
EU COMPASS FOR ACTION ON MENTAL HEALTH AND WELL-BEING

ACCESS TO MENTAL HEALTH CARE IN EUROPE

- Scientific Paper -

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1. Introduction

1.1 Access to mental health care as an EU priority

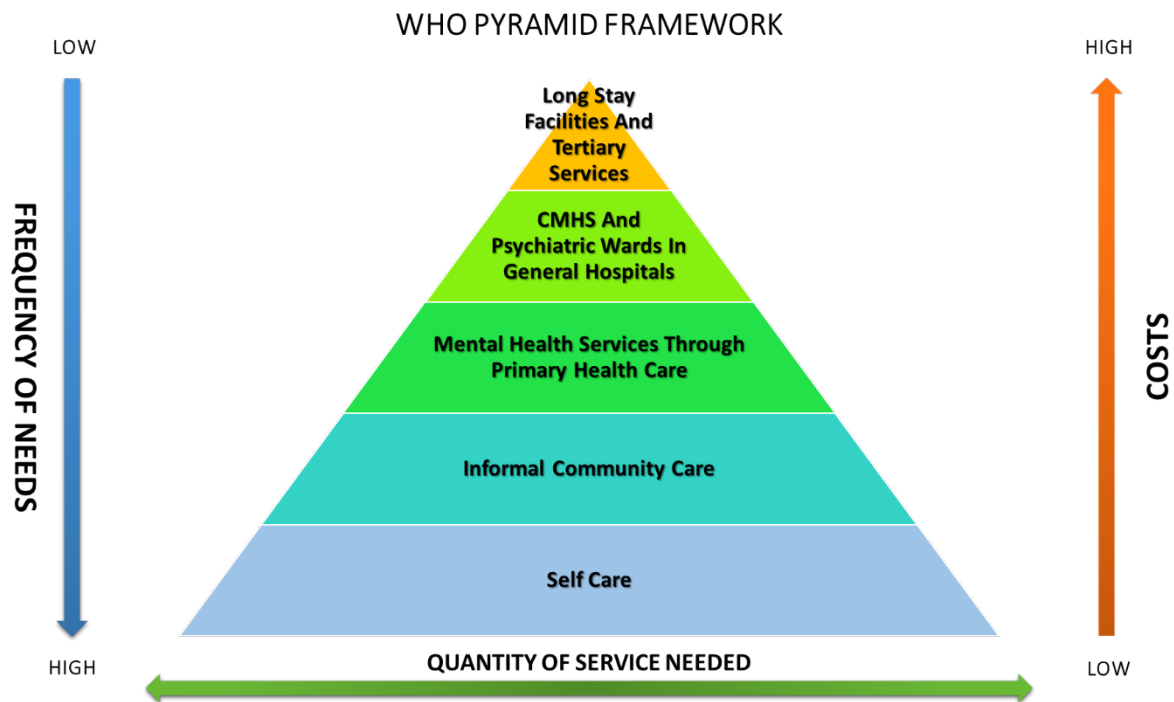
The need to include mental health among the first priorities of the public health agenda has been increasingly recognized by the European Union since the launch of the Commission's Green Paper on Improving Mental Health in 2005. This recognition is based on the growing evidence and awareness about the magnitude of mental health problems in European countries: mental disorders are highly prevalent in Europe and impose a heavy toll on individuals, society and the economy, representing a significant share of the EU's burden of disability (European Framework for Action on Mental Health and Wellbeing, 2016). Consequently, one of the most imperative health issues for EU member Countries is how to provide services that could adequately respond and meet needs of people with mental disorders.

Nowadays there is a broad consensus on the need to shift from the model of care based on the traditional large psychiatric institutions to modern comprehensive community-based models of care, including acute inpatient units in general hospitals (Caldas De Almeida & Killaspy, 2011). Community-based services are associated with greater user satisfaction, better participation in social life, increased met needs and adherence to treatment. Moreover, they promote better continuity of care and more flexibility of services, make possible to identify and treat more often early relapses and allow to fight stigma (Thornicroft & Tansella, 2003).

However, although access to mental health care of people is usually better with community-based services than with the traditional psychiatric hospitals (Thornicroft & Tansella, 2003), evidence shows that access to mental health care can be unsatisfactory even in high-income countries with universal health care coverage and well-developed community care systems (Alonso et al., 2004). Therefore, this issue still needs to be addressed thoroughly at national level.

World Health Organization proposed a multi-level model of mental health services organization, using a pyramid framework (World Health Organization 2003) (Figure 1).

FIGURE 1. WHO PYRAMID FRAMEWORK



As the Figure 1 illustrates, an important part of mental health care could be managed by informal organizations. Where additional support and expertise are required a more formal network is needed. In ascending order this includes primary care services, followed by specialized community mental health services and lastly mental hospitals and long stay institutions. In terms of accessibility, informal services (self care and informal community care) with primary care services are the more accessible and could meet the needs of an important share of persons with mental disorders. Informal services, as those provided by community organizations, religious groups, users and families associations, do not form the core of care provision, but they form an useful complement to specialized services and should form an alliance with mental health services.

The integration of mental health care in primary health services is a critical component of a comprehensive mental health system. Essential services at this level include early identification of mental disorders, management of stabilized severe mental disorders, referral of complex cases to specialized services. From a clinical perspective the most common mental disorders can be treated only at primary level. Including a mental health component in these services increases accessibility because these services are usually close to the places where the persons lives and are less stigmatizing than specialized mental health services, but integration of mental health care at primary health care level means careful staff training and supervision. Where there is no integrated primary care, additional pressures are put on specialized services, with inappropriate referral to them from primary care and lack of early identification of severe mental problems.

