, public infrastructure has been crumbling under the weight of the demand for health care, especially because of the impact of HIV; this has been true of the mental health care system as well.

- There are about 13,000 mental health therapists in South Africa (2.75 per 100,000 population), and 90% of those are serving the 37 million people who live in urban areas.

Snapshot of the Health System Landscape¹³

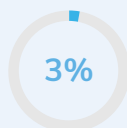


Mental hospital beds:
16.56 per 100,000
population

**General hospital
psychiatric unit beds:**
4.33 per 100,000
population



**Total mental health
workers:**
146.19 per 100,000
population



**Government mental
health spend as % of total
health spend**



Persons **pay nothing** (fully
insured) for mental health
services at the point of
service use.



12% of the inpatient
population stays for more
than a year.



National health insurance
or reimbursement scheme
includes the care and
treatment of persons
with major mental
disorders (defined as
psychosis, bipolar disorder,
depression).*



No government-adopted
or national policy for
suicide prevention
strategy.

*According to data submitted to the World Health Organization (2017)

- In the rural areas, there are only about 7 psychiatrists serving 18 million people.⁵³
- Researchers estimate that only 0.89% and 7.35% of the uninsured population of South Africa requiring care receives some form of public inpatient and outpatient treatment, respectively, leading to a treatment gap of 92%.⁵⁴
- Experts report that at times, family members say they have called the police on family members in order to get them access to inpatient treatment.⁵⁵

EAP: South Africa has a fairly mature EAP industry.

- It began in the 1960s in the mining sector due to concerns about safety and substance abuse.
- The government has historically relied on EAP to provide services to South Africans who are employed by corporations or non-governmental organizations.
- According to EAP providers in the country, utilization is about 5-20%, with major presenting issues including anxiety and stress, financial problems and trauma. Substance abuse is also on the rise.
- Higher EAP utilization is in companies where there is support from senior management.

A unique use of EAP in South Africa relates to the high prevalence of HIV/AIDS. Some vendors offer voluntary on-site screening services as part of the EAP offering in the workplace, as well as ongoing support or disease management programs for medication treatment. Critical incident support is often included in core EAP offerings instead of as an add-on because of the high rate of crime in the country, particularly business-related crime. Having it as a core offering means getting a practitioner on-site as quickly as possible in the event of an emergency, a practice that leads to better therapeutic outcomes. Virtual counseling is available through EAP providers but utilization has been very low, likely because of bandwidth and technology issues.¹¹

Insurance: Voluntary private health insurance, known as medical aid, does cover mental health conditions, although the richness of benefits depends on the plan.

- Higher end, more expensive plan options typically have psychiatry and counseling benefits.
- Lower end plan options tend to only have benefits for inpatient treatment and would not have outpatient coverage for a psychiatric condition.⁵³
- National Health Insurance (NHI) does not yet exist in South Africa, although it is being implemented in phases over a 14-year period that began in 2012.⁵⁶
- Currently less than 20% of South Africans can afford private health care, often subsidized by employers. Those who are unable to purchase private insurance receive care at under-resourced government hospitals.⁵⁷

Stigma

Stigma exists throughout the country but in some areas, particularly where people still go to traditional healers and spiritualists, it is higher.⁵³ In fact, family members are sometimes excommunicated, and “it’s not uncommon to hear people in the township or rural communities loosely calling someone “ihlanya,” or a mentally disturbed person, believing that the cause of the problem is “ubthakathi” or “izinto zabantu” (witchcraft).”^{55,58}

There isn’t a word for “depression” in the Zulu language, leading some to say it’s a Western construct and doesn’t actually exist in black culture. The feelings and symptoms associated with the disorder do exist, though, but it is highly stigmatized, particularly among men. One way to address this stigma and the treatment gap mentioned above may be making treatment more culturally relevant. Currently, “Western psychological models are used. These are not representative of the South African population. South Africa’s high prevalence of HIV/AIDS and TB means that specific mental health screening tools and treatment care models need to be developed. And the country isn’t using indigenous knowledge systems, such as traditional healers, for primary prevention. More generally, mental health care management and treatment is not integrated into other health care programmes.”⁵²



“Better managing the country’s existing health resources, advocating for the increased decentralization of health system resources to primary and community-level mental health care, in addition to intersectoral collaboration to address the upstream determinants of mental health conditions, ensuring earmarked funding for mental health in the short-term and the explicit integration of mental health plans in the NHI efforts were recommended as efficient and sustainable approaches to scaling-up the South African mental health service and its’ financing.”

Docrat, S., Lund, C., Chisholm, D.; International Journal of Mental Health Systems⁵⁹

Recommendations for Employers in South Africa

- In areas where people depend on traditional healers for mental health conditions, message that traditional healers and mental health providers/EAPs can operate in parallel with each other instead of in competition.
- Include EAP training hours on less stigmatized topics, such as financial well-being and legal issues, as part of core offerings so that employees become familiar with the service and are more likely to use it when they need it.

- Consider using EAPs in innovative ways as needed (i.e., HIV/AIDS screening services and disease management).
- Provide critical incident support as a core program offering due to crime and safety issues, as there is a particularly high prevalence of business-related crime in the country.

For more information about how global employers are offering well-being programs and which vendors are commonly used in South Africa, see [Benefits and Well-being Benchmarking Survey Results: South Africa](#).

“

“Findings from the WHO World Mental Health Survey show that only one in five people in countries with high income and one in 27 in countries with low/lower middle income received at least minimally adequate treatment for major depressive disorder.”⁶⁰

NGOs/National Campaigns in South Africa

Note: These resources are provided for informational purposes only. This list should not be considered complete or represent any organizational recommendation.

South African Federation for Mental Health
Rural Mental Health Campaign
South African Depression and Anxiety Group

Spain

Stigma

Stigma surrounding mental health conditions, especially for suicide, present obstacles to mental health access and care in Spain.

- EAP providers say that mental health is often seen as a weakness, and many managers think stress is a byproduct of high motivation and engagement.
- It is still difficult for employers in Spain to discuss topics like suicide, anxiety or depression, and it isn't easy to find accurate statistics on the topic, although generally the rate has increased.

Snapshot of the Health System Landscape¹³

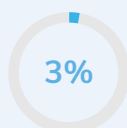


Mental hospital beds:
28.15 per 100,000
population

**General hospital
psychiatric unit beds:**
14.31 per 100,000
population



**Total mental health
workers:**
15.43 per 100,000
population



**Government mental
health spend as % of total
health spend**



Persons **pay nothing** (fully
insured) for mental health
services at the point of
service use.



43% of the inpatient
population stays for more
than a year.



National health insurance
or reimbursement scheme
includes the care and
treatment of persons
with major mental
disorders (defined as
psychosis, bipolar disorder,
depression).*



Government-adopted or
national policy for suicide
prevention strategy.

*According to data submitted to the World Health Organization (2017)

- In 2016, there were two times more deaths by suicide than by car accidents.²⁵
- Stress is more openly discussed.
- When it comes to services like EAP, providers say that confidentiality of service and how the EAP works are significant issues when employees make an initial call.
 - Employees often don't understand or believe that what they say will be kept confidential from their employer.²⁵

Organizational Stress

Spain has a strict labor law that includes regular psychosocial risk evaluations. Organizations are mandated to measure the level of stress in the workforce every 4 years, and the evaluation is reviewed by labor inspectors. Experts say that the government has made the law stringent as a way of ensuring that employers will comply with at least the minimum requirement, but currently there aren't many follow-up actions being taken, particularly in small and medium enterprises.²⁵ Policymakers are also currently debating whether it's a company's responsibility and workplace health issue if an employee suffers from burnout or stress.⁵⁵

Access and Treatment

To access mental health treatment in Spain, an individual must get a referral from his or her general practitioner, who will send them to a psychologist or psychiatrist.