Looking at specialized services, the top of the pyramid, a process of deinstitutionalization, limiting the role of mental hospitals and building a network of community services (including community mental health centers, general hospital psychiatric units, day centers and community residential facilities) increases the accessibility of services. Actually, hospital treatment is required for a minority of people with mental disorders, even in cases of severe disorders. According to WHO, an important aspect of improved accessibility is the implementation of a network of community facilities, where the vast majority of patients with mental disorders have access and can be treated, even in low and middle income countries (World Health Organization, 2010; 2011; 2014).

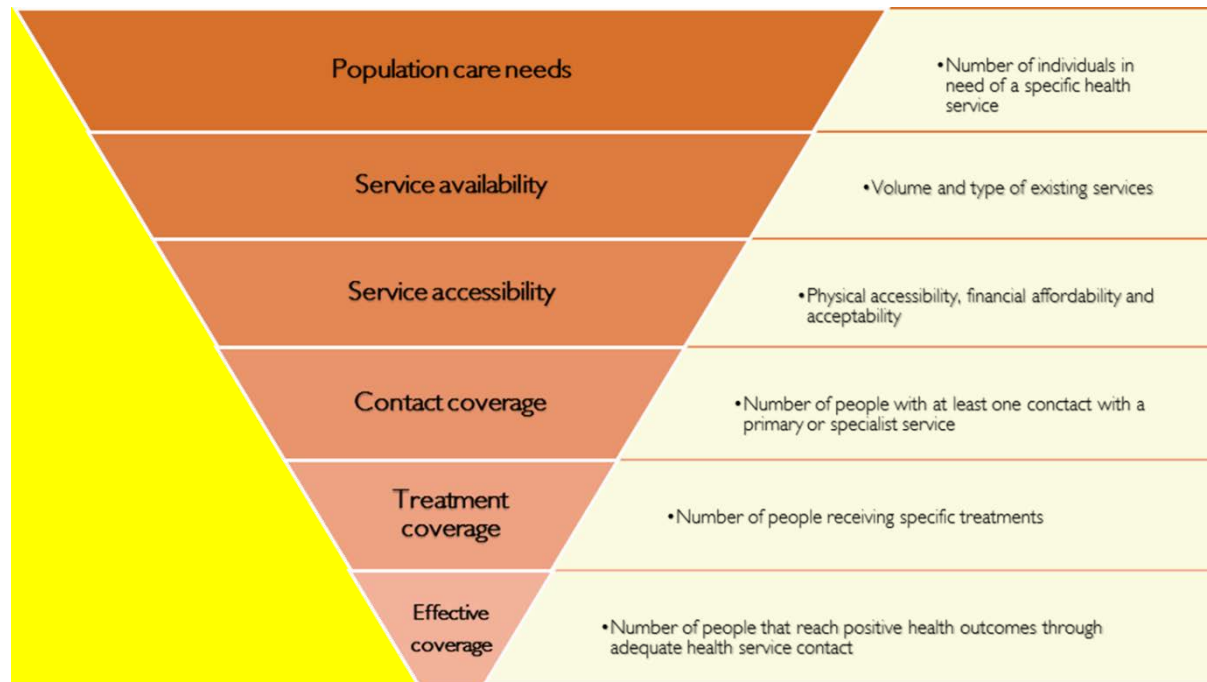
1.2 Definitions of accessibility

From a theoretical perspective (see Figure 2), only a proportion of individuals in need of a specific health service receives therapeutic benefit from a care intervention.

Service accessibility may be conceptualized as the potential degree of fit between patient need and the service's ability to respond to and meet those needs (Penchansky & Thomas, 1981). According to the health services research (Boerma et al, 2014; De Silva et al., 2014; Fradgley et al 2015), service accessibility may be broken down into three dimensions:

- **Physical accessibility:** all the organizational aspects of services that allow people to physically reach them, e.g. geographical proximity, opening hours, waiting times, referral systems. Territorial accessibility is considered as an important element that defines equity in health care (López-Lara et al., 2012);
- **Financial affordability:** people's ability to access services without financial hardship; it takes into account not only the price of the health services, but also indirect and opportunity costs (e.g., the costs of transportation to and from facilities and of taking time away from work) and it is influenced by the wider health financing system and by level of household incomes;
- **Acceptability:** psychological, social and cultural factors that may foster or hinder people's willingness to seek services, e.g. personal characteristics of providers, illness models, service organizational rules, provider perceptions of patients' needs, stigma.

FIGURE 2. CONCEPTUAL SCHEME OF SERVICE ACCESSIBILITY AND COVERAGE



Each dimension may determine the proportion of people suffering from a mental disorder that reach a health service for mental health problems (**contact coverage**). However, the contact with the service may not necessarily translate into effective care: evaluation of service accessibility must also take into account to what extent people receive treatments (**treatment coverage**), the adequacy of care, including issues of therapeutic response (**effective coverage**), as well as treatment adherence and service quality (De Silva et al., 2014).

1.3 Scope of this report

This paper is part of the wider project of The EU-Compass for Action on Mental Health and Well-being that supports the work of the EU-Group of Governmental Experts on Mental Health and Well-being through the preparation of four scientific papers. The aim is to develop these scientific reports in collaboration with the Group and under consultation of non-governmental stakeholders into consensus papers.

The EU-Compass for Action on Mental Health and Wellbeing (2016) is a mechanism to collect, exchange and analyze, information on policy and stakeholder activities in mental health and collect examples of good practices from EU countries and stakeholders on an ongoing basis.

The scope of this report is to provide a conceptual framework to inform policy makers about specific issues in access to mental health care for adult people with mental disorders, through a collection and critical analysis of research and administrative data, including recent scientific papers published in peer-reviewed journals.