- However, there are few available therapists in the national system, and most are based in a hospital, making access a challenge. Wait lists can be as long as 3-to-4 months.
- The national system is most likely to cover more severe mental disorders, while episodic, early intervention situations may be missed.
- It is easier to find care if you're able to self-pay or have private health insurance, which may be paid for or partially paid for by an employer.
 - Typically most plans cover 20-minute sessions with a psychologist or psychiatrist and cost approximately \$30-\$40/month to \$80-\$100/month maximum for good coverage.²⁵

EAP can often fill the gap in care for employees in Spain who are suffering from less severe mental health conditions, high stress levels or problems in their personal life. Employers can also combat the stigma related to mental health disorders by positioning the service as related to stress at work. Alternatively, employers can offer manager trainings instead of services just for mental health counseling. Providers say that this argument often helps employers make the business case to local human resources leaders to implement EAP in the country as well.²⁵

Recommendations for Employers in Spain

- Make case for EAP to local HR by selling improvements to productivity, absenteeism reduction, manager training and helping employees be better at work instead of as a mental health benefit.
- Utilize EAP services for HR/ manager training on how to identify signs of stress, mental health conditions, low motivation, difficult workers, and other similar issues. Encourage managers to refer staff to the EAP.
- Leverage the psychosocial risk stress law in order to get programs in place that may address mental health issues and stress.
- Educate employees about how common mental health conditions are and assure them about the confidential nature of employer-sponsored resources.

NGOs/National Campaigns in Spain

Note: These resources are provided for informational purposes only. This list should not be considered complete or represent any organizational recommendation.

Obertament

1 de cada 4



United Kingdom

Prevalence

About 25% of people in the U.K. will experience a mental health problem each year. In England, about 1 in 6 people report experiencing a common mental health problem like anxiety or depression in any given week. Data from England and Wales show that only 1 in 8 receive treatment.⁶² Mental ill-health at work is the leading cause of sickness absence in the U.K. “In a recent survey two in five employees said that they had experienced a work-related mental health issue in the last year while mental ill-health is estimated to cost an average of £1035 per employee per year.”⁶³

Access and Treatment

The NHS is the primary care provider of mental health services in England.⁶⁴

- Services are free, but in some cases a referral from a general practitioner (GP) is required.⁶⁵
- Depending on the issue, severity and need, services are provided by GPs, large local health centers, specialist mental health clinics or hospitals.⁶⁵
- The maximum wait time for all NHS consultant-led services is 18 weeks.⁶⁵
- Individuals can also choose to access private mental health treatment by using private medical insurance or paying out of pocket.
- Non-NHS providers may sub-contract with NHS providers or be commissioned by Local Clinical Commissioning Groups, who are responsible for using a percentage of the health budget to purchase most services that are provided by secondary health care providers.
 - This allows local governments, commissioners and patients, where appropriate, to decide which providers are most qualified to provide certain community and mental health services.⁶⁴

Snapshot of the Health System Landscape⁶⁰



Total mental health workers:
318.9 per 100,000 population



Government is the primary source of funding for people to access mental health services.

*According to data submitted to the World Health Organization (2014)

In October 2014, the NHS England and the Department of Health jointly published *Achieving Better Access to Mental Health Services by 2020*.⁶⁶ In 2016, an independent Mental Health Taskforce brought together health care leaders, people who use the services and experts in the field to create a *Five Year Forward View for Mental Health*. These reports and recommendations are all part of the NHS's strategy to revamp and improve mental health services in the country, with access to high-quality services, choice of interventions, integrated physical and mental health care, prevention initiatives, funding and interventions to challenge stigma as top priorities for changes needed to the system by 2020.¹¹

Key commitments include:²

- Providing a 24/7 urgent and emergency mental health liaison in acute hospitals (e.g., in emergency departments and adult inpatient wards).
- Improving access to psychological therapies for depression, anxiety disorders, bipolar disorder, psychosis and personality disorders. Seventy-five percent should be treated within 6 weeks.⁶⁴
- Transforming perinatal mental health so that more women experiencing mental ill health during or after pregnancy have access to the right care.
- “Working with partners to improve access to high-quality, evidence-based care which considers people’s physical and mental health needs and well-being, reducing premature mortality among people with severe mental health disorders and doubling the reach of Individual Placement and Support,”² an evidence-based program that helps people with severe mental health disorders find and retain employment.⁶⁷
- Investing in Crisis Resolution and Home Treatment Teams as an alternative to inpatient hospital care and working to eliminate the practice of sending people long distances for non-specialist acute care by 2020/21.
- Increasing access by 2020/21 so that at least 25% of people with common mental health conditions receive treatment, and to sustain and improve the quality of care, including recovery rates.
- Focusing on integrating primary and community health care services so that they are more convenient and timelier and can provide treatment for physical and mental health needs.

Organizational Stress

Employers in the U.K. have a legal requirement to address stress at work by doing a risk assessment and then acting on the results. The Health and Safety Executive defines stress as “the adverse reaction people have to excessive pressures or other types of demand placed on them.”⁶⁸

The National Institute for Health and Clinical Excellence (NICE) sets clinical guidelines about the quality of care that should be provided by the NHS. “NICE sets guidelines on care based on calculations of the cost-benefit of a treatment, following the Quality-Adjusted Life Year (QALY) index. The QALY measure aims to assess the potential for a specific treatment according to how many years of life the treatment may provide and the level of improvement that it is expected to make in the quality of life. Based on the QALY score, the “cost per QALY year” is calculated, with NICE guidelines currently suggesting that treatments costing over GBP 30 000 per year when adjusted for QALY should not be routinely prescribed by commissioning groups. All patients across England should be provided care to a standard no lower than that set by NICE guidelines, and should have access to all medical technologies, treatments and medications approved by NICE.”⁶⁴

The six primary areas of work design that affect stress levels are:⁶⁸

- **Demands:** Workload, work patterns and the work environment;
- **Control:** Autonomy in the way one does their work;
- **Support:** Encouragement, sponsorship and resources provided by the organization and its people;
- **Relationships:** How the company and leadership deal with conflict and unacceptable behavior;
- **Role:** Whether people understand their role and responsibilities within the organization; and
- **Change:** How change is managed and communicated.

Recommendations for Employers in the U.K.

- There are a number of mental health NGOs in the U.K., several of which are focused on addressing stigma in the workplace. Consider partnering with or utilizing materials from one of these instead of reinventing the wheel to develop your workplace program.
- Use [Health and Safety Executive \(HSE\)](#) resources for employers on the company website to help employers comply with the law and tackle organizational stress.⁶⁸
- Work with your broker and local staff to understand how the current limitations and projected improvements of the NHS may or may not affect your workforce and plan employer-sponsored programs appropriately.
- Consider using workplace champions to address mental health stigma and spread the word about resources that are available for employees.

- Consider offering mental health training to employees, such as Mental Health First Aid, ICU or a similar program.

For more information about how global employers are offering well-being programs and which vendors are commonly used in the United Kingdom, see [Benefits and Well-being Benchmarking Survey Results: United Kingdom](#).

NGOs/National Campaigns in the United Kingdom

Note: These resources are provided for informational purposes only. This list should not be considered complete or represent any organizational recommendation.

City Mental Health Alliance
Time to Change
Time to Change Wales
Niamh (Northern Ireland Association for Mental Health)
Mental Health Foundation
Mates in Mind
Mental Health at Work
Together for Mental Wellbeing
Samaritans

United Arab Emirates (U.A.E.)

Stigma

While the Middle East region is typically known to have extremely high stigma and challenges related to mental health conditions and access, a recent YouGov survey showed that in the U.A.E.- a country where expatriates outnumber citizens- 72% of respondents would seek help or would suggest seeking help if they or a person they were close to were struggling with their mental health.⁷⁰

- However, despite a willingness to seek treatment, “more than two in five (44%) say that they would not feel comfortable talking about their mental health, if they were to struggle with it in the future.”⁷⁰

Snapshot of the Health System Landscape¹³

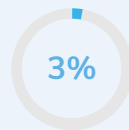


Mental hospital beds:
0.9 per 100,000
population

**General hospital
psychiatric unit beds:**
2.99 per 100,000
population



**Total mental health
workers:**
7.25 per 100,000
population



**Government mental
health spend as % of total
health spend**



**The majority of persons
pay nothing** (fully insured)
for mental health services
at the point of service use.



**47% of the inpatient
population stays for more
than a year.**



National health insurance
or reimbursement scheme
includes the care and
treatment of persons
with major mental
disorders (defined as
psychosis, bipolar disorder,
depression).*



No government-adopted
or national policy for
suicide prevention
strategy.

*According to data submitted to the World Health Organization (2017)

- Almost four in ten (38%) would feel embarrassed to deal with it.⁷⁰
- More than a third (36%) would be “uncomfortable” going to a professional for help.”⁷⁰
- Respondents felt that openly talking about mental health and well-being the same way one would talk about physical well-being was the best way to reduce or eliminate this stigma.⁷⁰

“

“While most nations no longer attempt to exterminate or sterilize people with mental-health issues, we do continue to shun, stigmatize, demonize and discriminate,” he added. “People will often exclude or ridicule individuals known to have experienced mental-health issues.”

Dr. Justin Thomas, professor of psychology at Zayed University in Abu Dhabi⁶⁹

The government has implemented several new initiatives in order to address the stigma related to mental health conditions and support those suffering from those conditions. One example is the Dubai Health Authority’s (DHA) ‘Happy Lives, Healthy Communities’ strategy. Similarly, the National Policy for the Promotion of Mental Health has five primary strategic objectives:⁷¹

1. Enhancing the effectiveness of the promotion of awareness of mental health;
2. Developing, strengthening and expanding comprehensive, integrated and responsive mental health services for patients of all ages;
3. Strengthening multi-sectoral collaboration to implement mental health promotion policy;
4. Promoting the prevention of mental disorders for people of all ages; and
5. Strengthening capacities and improving information systems and conducting mental health research to develop their services.⁷¹

Actions related to these objectives include developing mental health units for inpatients in mental health hospitals, providing outpatient mental health services and establishing community mental health services that incorporate outreach services, home support services and community rehabilitation. The Ministry of Health and Prevention has also launched new digital technology solutions to assist in the clinical practice of mental health and psychology in the country.⁷¹

Access and Treatment

Although mental health conditions are widely thought of as medical issues in the U.A.E., traditional healers still exist. A widely used and acceptable method of treatment of sickness in U.A.E. society is traditional healing, which is provided by a religious individual called “Mattawa,” who often employs nonmedical, nonpsychological methods of treatment such as using readings from the Qur’an and traditional medicine.⁷² A significant number of people (25% in the YouGov survey mentioned above)⁷⁰ are willing to receive this type of treatment instead of medical or psychological treatment because it is considered more acceptable in society and/or because they believe ill health is caused by evil.⁷² Mental health disorders may also be considered a consequence of weak faith,⁷⁰ which may explain why 30% of survey respondents say they would consult a religious leader and why psychological treatment is more of a last resort option when someone has a more severe condition.^{70,72}

Suicide is illegal in the U.A.E., and a person who attempts it may be punished by a prison term of up to 6 months, a fine of up to Dh5,000 or both.⁷³

- Anecdotes and research studies show that this policy may lead to guardedness, inability to accurately assess risk and unwillingness to seek care among individuals who have attempted suicide.⁷⁴
- One expert reported that saying someone “fell off the roof” was code for a suicide attempt in many places throughout the Middle East.
- In 2018, Dubai police decriminalized those who attempted to end their life in the emirate. Instead of being arrested, they are now provided with psychological support and treatment for existing mental health conditions.⁷³

Additional barriers to care in the U.A.E. include a lack of qualified, culturally-competent providers; the role of and expectations of family and loyalty to family members; women’s lack of autonomy to make decisions; a cultural tendency to repress or hide emotions; the role of religion; and more. However, the more recent recognition of mental health conditions as an area of need provides opportunities for the future.⁷²



“Ignorance, lack of motivation, non-availability of facilities and properly trained professionals, lack of government funding and insurance coverage — each of these could be playing a role.”

Dr. Shaju George, a specialist in psychiatry at Al Zahra Hospital in Sharjah, the U.A.E.⁶⁹

Recommendations for Employers in the U.A.E.

- Make addressing stigma and providing mental health psychoeducation top priorities. It is important that employees understand what (and what doesn't) cause mental health disorders, and how it can be treated.
- Ensure easy, confidential access to treatment. Since there are not enough providers in the country, utilizing telemental health or virtual counseling may be necessary.
- Support the large percentage of expat workers and their families in the country by providing resources like informal networking groups, host-family support programs, social activities, and social media sites geared towards expatriate and local families in the community, in addition to mental health benefits and EAP.

For more information about how global employers are offering well-being programs and which vendors are commonly used in the Middle East, see [Benefits and Well-being Benchmarking Survey Results: Middle East](#).

NGOs/National Campaigns in the U.A.E.

Note: These resources are provided for informational purposes only. This list should not be considered complete or represent any organizational recommendation.

Mental Health U.A.E.
Alcoholics Anonymous U.A.E.
Safe Space
Run Talk Run

Example Employer Tools and Resources

General

- Time to Change Resources for the Workplace
- American Psychiatric Association Foundation Mental Health in the Workplace

Organizational and Individual Assessments

- Health and Safety Executive (U.K.): Tools and Templates
- Maslach Burnout Inventory
- The Warwick-Edinburgh Mental Wellbeing Scales
- Center for Workplace Mental Health, Mental Health America and One Mind at Work Organizational Assessment
- Evaluation and Measurement
- MIND Workplace Well-Being Index
- CDC Worksite Health ScoreCard
- Workplace Outcomes Suite

Training

- Beyond Blue (Australia) Training Template: Approaching an Employee You're Concerned About
- The Working Mind (Canada)

The Business Case

- One Mind at Work Depression Cost Calculator and Business Case
- Time to Change Business Case for Training

Promotional Materials and Communications

Time to Change (U.K.) Materials for Time to Talk Day 2020

Best Practices

- Global Anti-Stigma Alliance

Publicly Available Employer Videos

- Barclays
- PwC
- Deloitte
- Materials for Employees
- MIND Mental Health at Work- Taking Care of Yourself
- Employer Case Studies
- The Global CMO Network: Health: Our Business, Volume 3. Case studies from the corporate world — putting mental health and wellbeing into action.