2. Methodology

Data for this report have been collected on adult mental disorders from the following sources of information:

1. Surveys among member states from the EU Compass for Mental Health and Wellbeing;
2. The report European profile of prevention and promotion of mental health (EuroPoPP-MH) prepared for the EU Executive Agency for Health and Consumers;
3. The report Towards Community-Based and Socially Inclusive Mental Health Care. Situation analysis and recommendations for action, produced in the framework of the EU Joint Action on Mental Health and Well-being;
4. The 2011 and 2014 editions of the World Health Organization Mental Health Atlas;
5. The report of World Health Organization European Office on Policies and Practices for Mental Health in Europe. Meeting the challenges;
6. The scientific papers coming from the World Health Organization World Mental Health surveys;
7. A European literature review focused on scientific papers, published in peer-reviewed journals, reporting research on prevalence of mental disorders, access to care and adequacy of treatments for people with mental disorders;
8. A review of grey literature and policy briefings describing best practices in European countries aimed at improving access to care for people with mental disorders.

3. Access to mental health care – Situation in Europe

3.1 Prevalence of mental disorders in Europe

According to a number of reports the prevalence of mental disorders in general population is substantial. Although data on all mental disorders are not available for many countries, the most recent epidemiological update available for European countries suggest an overall estimate of one-year prevalence of any disorder around 38% (Wittchen et al., 2011).

Best estimates of prevalence of a core group of disorders are shown in table 1. Although the overall prevalence of mental disorders appears not to be increasing, considering the figures from a previous survey carried out in 2005 with a similar methodology (Wittchen & Jacobi, 2005), the rate remains significantly high.

TABLE 1. BEST ESTIMATES OF SELECTED MENTAL DISORDERS ONE-YEAR PREVALENCE

Diagnosis	Prevalence, %
Psychotic disorders	1.2*
Major Depression	6.9*
Bipolar disorders	0.9*
Anxiety disorders	14.0*
Personality disorders	2.4**
Eating disorders	0.4 (0.3-1.4)*

Source:*Wittchen et al., 2010; ** Huang et al, 2009

The social costs associated with mental disorders are very relevant. The level of Disability-adjusted life years lost (DALYs) related to the most severe disorders represents a remarkable social burden. Major depression ranks first, with an estimate of 71 DALYs per 10,000 population, bipolar disorder is second with 18 and schizophrenia third with 16 (Wittchen et al., 2011). The distribution by gender shows higher rates of DALYs attributable to depression and bipolar disorders in females and for schizophrenia in males (Whiteford et al., 2013; 2015). As a consequence, the financial burden is overwhelming. It has been recently estimated in Europe around 800 billion Euros, including mental and neurological disorders together (Gustavsson et al., 2011). The highest proportion (40%) was attributable to indirect costs in terms of individuals' loss of production, followed by healthcare costs (37%) and social service costs (23%). Beyond the social and financial burden, the hidden emotional impact of mental disorders on affected individuals, their families and social networks should not be

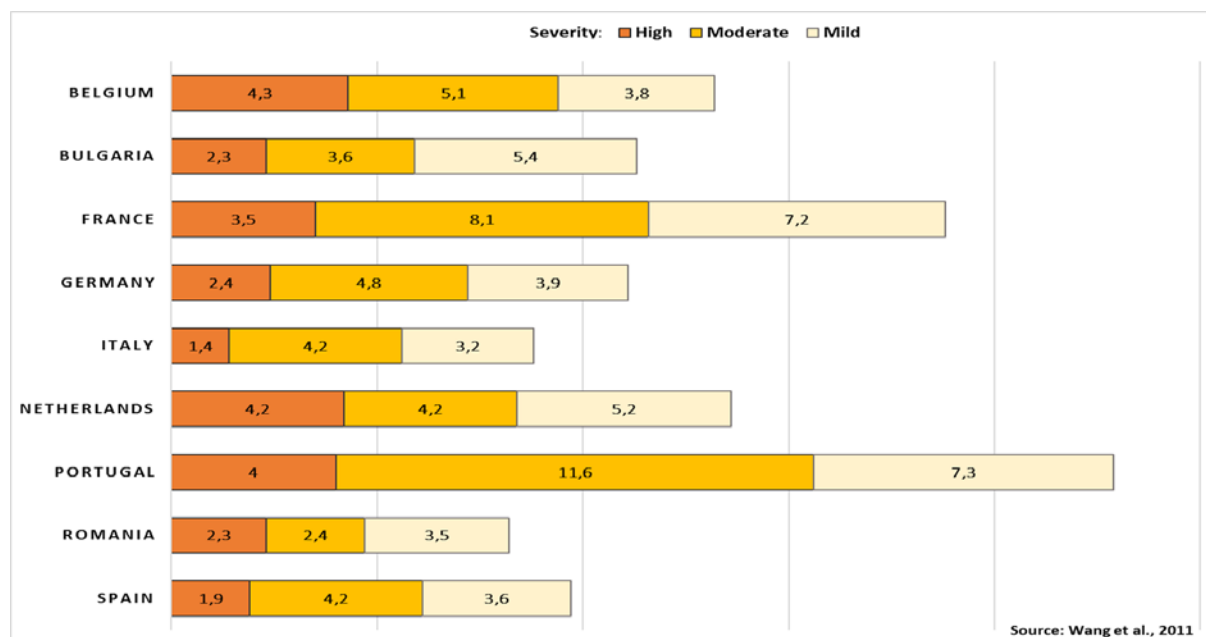
overlooked. Stigma and discrimination are widely reported as an enormous problem. An international study, including a number of European countries, examined the global pattern of both experienced and anticipated discrimination in people with schizophrenia. Nearly half of the participants experienced discrimination in making or keeping friends; 29% had experienced discrimination in finding a job, and 29% discrimination in maintaining employment (Thornicroft et al., 2009).

It is worth noting that prevalence rates based on diagnostic categories have been challenged as a measure of need for two reasons: first because the addition of categorical diagnoses does not take into account the widespread comorbidity leading to overestimated rates, second because in many cases common disorders are transient, self-limited and not associated with impairment.

Studies taking into account severity in addition to diagnosis suggest that between 40 and 50% or more of mental disorders in Europe are mild, therefore not necessarily reflecting a need for treatment (Demyttenaere et al., 2004).

The WHO World Mental Health surveys reported data on prevalence of mental disorders by severity in ten countries of the European Union, i.e. Belgium, Bulgaria, France, Germany, Italy, Netherlands, Portugal, Romania and Spain (Wang et al., 2011). Three levels of severity were identified: high, moderate and mild. It is reasonable to consider both high and moderate severity as a proxy indicator of need for treatment.

FIGURE 3. TWELVE-MONTH PREVALENCE MENTAL DISORDER BY SEVERITY IN WMH SURVEYS



As reported in Figure 3, the rates of highly and moderately severe disorders taken together ranged from 4.7% in Romania to 15.6% in Portugal. However, if we exclude one outlier with unexplained very high rates (Portugal), the median is around 7%. The results of this survey should be considered with caution, because of response rates below acceptable standards in some countries (i.e. 46% in France and 51% in Belgium) and the accuracy of diagnoses probably varied across countries. Moreover, the survey targeted the common mental disorders and excluded clinically important disorders, such as non-affective psychoses and dementia, thus leading to an underestimation of rates of the very severe disorders. However, a tentative interpretation of the findings could lead to conclude that across Europe a conservative figure around 10% represents the mean prevalence of mental disorders severe enough to benefit from treatment.

3.2 Treatment gap

The magnitude of disability of mental disorders is due to a variety of factors, including their early age of onset and their impact on social functioning. However, it results also from the failure of many people to receive treatment because of lack of services, barriers or delayed access to care. This is the well-known problem of treatment gap, which can be defined as the difference between the true prevalence of a specific disorder in a population and the proportion of affected individuals receiving treatment for the disorder. Alternatively, it can be expressed as the percentage of individuals requiring care but not receiving treatment (Kohn et al., 2004).

A World Health Organization report summarizing service utilization from more than thirty studies, raised a lot of concern twelve years ago showing a wide treatment gap even in the most severe mental disorders (Kohn et al., 2004). Main data available from few European countries are shown in Table 2, although cross-national comparisons were difficult because of differences in survey methods and calculations. However, considering a prevalence period for help-seeking of one year, estimates of treatment gap for major depression from nationally representative samples ranged from 36% in the Netherlands to 73% in Finland. For schizophrenia, only data from Netherlands and United Kingdom were available, showing a huge difference between low rates in United Kingdom and very high rates in Netherlands. Estimates of the median treatment gap by WHO regions showed in Europe a 45% gap for major depression, 40% for bipolar disorder and 18% for schizophrenia. However, the authors pointed

out that data were limited and rates were probably underestimated. Moreover, it is worth noting that WHO European region includes many countries not belonging to European Union.

The WHO Mental Health Surveys addressed the issue of treatment gap in relation to different levels of severity. Although the treatment gap was decreasing in relation to the disorder severity, it remained huge even in severe disorders. In this group marked differences across countries were found, with figures ranging from 34% (Portugal) to 69% (Bulgaria). In the moderately severe sample the figures ranged from 63% (Spain) to 83% (Romania). For mild disorders the differences were small, from 79% (France) to 86% (Romania) (Wang et al., 2011). These findings should be considered in relation to the above mentioned limitations of the surveys.

TABLE 2. PERCENTAGE DIFFERENCE BETWEEN NUMBER OF PEOPLE NEEDING TREATMENT AND NUMBER OF PEOPLE RECEIVING TREATMENT

	Czech Republic	Finland	France	Germany	Italy	Netherlands	United Kingdom
Prevalence period for help-seeking	Lifetime	1 year	Lifetime	Lifetime	1 year	1 year	1 year
Diagnosis							
Schizophrenia and non-affective psychoses	-	-	-	-	-	53.3	15.0
Major depression	54.8	73.0	54.8	60.0	15.9	36.2	56.0
Dysthymia	-	-	-	54.0	14.3	-	-
Bipolar disorders	-	-	-	65.0	-	-	-
Panic disorders	-	-	-	65.3	7.0	-	64.0
Generalized anxiety disorder	-	-	-	42.0	-	-	67.0
Obsessive-compulsive disorder	-	-	-	59.0	-	-	60.0
Alcohol abuse or dependence	-	-	-	-	-	82.5	96.0

Source: Kohn et al. 2004

A recent WHO study focused on schizophrenia, but reported data from low and middle-income countries only (Lora et al., 2012a).

A population-based Italian study reported a treatment gap for schizophrenia of 36% in a 10-million people region, suggesting that, even in a system based on universal health coverage and community care, the treatment gap for severe mental disorders requires ongoing attention and appropriate strategies (Lora et al., 2012b). It should be noted that findings about treatment patterns in high-income

countries for long-term physical illness with important public health consequences show a very different picture: the gap has been estimated at 6% for diabetes, 10% for hypertension and 22% for heart disease (Ormel et al., 2008).

Although data on treatment gap in Europe for severe disorders, such as schizophrenia and bipolar disorders are limited, the available evidence on indicators of contact coverage for depression and common mental disorders points out a serious problem in for all countries, especially in countries with a lower level of resources and a less developed healthcare system.

3.3 Access to care

Nationwide administrative data collected by World Health Organization and European Union are shown in table 3.