Additional NGOs/National Campaigns

The following campaigns are from countries not covered in this toolkit. They are meant to provide additional resources to global employers.

Note: These resources are provided for informational purposes only. This list should not be considered complete or represent any organizational recommendation.

Global

- Clubhouse International

Ireland

- See Change

Portugal

- UPA - Unidos para Ajudar

Australia

- beyondblue
- Black Dog Institute
- SANE Australia

Kenya

- Basic Needs Basic Rights Kenya

Scotland

- See Me

Canada

- Opening Minds / Mental Health Commission of Canada

The Netherlands

- Samen Sterk Zonder Stigma

Switzerland

- Association for the Improvement of Mental Health Programmes

Denmark

- ONE OF US

New Zealand

- Like Minds Like Mine

Sweden

- Hjärnkoll

Nigeria

- Gede Foundation

Uganda

- Mental Health Uganda

Creative Ways of Increasing Access at the in Other Locations: The Friendship Bench

In Zimbabwe, researchers have trained “grandmothers” to act as free lay therapists in order to bridge the mental health treatment gap in the country. The friendship bench “uses a cognitive behavioural therapy-based approach at primary care level to address ‘kufungisisa’ – the local word closest to depression (literally, “thinking too much” in Shona).”⁷⁵ Community volunteers are trained to counsel patients for six 45-minute sessions on wooden benches on clinic grounds. A randomized controlled trial published in 2016 in JAMA showed that individuals who received support from friendship bench therapists had a significant decrease in depressive symptoms compared to a control group.⁷⁵

In 2017, over 30,000 people were seen by the grandmothers, who are trained in evidence-based techniques. Over 600 therapists have been trained in Zimbabwe, and the friendship bench has expanded to Malawi and Zanzibar.⁷⁵

Employer Highlights

*See additional case studies submitted to the Global CMO Network in its recent document, Health: Our Business, Volume 3. Case studies from the corporate world — putting mental health and wellbeing into action listed in the Example Employer Tools and Resources section.



McCormick noticed that in China, there wasn't a lot of awareness about mental health and wellness. People generally didn't ask for help for mental health until problems were very severe. As a result, the company began hosting lunch- and- learn programs, where they invited professional experts to lecture on topics such as stress management and work/life balance.

In the U.S., McCormick's Young Professionals' Employee Ambassador Group decided to address the subject of self-doubt and anxiety at work and hosted an event to do so. They teamed up with experienced facilitators to run a 1.5-hour workshop. The subject was Self-Talk: Take Control of your Inner Critic. Attendees were led through activities to take control of self-talk, to learn how to turn off the negative voice when it appears and how to use self-talk to "soar instead of to sabotage." The company believes that there is a huge benefit in empowering ambassador groups to run wellness initiatives that are targeted to the populations they support.



In Japan, Kao Corporation implemented an obligatory mental stress check program for employees in accordance with the 2016 law. Group results are analysed to identify problems in each department so managers and leadership can work to eliminate the causes of stress. Additionally, all employees receive the results of their stress check annually and interviews follow with those who are highly stressed. The EAP acts as a resource for those with high stress levels. The company also offers electronic manager training for employee stress management.

Kao says their biggest challenge has been that as the company becomes a huge complex organization and the stress factors of employees are becoming more complicated, there are elements to be solved and it becomes more difficult. Recommendations for other employers including getting top management's understanding and approval about the importance and direction of employee mental health management and understanding that it will be costly to implement this program and implement it continuously.



In Norway, NorgesGruppen tends to see mental health as one of several factors of importance related to its workforce, as well as its policies and practices. For example, physical training has been shown to have a positive impact on mental health, so the company supports/subsidises training expenses for staff. The company also supports/subsidises psychologist consultations if needed.

NorgesGruppen has also started to engage in how to solve what in Norway is called “Tidsklemma” (the increasing challenge of managing a full-time job while simultaneously being a caregiver to someone who needs your support and help). This is also partly, but certainly not completely, seen as related to mental health and/or stress. The company has recently become member of “Pårørendealliansen,” a membership organization focused on caregiving.



Microsoft wanted to expand global access to employee assistance but did not have a central budget to do so. Instead, the company relied on local countries to manage the funding and vendor management, which was very time-consuming and complex. It was also challenging that supplier requirements limited countries' ability to find resources to manage the program locally. As a result, HR at the corporate level undertook an initiative to develop a central budget to fund EAP at all sites that wanted to be included. Steps included, among others:

- Obtaining finance approval to fund centrally;
- Establishing a master contract and PO;
- Inventorying current offerings by country;
- Allowing countries to choose if they wanted to stay with their local provider and continue to fund locally or go with the global provider and have it funded centrally;
- Creating custom content on the internal HR website that could be changed based on an employee's geographic location;
- Moving toward using one link globally to communicate EAP offerings to employees: and
- Developing a communication plan that included a single communication to all employees globally, as well as content that could be edited be customized locally.

Feedback so far has been extremely positive, and employees seem very excited about the expanded offering and what it means for themselves and their families.



In the United Kingdom, PepsiCo identified a need to do more, as mental health was increasingly becoming a significant reason for absence. The company hoped to break down stigma by getting people to talk openly about mental health. They also wanted to speed up the process of accessing support to circumnavigate any National Health Services waiting lists by providing a psychological therapy service accessible to all employees.

PepsiCo began offering three arms of support:

- An EAP service as well as a work-focused Psychological Therapy Service offering an end-to-end care pathway;
- Mental Health First Aiders available on all sites to listen, signpost to support and deal with any crisis situation; and
- A well-being digital solution available to all U.K. employees to help build resilience as well as offer first-line support for those with mild depression/ anxiety.

The company also implemented awareness and education campaigns to keep the conversation about mental health going. These included the #ThisIsMe campaign, which encourages the sharing of personal stories and lived experiences to break down the stigma around mental health and to offer hope for recovery; a quarterly feature in the “PepTalk” magazine that highlights employees’ personal stories related to mental health; e-learning programmes for people managers on behaviours in the workplace and the impact on mental health; and Mind’s Workplace Wellbeing Index. As a result, survey results show that 71% of respondents felt that the company would support them if they experienced a mental health problem.



Mental health is an important component of Tesco's overall well-being strategy. Tesco saw a need to continue breaking down stigma surrounding mental health, as well as to train and build awareness among employees and line managers about its importance and available resources. As a result, the company collaborated with seven other retailers and the Samaritans in the U.K. to create a *Wellbeing in Retail Guide*. The Guide was specifically designed for retail workers and highlighted challenges employees face about mental health and time. Collaborating made the tool affordable for all of the retailers involved, and they were able to have input into what the final deliverable would look like.

Other areas of focus for Tesco's mental health and well-being strategy this year include:

- **Age-related mental health:** Supporting the workforce of the future;
- **Line manager capability:** in-house mental health training to address manager needs and concerns; and
- **Awareness and resource promotion:** Ensuring that colleagues are aware of what is available and running targeted campaigns.