TABLE 3. INDICATORS OF ACCESS TO CARE IN EUROPEAN UNION COUNTRIES (RATES PER 100,000)

	Mental health services		Mental health professionals				Access to mental health services		
	Psychiatric beds in hospitals	Outpatient facilities	Psychiatrists	Nurses	Psychologists	Social Workers	Inpatient treatment prevalence	Hospital Admissions	Outpatient treatment prevalence
Austria	61.6 ^f	-	19.7 ^b	-	79.9 ^b	-	518.5 ^e	9.3 ^b	-
Belgium	173.5 ^f	0.8 ^c	20.3 ^e	0.0 ^b	1.3 ^b	0.9 ^b	0.9 ^c	-	-
Bulgaria	66.8 ^f	0.2 ^c	6.7 ^b	431.0 ^b	0.9 ^b	0.5 ^b	-	374.7 ^b	-
Croatia	98.8 ^f	4.1 ^e	10.2 ^b	35.6 ^b	2.9 ^b	1.0 ^b	-	996.7 ^b	-
Cyprus	21.8 ^f	2.1 ^e	2.7 ^e	20.5 ^e	2.7 ^e	0.2 ^e	98.7 ^c	-	575.2 ^b
Czech Republic	96.6 ^f	9.4 ^e	11.8 ^b	28.2 ^b	2.0 ^b	0.9 ^b	75.7 ^e	-	-
Denmark	53.8 ^d	-	88.1 ^e	60.2 ^e	12.7 ^e	9.6 ^e	866.1 ^e	-	-
Estonia	55.5 ^f	-	13.5 ^b	-	-	-	-	-	-
Finland	60.7 ^f	1.2 ^e	18.4 ^e	-	56.8 ^e	-	62.5 ^e	876.4 ^b	-
France	87.5 ^f	-	14.1 ^e	90.9 ^e	10.8 ^e	3.8 ^b	-	-	-
Germany	127.1 ^f	1.4 ^c	15.2 ^b	56.1 ^b	-	-	1132.9 ^e	-	-
Greece	72.0 ^f	1.4 ^e	14.1 ^e	50.6 ^e	12.1 ^e	6.9 ^e	-	92.2 ^b	-
Hungary	89.3 ^f	4.1 ^e	6.5 ^b	21.9 ^b	2.6 ^e	3.0 ^b	14.6 ^e	2517.3 ^b	4976.4 ^b
Ireland	35.5 ^f	-	6.1 ^b	112.8 ^b	3.5 ^b	3.8 ^b	-	440.1 ^b	-
Italy	9.5 ^d	2.8 ^b	7.8 ^b	19.3 ^b	2.6 ^b	1.9 ^b	-	441.1 ^b	865.3 ^b
Latvia	126.0 ^f	3.6 ^b	10.8 ^b	30.8 ^b	-	-	-	778.5 ^b	-
Lithuania	107.9 ^f	3.1 ^b	17.8 ^b	-	-	-	-	-	171.3 ^b
Luxembourg	83.8 ^f	61.5 ^e	21.1 ^b	-	-	-	-	257.1 ^b	-
Malta	133.4 ^f	3.9 ^b	3.2 ^b	66.8 ^b	4.4 ^b	5.1 ^b	-	1569.0 ^b	3002.4 ^b
Netherlands	139.3 ^a	261.2 ^e	20.1 ^e	2.9 ^e	90.8 ^e	-	-	-	4092.4 ^b
Poland	65.2 ^f	4.1 ^e	5.1 ^e	18.7 ^e	5.3 ^e	0.7 ^e	82.7 ^e	-	304.1 ^b
Portugal	62.7 ^f	0.3 ^e	4.5 ^e	12.5 ^e	2.2 ^e	0.7 ^e	12.6 ^e	-	-
Romania	82.9 ^f	0.5 ^e	6.0 ^e	16.9 ^e	1.4 ^e	0.5 ^e	-	1211.4 ^b	-
Slovakia	81.8 ^f	6.7 ^b	11.5 ^b	19.3 ^b	-	-	-	616.5 ^b	-

	Mental health services		Mental health professionals				Access to mental health services		
	Psychiatric beds in hospitals	Outpatient facilities	Psychiatrists	Nurses	Psychologists	Social Workers	Inpatient treatment prevalence	Hospital Admissions	Outpatient treatment prevalence
Slovenia	66.2 ^F	5.7 ^B	7.1 ^B	69.7 ^B	4.5 ^B	3.7 ^B	-	3124.0 ^B	2909.0 ^B
Spain	32.2 ^F	3.1 ^E	8.1 ^E	9.7 ^B	5.7 ^E	2.6 ^E	-	573.9 ^B	-
Sweden	135.5 ^F	-	18.3 ^E	52.9 ^E	0.9 ^B	18.4 ^B	-	988.6 ^B	-
United Kingdom	46.1 ^F	7.8 ^{C*}	14.6 ^E	67.3 ^E	12.8 ^E	2.0 ^E	-	427.9 ^{B*}	2340.2 ^{B*}

Source: ^A = European Core Health Indicators 2009; ^B = WHO Mental Health Atlas 2011; ^C = EuroPoPP-MH 2013; ^D = European Core Health Indicators 2013;

^E = WHO Mental Health Atlas 2014; ^F = European Core Health Indicators 2014; * = England only.

As can be seen, data are incomplete for most indicators and show huge variations often not easily explainable, making cross-national comparisons difficult. Rates of hospital beds, which is a gross indicator of service availability and the only information provided by all countries, show a more than fifteen-fold variation between the lowest rate in Italy and the highest one in Belgium. Moreover, in absence of further information, a low rate can be considered as an indicator of shortage of resources or, by contrast, of an advanced shift towards community care. It is worth noting that, despite the policy indications of moving resources from standalone mental hospitals to community care, a number of countries, such as France and Germany, increased their supply of mental hospital beds between 2005 and 2011. This happened even in countries with a previous high level of psychiatric hospital resources, such as Belgium and Lithuania (European Commission, 2013).

Scanty information was available on other resources considered as important in modern community care, such as residential facilities (Thornicroft & Tansella, 2013). Variations in professional resources availability showed also striking differences, with very large unexplained cross-country variations in number of psychiatrists and psychologists.

Data available from few countries on treatment prevalence are difficult to interpret because of differences in service definitions, methods for data collection and quality of data. Therefore, administrative data of mental health services in Europe provide some information on service availability and little usable information to estimate service accessibility and contact coverage.

Few large scale epidemiological surveys addressed at European level access to care for mental disorders. The most important are the findings from the European Study of the Epidemiology of Mental disorders (ESEMed), included in the WHO World Mental Health Surveys. This study showed that about

33% of respondents who had a mental disorder in the past year reported a visit to a health professional because of concerns for their emotional problems (Codony et al., 2009).

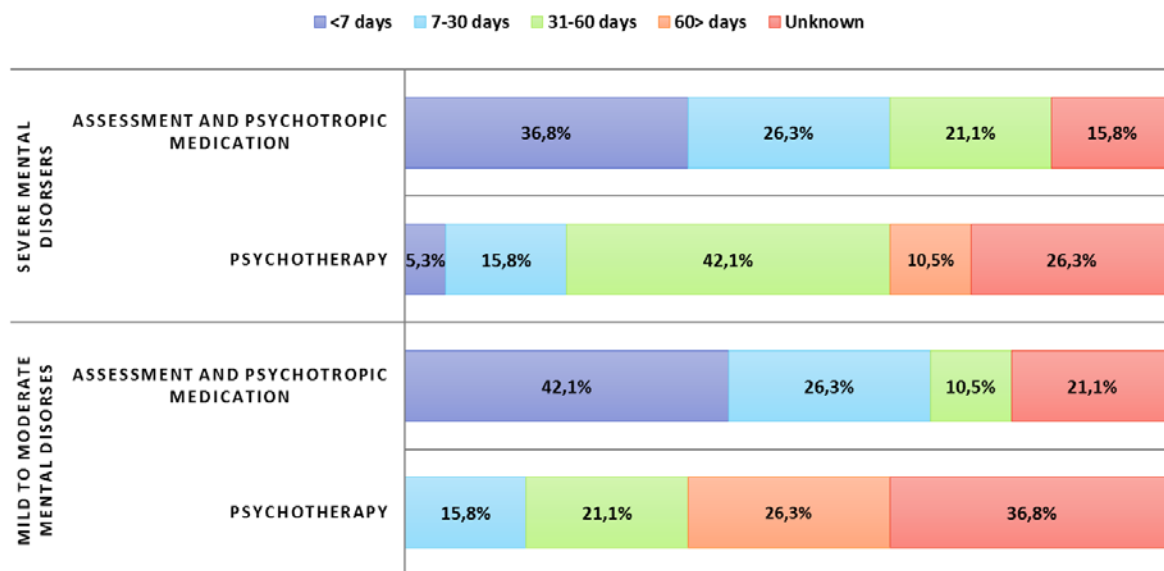
3.4 Access to treatments

Access to mental health care, broadly defined as contact with any healthcare service or professional for mental problems, tells us nothing about the treatment received. Therefore, the analysis of access to treatments (*treatment coverage*) is a further step to understand patterns of care for people with mental disorders. To this respect, relatively few data from European countries are available. Most investigations addressed treatment use by people with depression.

Rates of depressed people receiving antidepressant drug treatment was 36% in the Finnish study by Hämäläinen et al. (2009) and 40% in the German study by Bramesfeld et al. (2007). Bet et al. (2013) reported in the Netherlands different rates for drug treatment prescribed in primary care (23%) and in specialist care (55%). Rates of access to psychological therapies for depressed people were considerably lower: 8% in Italy (Barbato et al., 2016) and 15% in Germany (Bramesfeld et al., 2007), while in the Netherlands, Bet et al. (2013) reported a low rate of 11% for people treated in primary care, by contrast with a much higher rate in specialist settings (46%).

The time between user request of care and service intervention may have a relevant impact on user wellbeing. Figure 4 displays data from a recent survey carried out by the EU Compass for Action on Mental Health and Well-being, indicating average waiting time to care for people with severe and mild to moderate mental illness.

FIGURE 4. WAITING TIME TO CARE FOR PEOPLE WITH MENTAL ILLNESS BY SEVERITY IN EUROPE



Source: EU Compass for Action on Mental Health and Well-Being, 2016 - Information and data collected on annual activities of member states and stakeholders

The median time to receive a psychiatric assessment and appropriate psychotropic medication is between 7 and 30 days in most of EU countries, without differences regarding severity level. Longer waiting times are reported for access to psychotherapy, often requiring more than two months.

No large scale epidemiological survey in Europe assessed access to treatment delivered in office-based private practice by psychiatrists and psychologists. However, sparse indications suggest that, at least in some countries private practice can play a role in care pathways, as shown in a cross-country study on pathways to care in subjects at high risk for psychotic disorder, the role of private practice resulted especially relevant in Germany (Graf von Reventlow et al., 2014). Private practice remains to large extent an uncharted territory for mental health services research.

3.5 Access to adequate treatments

The issue of adequacy of treatments for mental disorders has been the focus of a growing concern over the past years, as a result of a number of studies showing low rates of adherence to good practice guidelines for all mental disorders even in countries with a well-developed system of care (Bauer, 2002). The concept of “minimally adequate treatment” has been used to set thresholds for detection of inappropriate treatments. Although a variety of criteria have been used, there is some consensus on adequacy for drug treatment, while research on identification of quality of psychological treatment is

much less developed and no criteria have been set for more complex packages of interventions, such as psychosocial rehabilitation.

With these caveats in mind, we will consider first the findings from the WHO World Mental Health surveys (Wang et al. 2011), providing data on access to various care sectors (primary care, mental health specialty, human services, complementary alternative medicine), on continuity and adequacy of treatment. In all ten European countries primary care was the main entry point of help for the majority of patients, ranging from 81% in Bulgaria to 52% in Germany. Human services and complementary alternative medicine, taken together, did not play a significant role, with the partial exceptions of Germany and Netherlands, where slightly less than 20% of patients identified them as a source of help. Continuity of treatment was assured to more than 80% of patients with serious or moderate disorders in all countries, with the exception of Romania, where a rate of 77% was found. In most countries the proportion approached 100%. The picture was substantially different for adequacy. The rate of patients who received minimally adequate treatment (defined by considering drug or psychological therapies), although increasing with increasing disorder severity, was relatively high only in Germany and Netherlands (67%). In other countries, for serious disorders ranged from 30% in Romania to 58% in France. It is worth reminding that the WHO surveys did not include people with psychoses.