Key takeaways for creating a mental health and well-being program for global employers include:

- Ensure that your health and well-being strategy links back to the wider business (i.e., to health and safety);
 - Embed mental health throughout the culture (i.e., look at the employee's life cycle from entry level to exit interview);
 - Measure success (Tesco does so through EAP data, occupational health referrals of mental health, employee sentiments surveys and health surveys);
 - Have an executive sponsor;
 - Build awareness and buy in from leaders across the business;
 - Speak to similar businesses that are already on the journey and meet with their health and well-being leads; and
 - Publicly sign pledges to commit to mental health (i.e. Time to Change pledge for the U.K.) to demonstrate your commitment.
-

Promoting Evidence-Based Mental Health Interventions in the Workplace: An Expert Interview with Dr. Neil Greenberg

Global employers are providing a number of programs to support the mental health and emotional well-being of their global workforces. Many are wondering, though, which are most effective and where they should put their limited dollars. To provide some context about what the available evidence shows regarding organizational interventions, the Business Group on Health spoke to Professor Neil Greenberg, **BM, BSc, MMedSc, FHEA, MFMLM, DOccMed, MInstLM, MEWI, MFFLM, MD, FRCPsych**; Professor of Defence, Mental Health at King's College London, and leading occupational and forensic psychiatrist in the U.K. A transcript of that interview, in Dr. Greenberg's words, is below.

What does the evidence show regarding the effectiveness of mental health screening?

Mental health screening within organizations is quite different than an individual mental health screening conducted at a doctor's office. If an individual goes to the doctor and he/she is not sure what is going on, voluntarily completing a screening tool can be useful. The results of the screening can help the doctor identify whether an individual has a disorder or not. That is a very different context from an employer wanting to know whether an employee is fit or capable of doing a job. In that case, there are numerous barriers that make people hesitant to tell the truth.

We also know that if people are screened after exposure to a traumatic event or after exposure to particularly challenging circumstances, they tend to be very cautious about what is going to happen if they tell the truth. As a result, while mental health screening has potential to be useful, within organizational settings, the evidence shows that there are very distinct barriers that prevent it from being as effective as employers would wish. This can cause problems for several reasons. First, the employer may be reassured that the workforce is psychologically robust when it may not be. Second, it may exclude perfectly capable people from doing certain roles which has no scientific basis.

Furthermore, when employers use mental health screening tests, personality schedules, clinical interviews or self-report measures after staff have been exposed to traumatic event, the reality is that they do not really predict anything. In the short-term, they may provide an indication as to what an employee is willing to reveal, but not what he or she might truly be feeling. In the long-term, these tests do not predict who is going to have a psychological problem. For instance, in a forthcoming study looking at a major Australian police force, applicants were pre-screened using the Minnesota Multiphasic Personality Inventory (MMPI), which has over 300 questions. The MMPI measures personality and psychopathology, and the goal of the screening was to try to ensure that applicants who might be particularly psychologically vulnerable were prevented from joining up. If the MMPI is a good screening measure, then people who score as being more highly psychologically resilient should be more likely to have a good mental health state during their career, certainly in the first few years. Applicants who score lower should be more likely to have mental health problems. The research findings, however, do not show that at all; instead, the results show that pre-screening has no predictive ability at all.

We did a similar study looking at British troops before the Iraq War in 2003. We used a wide range of mental health measures in a confidential survey that we administered in 2002, before U.K. military personnel deployed to Iraq. We then we followed up in 2004, after 1,614 of the personnel we sampled in 2002 had deployed to Iraq. The results showed that 80% of the time, those who our measures predicted to be at high risk of suffering mental health problems coped fine with the deployment. Our screening tests also missed a whole range of people who appeared to be highly resilient in 2002, but in fact in 2004, were found to be suffering from psychological difficulties. Overall, the screening failed to predict psychological vulnerability.

There are two main reasons why pre-role/pre-recruitment screening does not work. The first has to do with the risk factors related to the development of post-traumatic mental health problems, including PTSD [post-traumatic stress disorder]. There are numerous risk factors as to why someone might develop mental health problems after traumatic events:

- What they were like and what happened to them before the trauma (e.g., gender, intelligence, background, family history, education, etc.);
- How difficult or challenging the trauma itself was; and
- What happened after the trauma in terms of care and support.

Looking at those items reveals that the strongest risk factors are those which take effect after the event; that is, how well supported people are and how their workload is adjusted to take into account the recovery process. These factors are far more impactful than any that could be screened for before the event.

The second reason why psychological health screening within organizations does not work is people's propensity not to provide truthful answers to questions they are worried may impact their career or their reputation. We did a study in Iraq in 2009, surveying deployed British troops. We were primarily looking at the mental health of the entire force, not of individuals. Therefore, when we handed out the surveys, we gave everyone the same message: No one would find out individual results, no participants were going to be identified and the study was only looking at the mental health of the entire force. However, half of the forms asked for identifying information and the other half did not. What we found was that those personnel who completed it without identifying information reported three times the level of mental health concerns than the ones who could have been identified if we had chosen to so. People were very reticent to tell the truth if they feared they could be identified even when we had reassured them that we would not do so. If you put all that together, I think it becomes clear that pre-screening is really difficult to do successfully. The danger is that it doesn't work and has the potential to cause managers to be falsely reassured that their teams are okay when that is not the case. What we really want instead is for managers to be open to the fact that every employee may potentially be affected by a mental health condition. Post-screening is routinely done in many organizations, especially in the military, after troops come back from deployment. The U.S. military has had millions of troops who have deployed to Iraq and Afghanistan and other conflict zones over the past 20 years.

When they come back, they are routinely screened almost immediately and then some months later. Should someone be detected as having a potential problem, they are advised and given information about how to go and seek professional care. The U.S. military looked at their screening data in detail in 2009 and found a worrying finding: Troops who were identified as needing mental health treatment and did so actually had worse mental health in the long term than those who did not. The U.S. military was concerned about this outcome and funded the U.K. military to carry out a large randomized controlled trial of screening on about 9,000 British troops who came back from deployment to Afghanistan over a 3-year period. We also found that screening made no difference. Generally, when we look at similar studies, we find the same thing. The intention with screening is to do good, but the fact is that people do not answer the questions truthfully, and indeed, even if they do, people's mental health varies. On the day you do the screen, you might feel particularly bad or good and that may not reflect how you are really doing most of the time.

Regarding tools like occupational stress surveys, the difficulty is that you can pick up a lot of concerns that do not always translate into actual practical problems, particularly when response rates are low. There is a danger in acting too strongly on the results of the small sample that filled out the survey when it may not reflect the needs of the whole organization. As an example, an organization in the U.K. handed out a stress survey asking the police about how stressed they were. They found that 16% of police officers showed signs of significant stress, perhaps even PTSD. However, when we got data from 48,000 police employees who were asked to complete psychological health measures during a free physical health examination, the rates were about 4.5%, which is much more in line with general rates in the U.K. However, it is accurate to say that police officers who had recently been exposed to trauma had a higher stress rate, which was not surprising.

What are the most common barriers to care, and how can employers address those?

Stigma is one of a number of barriers to care, but our data suggest that it's only a strong barrier the first time someone seeks treatment. What the evidence shows is that the likelihood of people experiencing stigma increases as people become psychiatrically unwell. Commonly, people only seek professional help when something bad has happened, often because of a crisis. After seeking help, if someone has a positive experience, then the next time they have symptoms, stigma does not operate as a strong barrier because care worked well the last time. If, however, they had a negative experience the first time they got care, their chances of going back again are drastically lower.

When looking at someone's journey to mental health care, the initial barriers to seeking care include:

- Difficulty in identifying the symptoms as a mental health problem;
- Feelings of not deserving of care;
- Not knowing where to go;
- Difficulty in getting time off; and
- Concerns that the care won't work out.

Those are barriers before an individual even gets to the point of care. After making the decision to seek out care, stigma and all the associated concerns about how people will view you and how you will view yourself emerge. Also, many people who are brave enough to attend one session may not go back because they're afraid of what is going to happen, and because of their own internalized stigma. It can be difficult for some people to accept that they might be ill. In fact, our data show that if a therapist actively addresses people's concerns about coming back for treatment in the first few sessions, strategies can be put in place to deal with those concerns, making it more likely that people will stick with a treatment plan. Then there's a greater chance that they will get better. In sum, stigma plays a role early on, while barriers like identification of the problem, feeling deserving and good clinical care are important later. Many organizations have adopted a psychoeducational approach, where they bring in speakers to discuss stigma or mental health, or counselors come to the company to discuss the therapeutic process. Over time, this approach sends the message that the company is interested in its employees' mental health. But the evidence shows that people who have mental health problems do not necessarily trust that therapy, as described by the speakers, is going to make a difference. What does make a big difference is an approach called contact, which is having people who are successful in the organization share their own mental health difficulties and how they overcame them. People who are role models can reach out to people who have problems and persuade them to get care. If, however, the employee speaking out is not someone that people identify with or look up to, the testimonial may have the opposite effect. People with mental health problems may think, "I don't want to turn out like them."

The last overall strategic approach is what's called protest. Within organizations, even when a company is very savvy, things do not always go well. A boss may not treat someone properly or a policy or procedure may inadvertently discriminate against someone with a mental health problem. For example, this often happens in the security industry, where people must have security clearances. The forms ask if someone has ever had a mental health problem, even though there is no evidence that people with mental health problems give away secrets. In such an instance, when company leaders realize that they made a mistake, rather than trying to sweep it under the carpet, they should hold their hands up and admit that this was wrong. That sends a protest message and is a strong indication to people that things really have changed. An overall strategy would put together psychoeducation, contact and protest to change the culture over time within the organization.

How can peer support be most effective in the workplace?

When designing and implementing a mental health strategy, it is important to make sure that the supervisors understand enough about mental health to be able to have a conversation with their team. The evidence shows that feeling confident starting a conversation about an employee's mental health is a powerful tool. For this reason, it's important to empower supervisors alongside peers.

Most people who have mental health problems, particularly in the workplace, first look for support to people who are like them: similar in seniority, do a similar job, or speak a similar language. It is much less stigmatizing speaking to a trusted colleague than going to see the health care professional who sits in an office at the end of the corridor. This leads

to the question of how peers can be empowered to have good conversations. Ideally, peer support should be done by people who have been at the organization for a while and understand it and are interested in being a part of a peer support network. But being well-meaning isn't enough; these employees need evidence-based skills as well.

In the U.K., we started a concept called Trauma Risk Management (TRiM) in 1990. It's not penicillin for trauma, but it is a good tool that helps organizations adopt a practical, evidence-based approach to dealing with the short-term impact of psychological trauma. TRiM is a peer- support program that is primarily focused on mitigating the impact of traumatic stress in the military. We've known for years that bringing in health care professionals after trauma for psychological debriefing or trauma counseling for everyone has not been shown to work. In fact, the published evidence shows that trauma counselors who get involved early- on may make people worse than having no intervention at all.

What we aim to do instead is capitalize on the fact that people speak to each other. We developed the TRiM program to train military personnel to have a structured conversation with their colleagues a few days after the event to find out how they are doing. If they are not doing well, the TRiM practitioner ensures that the distressed colleague gets support and possibly a temporary alteration of his or her assignment. The TRiM practitioner also continues to support and monitor the distressed individual, and importantly, the practitioner formally checks in with the individual in distress a month or so later. If the individual is still not getting better, then he or she is referred to professional care. We have now published 13 different academic papers on TRiM and have a really good evidence base showing that it provides a structured, organizational response to traumatic events. It is based upon using existing networks of peers in the workplace while also providing people with the ability to get professional care if social support and mentoring do not work.

We also wanted to develop a program where the same principles would apply for workplace mental health. We began by looking at the risk factors indicating that someone within a workplace may not be functioning well. Signs include taking work home frequently or not feeling rewarded for the job being done. Then we looked at a range of coping strategies and symptoms and put it all into a 10-item checklist, which is a set of risk factors, and then designed a program that we called Sustaining Resilience at Work (StRaW). Over a 2-day course, we train appropriately experienced volunteers within the organization to help them understand what mental health at work is and how to conduct a structured interview with a colleague who may or may not be distressed. After the interview, the volunteer generates a score of green if the colleague is doing okay; yellow if the individual has a few issues; amber if the colleague has a lot of issues; and red if that individual has some severe challenges. If the individual scores in the red zone, the peer supporter needs to get them to a professional who is trained in how to do a proper assessment. But if a person is at a yellow or amber level, the StRaW practitioners should try and help that person solve his or her problems. We teach them how by using a technique called decisional balance, which comes from an approach called motivational interviewing. This tool helps people overcome resistance to taking positive action, such as speaking to one's manager, taking some leave or turning a work phone off. Teaching StRaW practitioners how to nudge individuals in the yellow or

amber zone toward positive behaviors is a powerful tool that can help their colleagues; it is very much akin to some aspects of coaching.

A peer support network within the workplace is easily accessible and non-stigmatizing. It is important, though, that it is supervised. Some programs are not, which could lead to problems with the peer supporter's mental health or to ineffective interventions for the colleague in trouble. Therefore, it's crucial that the peer support teams be linked to the mental health, occupational health or well-being teams within the organization so that they have resources and a point of contact.

What other strategies may be effective?

Mindfulness and similar programs can be useful for some people who utilize them, but many will not. What appears to have a greater impact on employee mental health is strengthening the social bonds within the workplace. There is a great deal of evidence indicating that a well-functioning social support system can protect everyone's mental health.

Another potential resilience-boosting intervention is to improve employee's communication skills. People often have trouble communicating and initiating supportive conversations. Teaching conversational analysis and conducting conversational skills training sessions are two ways to create more opportunities for people to share what is going on in their lives. These strategies complement peer support and go a long way toward building resilience in the workforce.

Gaming and digital solutions could be helpful, but at this point, the evidence is not very strong that they have a sustained and positive impact. Most people who download digital solutions do not actually end up using them, which means that they don't experience any long-term benefits. Apps could, however, be part of a suite of interventions an employer might offer. Where digital solutions can be most useful is when they are paired with guided self-help, which can be provided through a therapist who checks in with the user every week or so about how things are going with the app or guided resource. Guided, rather than simple, self-help has been shown to be more likely to result in positive change.

Finally, it is important that EAPs offer enough sessions to make a difference and provide an effective course of treatment. Four to six visits are not going to be adequate for most people to get a decent treatment response.