A few other studies used an epidemiological approach to address the issue of minimally adequate treatment or effective coverage of specific disorders in single countries. Fernandez et al. (2007) used data from the ESEMedto describe treatment adequacy for depressive and anxiety disorders, by assessing both drug therapy and psychotherapy. Overall proportion of adequacy was 46% for depression and 55% for anxiety. By country, adequacy for depression ranged from 33% in Spain to 78% in France and was generally higher in specialist care. In Netherlands Bet et al. (2013) reported a rate of adequacy for drug treatment in severe depression of 69% in primary care and 84% in specialist care. However, adequacy was considerably lower in mild and moderate depression. Hämäläinen et al. (2009) in Finland reported a rate of adequacy of 54%. The authors noted a better satisfaction for patients receiving psychological treatments. Lora et al.(2011) broadened in Italy the study of adequacy by including people with depression, schizophrenia and bipolar disorders treated in psychiatric services in Lombardy. Adequacy was higher for bipolar disorders (56%) and lower for schizophrenia (49%) and depression (46%).

Overall, despite the limited research base, the available information shows, with few exceptions, that too often people seeking help for their mental health problems receive ineffective treatment for their mental health problems. This is more troubling if we consider that the definition of ‘minimally adequate treatment’ used in all surveys is below the good quality standards. Although the specialist sector does not necessary guarantee adequate treatments, the problem is especially serious in primary care.

4. Barriers to treatment

Evidence of high levels of unmet needs for treatment in mental disorders prompted studies of barriers hindering treatment (Mechanic, 2002). Most researchers agree that the main barrier determinants are in the demand side. Low perceived need has been considered the main problem preventing people in need to access formal help (Andrade et al., 2014; van Beljouwet al., 2010). This has been strengthened by the findings of the WHO World Mental Health surveys, where this issue has been investigated (Andrade et al., 2014). Actually, in the European countries participating in the survey, low perceived need has been reported as the main barrier to access by most respondents, with rates of 80% or more in Netherlands, Italy, France, Bulgaria, Germany and Belgium. Among those who felt themselves in need because of mental health problems, attitudinal barriers (negative health beliefs, fear about adverse effects of treatment, fear of stigma) played a major role. Structural and financial barriers (inconvenient location of service, waiting times, costs) were mentioned by a minority of subjects.

However, this issue is far from being settled. First, structural barriers were relatively more important by severe cases, second, other studies presented a different picture. A recent American study showed that inadequate insurance cover was strongly associated with both low perceived need and lack of access despite a felt need. Compared to respondents with insurance, uninsured individuals reported significantly more structural barriers and fewer attitudinal barriers. This hold especially true for people with severe disorders (Walker at al., 2015). This confirmed the findings from previous studies. Sareen et al.(2007)found that low-income respondents were significantly more likely to report a financial barrier in the United States than in either Canada or the Netherlands; Simon et al. (2004) presented data from an international study on predictors of depression treatment in primary care, includingan European site (Barcelona, Spain): 51% of depressed people who perceived need for treatment did not

accessed service (71% in Barcelona). Concern about costs was the most reported barrier and ranked first or second at every site. In sites where universal health coverage was not available costs were considered as a barrier by high rates of respondents: 38% in USA, 40% in Brazil and 75% in Russia. In Spain the rate was 24%, despite free access to primary care provided by the health system.

Respondents to the EU Compass for Action on Mental Health and Well-being 2016 survey indicated the following barriers as having the highest impact on accessing mental health services in member states:

- insufficient funding for mental health services was reported by 19 out of 22 member states having some (27.3%), high (18.2%) or very high impact (27.3%);
- insufficient availability of mental health professionals was reported by 16 out of 22 member states, having some (31,8%), high (27,3%) or very high (13,6%) impact;
- attitudinal barriers (lack of trust, willingness to handle problems by one's own, stigma) was reported by 17 of the 22 member states, having some (40.9%) high (27.3%) or very high(9.1%) impact.

It is possible that financial barriers are more important in health care systems requiring a more or less relevant out-of-pocket payment for access to services or for selected treatments. It is worth noting that psychotherapy and counselling are not always covered by private or public insurances in many European countries or are not available although on paper provided by the national health services, as shown by an Italian study (Barbato et al., 2016).

As far as attitudinal barriers are concerned, some authors noted that stigma role has to be better considered (Clement et al., 2015). Although stigma in itself shows only a moderate negative effect on help-seeking, being reported as a barrier by about 20% of participants across studies, most reported attitudinal barriers, such as low perceived need or wish to handle the problem on one's own, may be partly stigma-related (Clement et al., 2015). Moreover, attitudes cannot be considered as characteristics of the individuals, but within the context of the interaction between people's expectations and illness model with professionals' ideology, behaviours and treatments offered. To this respect, evidence shows that a biomedical illness model is not accepted by many people as an explanation of their mental distress. Psychological approaches to widespread disorders, such as mood disorders, are preferred by patients, but seldom offered by services, especially in primary care (McHugh

et al., 2013; Pontin et al., 2009). It has been also documented that even mental health professionals might carry stigmatizing attitudes (Nordt et al., 2006), thus negatively influencing users' treatment beliefs.

To address the complex issues related to help-seeking as a result of interaction between users and professionals, WHO introduced the concept of responsiveness, as a central feature identified by users for quality of mental health services. It pertains to non-health dimensions including very simple and primary things, such as respect, dignity and consideration for users' values (Bramesfeld et al., 2016). This concept looks as a significant contribution to understand attitudinal barriers to help-seeking. Overall, the interplay between structural and attitudinal barriers in different social, cultural and political contexts need more research to be clarified.