In my view, a good organizational strategy would be to have in-house peer support for those with early, episodic problems, along with access to an a well-resourced EAP or other therapeutic service that offers enough sessions for effective treatment. It would also be helpful to have an integrated approach that ensures that the first clinical step is with a clinician who can provide a good, confidential holistic assessment and subsequently refer the client to appropriate resources, whether that's a therapist for cognitive-behavioral therapy or a peer supporter to talk through a problem.

References

1. Ritchie H and Roser. Mental health. The University of Oxford and the Global ChangeData Lab. Mental health. April 2018. <https://ourworldindata.org/mental-health>. Accessed January 6, 2020.
2. NHS England. Mental health: Adults and older adults mental health. <https://www.england.nhs.uk/mental-health/adults/>. Accessed December 5, 2019.
3. United States Office of Disease Prevention and Health Promotion. Mental health. <https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health>. . Accessed January 13, 2020.
4. World Health Organization. Mental health in the workplace. https://www.who.int/mental_health/in_the_workplace/en/. Updated May 2019. Accessed January 6, 2020.
5. World Economic Forum. It's time to end the stigma around mental health in the workplace. <https://www.weforum.org/agenda/2019/05/its-time-to-end-the-stigma-around-mental-health-in-the-workplace/>. Accessed January 6, 2020.
6. World Health Organization. Mental health: Massive scale-up of resources needed if global targets are to be met. https://www.who.int/mental_health/evidence/atlas/atlas_2017_web_note/en/. 6 June 2018. Accessed January 6, 2020.
7. *The WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health*. Geneva: World Health Organization;2019.
8. *The Workplace Wellness Alliance. Making the right investment: Employee health and the power of metrics*. Geneva: World Economic Forum;2013.
9. Medline Plus. Mental disorders. <https://medlineplus.gov/mentaldisorders.html>. Accessed December 10, 2019.
10. Deloitte Insights. The ROI in workplace mental health programs: Good for people, good for business. <https://www2.deloitte.com/us/en/insights/topics/talent/workplace-mental-health-programs-worker-productivity.html>. 04 November 2019. Accessed January 22, 2020.
11. Que J, Lue L, Shi L. Development and challenges of mental health in China. *General Psychiatry*. 2019;32(1).
12. Lora A, Hanna F, Chisholm D. Mental health service availability and delivery at the global level: an analysis by countries' income level from WHO's Mental Health Atlas 2014. *Epidemiology and Psychiatric Sciences*. 2017;1-12.

13. Mental Health Atlas: Country Profiles. World Health Organization. https://www.who.int/mental_health/evidence/atlas/profiles-2017/en/. Published 2017. Accessed October 25, 2019.
14. Magoon C. In China, mental health care goes virtual. In. Scientific American: Springer Nature America, Inc.; 2019.
15. Shi S. What will the development of psychiatry in China be in 10 years? *Gen Psychiatr*. 2019;32(2).
16. Chelala C. China's unaddressed mental health problems. *Japan Times*. May 25, 2015;World.
17. Xu J, Wang J, Wimo A, Qiu C. The economic burden of mental disorders in China, 2005–2013: implications for health policy. *BMC Psychiatry*. 2016;16(137).
18. China wakes up to its mental-health problems. In. *The Economist*. Hangzhou 2017.
19. Zhang L. China: Mental health law takes effect on May 1. In. Washington, D.C.: Library of Congress; 2013.
20. The Commonwealth Fund. International health care system profiles: The Chinese Health Care System. <https://international.commonwealthfund.org/countries/china/>. Accessed November 26, 2019.
21. White paper: Analyzing trends to deliver optimal EAP services in the Asia Pacific. ComPsych Corporation; 2019.
22. Gorvett Z. Can you work yourself to death? BBC. <https://www.bbc.com/work-life/article/20160912-is-there-such-thing-as-death-from-overwork>. Published 2016. Accessed October 25, 2019.
23. Asia Dialogue. From treatment to prevention: The role of workplace psycho-education for mental health in China. March 20, 2019. <https://theasiadialogue.com/2019/03/20/from-treatment-to-prevention-the-role-of-workplace-psycho-education-for-mental-health-in-china/>. Accessed December 9, 2019.
24. State of health in the EU: France country health profile. Paris and Brussels: OECD/European Observatory on Health Systems and Policies 2017.
25. Launay C. Interview with EAP provider from EAP Iberia regarding mental health in France, Spain, Italy. In: Demmer B, Ford A, O'Driscoll K, eds. Washington, DC: Business Group on Health and ComPsych; 2019.
26. Millet L. Challenges and hopes for French Psychiatry. In. Vol 2019: Institut Montaigne; 2018.
27. Why do there seem to be so many mentally ill people in French cities? *The Local*. January 16, 2019.

28. Suicide rate by country population. Published 2019. Updated August 27. <http://worldpopulationreview.com/countries/suicide-rate-by-country/>. Published 2019. Updated August 27.
29. France announces extra €40m fund for mental healthcare. *The Connexion*. January 25, 2019.
30. Bijal AS, Kumar CN, Manjunatha N, Gowda M, Basavaraju V, Math SB. Health insurance and mental illness. *Indian J Psychiatry*. 2019;61:S791–S797.
31. Kumar A, Singh S. Interview with Santulan and ComPsych India. In: Demmer B, Ford A, O'Driscoll K, eds. Washington DC: ComPsych and Business Group on Health; 2019.
32. Mahapatra D. Court takes first step towards taking suicide off list of crimes. *Times of India*. March 9, 2018.
33. Bhaskaran, D. *livemint*. Health insurance plans to cover mental illness too, but will that help? August 20, 2018. <https://www.livemint.com/Money/o0pRqJbfCk-MiaiPHRV0TSK/Health-plans-to-cover-mental-illness-too-but-will-that-help.html>. Accessed November 12, 2019.
34. Forti A. OECD Health Working Papers No. 71. *Mental Health Analysis Profiles (MhAPs): Italy*. OECD;2014.
35. OECD. Italy led the way in deinstitutionalisation, but regional disparities remain a concern. <https://www.oecd.org/els/health-systems/MMHC-Country-Press-Note-Italy.pdf>. . Accessed November 25, 2019.
36. World Health Organization. The Italian mental health-care reform: public health lessons. <https://www.who.int/bulletin/volumes/96/11/18-216002/en/>. . Accessed November 25, 2019.
37. The Commonwealth Fund. International health care system profiles: Italy. <https://international.commonwealthfund.org/countries/italy/>. Accessed November 21, 2019.
38. Barbato A, Vallarino M, Rapisarda F, Lora A, Caldas de Almeida JM. Access to mental health care in Europe. *European Union Health Programme*;2016.
39. Inoue A, Okido S. Interview with PeaceMind. In: Demmer B, Ford A, O'Driscoll K, eds. Washington, DC: ComPsych and Business Group on Health; 2019.
40. Kobayashi N. Employers must help cut Japan's suicide rate. *Nikkei Asian Review*. September 10, 2018.
41. Society for Human Resources and Management. Japan: Anti-power harassment law passed. <https://www.shrm.org/resourcesandtools/legal-and-compliance/employment-law/pages/global-japan-anti-power-harassment-law-passed.aspx>. Published 2019. Updated September 6. Accessed November 18, 2019.

42. The Commonwealth Fund. International health care system profiles: the Japanese health care system. <https://international.commonwealthfund.org/countries/japan/>. Accessed November 18, 2019.
43. This Week in Asia. In Japan, workplace bullying and harassment are driving women to seek mental health treatment. <https://www.scmp.com/week-asia/lifestyle-culture/article/3034742/japan-workplace-bullying-and-harassment-are-driving>. Published 2019. Updated October 27. Accessed November 18, 2019.
44. PAHO. Mexico – Quality & Rights: Mental health care and human rights. https://www.paho.org/hq/index.php?option=com_content&view=article&id=14654:-mexico-calidad-y-derechos-atencion-a-la-salud-mental-y-derechos-humanos&Itemid=42050&lang=en. Accessed November 13, 2019.
45. Zabudovsky K. Ex-patients police Mexico's mental health system. *The New York Times* 2013.
46. Dartiz J, Cuevas J, Aviles JL. Interview with Marsh Mexico. In: Ford A, O'Driscoll K, eds. Washington, DC: National Business Group on Health; 2019.
47. Interview with Martha Pena, EAP provider in Mexico. In: Demmer B, Ford A, O'Driscoll K, eds. Washington, DC: ComPsych and Business Group on Health; 2019.
48. The Conversation. Rising suicides in Mexico expose the mental health toll of living with extreme, chronic violence. August 2, 2018. <https://theconversation.com/rising-suicides-in-mexico-expose-the-mental-health-toll-of-living-with-extreme-chronic-violence-99131>. Accessed November 15, 2019.
49. Baker McKenzie. Psychosocial risk factors at work. <https://www.bakermckenzie.com/en/insight/publications/2018/11/psychosocial-risk-factors-at-work>. November 2018. Accessed November 15, 2019.
50. Mexico issues new psychosocial risk legislation for all employers. ComPsych Corporation; 2019.
51. El Universal. Mexico, one of the countries with the highest work-related stress, says UNAM. <https://www.eluniversal.com.mx/english/mexico-high-work-stress>. Accessed November 15, 2019.
52. The Conversation. Why South Africa is failing mental health patients and what can be done about it. October 5, 2016. <https://theconversation.com/why-south-africa-is-failing-mental-health-patients-and-what-can-be-done-about-it-66445>. Accessed December 10, 2019.
53. Stevens C. Interview with EAP provider LifeAssist. In: Demmer B, Ford A, O'Driscoll K, eds. Washington, DC: ComPsych and Business Group on Health; 2019.

54. Docrat S, Besada D, Cleary S, Daviaud E, Lund C. Mental health system costs, resources and constraints in South Africa: A national survey. *Health Policy and Planning*. 2019;czz085.
55. National Business Group on Health. Mental Health Virtual Summit Part 4: Global Approaches to Address Access and Stigma. <https://www.businessgrouphealth.org/resources/mental-health-virtual-summit>. November 19, 2019. Accessed December 10, 2019.
56. South African Government. National Health Insurance. <https://www.gov.za/about-government/government-programmes/national-health-insurance-0>. Accessed November 16, 2019.
57. Reuters. South Africa puts initial universal healthcare cost at \$17 billion. <https://www.reuters.com/article/us-safrica-health/south-africa-puts-initial-universal-healthcare-cost-at-17-billion-idUSKCN1UY1R2>. August 8, 2019. Accessed November 16, 2019.
58. Huffington Post. 5 myths black people need to stop believing about depression. https://www.huffingtonpost.co.uk/entry/5-myths-black-people-need-to-stop-believing-about-depression_uk_5c7e91cbe4b048b41e39aa74?guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xLmNvbS8&guce_referrer_sig=AQAAA-IP_isdFLy6Ormr0_iZ4Kyihkm7EPqAVX1VNRewhW0VtasZFIHppniMrTLMzb-GOPQ5E-2dwBd8GdDQ0dvjC3Za9QZ7s8HVYyfBUZPwlEoaeFiYnr5xNZsETy-hiO3oA2X-p05ieszD_D4YVgOsbyUIWI0kGHA0WSCnBNK6slo_-0P. Accessed December 10, 2019.
59. Docrat S, Lund C, Chisholm D. Sustainable financing options for mental health care in South Africa: findings from a situation analysis and key informant interviews. *International Journal of Mental Health Systems*. 2019;13.
60. World Health Organization Regional Office for Europe. Fact sheets on sustainable development goals: health targets. Mental health. http://www.euro.who.int/__data/assets/pdf_file/0017/348011/Fact-sheet-SDG-Mental-health-UP-DATE-02-05-2018.pdf. Accessed December 9, 2019.
61. Mental Health Atlas 2014: Country profiles. World Health Organization. https://www.who.int/mental_health/evidence/atlas/profiles-2014/en/. Published 2014. Accessed October 25, 2019.
62. Mind. Mental health facts and statistics. <https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#.XemcMOhKg2x>. Accessed December 5, 2019.
63. Mental Health at Work. <https://www.mentalhealthatwork.org.uk/?ctaId=%2F-workplace%2Fmental-health-at-work-gateway%2Fslices%2Fmental-health-at-work%2F>. Accessed December 6, 2019.

64. Hewlett E, Horner K. OECD Health Working Papers No. 81: Mental Health Analysis Profiles (MhAPs): England. Paris: Organisation for Economic Co-operation and Development;2015.
65. NHS. How to access mental health services. <https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/how-to-access-mental-health-services/>. Accessed December 5, 2019.
66. Achieving better access to mental health services by 2020. NHS England and Department of Health;2014.
67. NHS England. Individual Placement and Support offers route to employment for people with severe mental health conditions. <https://www.england.nhs.uk/mental-health/case-studies/individual-placement-and-support-offers-route-to-employment-for-people-with-severe-mental-health-conditions/>. Accessed December 5, 2019.
68. Health and Safety Executive. Work-related stress. <https://www.hse.gov.uk/stress/index.htm>. Accessed December 6, 2019.
69. Arab News. The hidden face of mental illness in the Middle East. <https://www.arabnews.com/node/1496661/middle-east>. Accessed December 1, 2019.
70. YouGov. Most UAE residents would seek professional help for mental health issues. <https://mena.yougov.com/en/news/2019/05/07/most-uae-residents-would-look-for-professional-help-for-mental-health-issues/>. May 7, 2019. Accessed December 1, 2019.
71. The Government of the United Arab Emirates. Mental Health. <https://www.government.ae/en/information-and-services/health-and-fitness/health-of-vulnerable-groups/mental-health>. Accessed December 1, 2019.
72. Sayed MA. Mental Health Services in the United Arab Emirates: Challenges and opportunities. *International Journal of Emergency Mental Health and Human Resilience*. 2015;17:661-663.
73. Ramahi NA. The National. Suicide attempters to be treated not punished, say Dubai Police. June 27, 2018. <https://www.thenational.ae/uae/suicide-attempters-to-be-treated-not-punished-say-dubai-police-1.744874>. . Accessed December 1, 2019.
74. Shahrour T, Mohan S, Siddiq M, Hammasi KE, Alsaadi T. Suicide attempters in Abu Dhabi: Is criminal prosecution associated with patients' guardedness? *Journal of Death Studies*. 2018;42:636-639.
75. Centre for Global Mental Health. The friendship bench. <https://www.centrefor-globalmentalhealth.org/the-friendship-bench>. . Accessed December 11, 2019.