5. Relevant activities in the EU and in the Member States

In recent years, important developments took place in the EU and in the Member States aiming at the improvement of the access of people with mental disorders to effective services and programmes. The EU Joint Action on Mental Health and Wellbeing report dedicated to the transition to community mental health care provides an overview of these developments. It reveals that the European Commission, particularly in the context of the Green Paper on Improving Mental Health (2005), the European Pact for Mental Health (2008) and the Joint Action on Mental Health and Wellbeing (2013-16), has supported several European projects and initiatives that contributed to this objective by promoting research, strengthening networks, mapping of resources and practices, and developing recommendations and guidelines. For instance, the *DECLOC (Deinstitutionalisation and Community Living – Outcomes and Costs)* project identified successful strategies for replacing institutions with community-based services, paying particular attention to economic issues in the transition process. The *MHEEN (Mental Health Economics European Network)* project estimated cost-effectiveness of mechanisms and strategies to assess mental health service utilisation and costs. The *Development of a European Measure of Best Practice for people with longer term mental health problems in institutional care (DEMOBinc)* project led to the development of a toolkit that assesses the living conditions, care and human rights of people with longer term mental health problems in psychiatric and social care institutions. The *ITHACA (Institutional Treatment, Human Rights and Care Assessment)* project developed a toolkit that provides information on monitoring practices, explain appropriate human

rights literature and conventions and outline audit/monitoring procedures for an on-site visit. With a focus on the ways in which mental health care is financed, the *REFINEMENT (Research on Financing Systems' Effect on the Quality of Mental Health Care)* project led to the development of toolkits for mapping services, analyse data and information available from disparate and fragmented sources, and to aid decision-makers select health care financing arrangements. Practical advice is provided by the *Common European Guidelines on the Transition from Institutional to Community-based Care*. With a different perspective, the *European Network on Independent Living / European Coalition for Community Living Report* provides relevant information to assess the extent to which the EU has complied with its obligations set out under Article 19 of the UN Convention on the Rights of Persons with Disabilities (CRPD).

The above mentioned Joint Action Mental Health and Wellbeing report also includes an analysis of the activities developed by Member States contributing to the development of a more community-based and accessible mental health system. This analysis reveals that the integration of mental health in primary care, deinstitutionalisation, and development of community-based care were assumed by more than half of EU countries as major goals of their mental health policies. Most countries have promoted the availability of mental health care in primary care. Very significant advances were also made in the development of short-stay inpatient care in general hospitals. Although in a less systematic and variable way, residential facilities in the community were developed in most EU countries, contributing to provide residential support and psychosocial rehabilitation in the community to people with severe mental disorders who have not the possibility to live independently. The number of outpatient facilities and outpatient visits has been increasing in most countries where information is available. Community mental health centres also increased in a significant way in most countries.

Information collected through the EU Compass survey show significant advances in the last year. Several countries developed activities aiming at the preparation of a National Mental Health Program (Slovakia), or the updating of the national MH strategy and new agreements concerning the reform of child and adolescent care (Belgium). The majority of the countries (80%) reported activities related to reorganization of services in the last year. Most of these activities were focused on the creation/development of community services and deinstitutionalization, as well as in the development of psychological support in primary care. For example, a reform of mental health care for adults in Belgium included the increase of mental health professionals in the existing mobile teams and the

creation of new mobile teams. Latvia approved an Action plan for deinstitutionalization and developed guidelines on community based social services and efficient management for people with mental disabilities. In Lithuania, the network of day centres was expanded and crisis intervention centres were created. Netherlands reported an increase of the general practitioners that contracted a psychological assistant up to 80%. Norway also invested in having psychologists in municipalities, and developed the project Mental Health Care Now, which is based on the British program on improving access to psychological interventions. A special attention has been dedicated by several countries (e.g. Belgium and Italy) to the improvement of information systems and the development of monitoring programmes. More than 70% of Member States reported new developments in the involvement of patients, families and NGOs. For instance, in Belgium, both patient and family organisations, as well as NGO's, were involved in the reform of mental health care, while representatives of patients, families and NGOs participated in the preparation of the Mental Health Law in Slovenia.

6. Best practices

Over the past few years a number of best practices have been implemented in broader European contexts and provide good examples of innovative and creative approaches to promote mental health care access in relation to evidence-based programs. Here are some examples

6.1 Germany Alliance against Depression (GAAD)- Germany

In 2001 the “Nuremberg Alliance against Depression” (NAAD) was initiated as a pilot project within the German Research Network on Depression and Suicidality, funded by the German Ministry of Education and Research. It took place on a community-based level in the city of Nuremberg (500,000 inhabitants).

This project included the following actions at different levels of the health care system :

1. cooperation with primary care physicians to optimize diagnosis and treatment;
2. promotion of public campaigns to inform the population about depression (by posters, leaflets, community events);
3. cooperation with community facilitators (e.g. teachers, counsellors, priests, nurses, policemen, media);

4. development of services for persons with depression and their relatives (hotline for patients after suicide attempt, self-help groups).

During the 2-years intervention, the frequency of suicidal acts in the city of Nuremberg showed a decrease of 24% compared to the baseline and to a control region. Since 2003, the “Nuremberg Alliance Against Depression” model has spread all over Germany, more than 40 German regions have initiated their own intervention programmes under the umbrella of the “German Alliance Against Depression” (GAAD)(www.buendnis-depression.de).

The four-level intervention concept appears to be cost-effective and has been implemented in 16 European countries which established the ‘European Alliance Against Depression’ (EAAD) in 2004 (Hegerl et al., 2008). Based on the Nuremberg project, all regional partners initiated respective regional intervention programmes addressing depression and suicidality. Evaluation of the activities takes place on regional and international levels. This programme is a relevant example of how European community-based ‘best practice’ models for improving the care of depressed patients and suicidal persons can be implemented using a bottom-up approach. EAAD is mentioned by the European commission as a best practice example in the Green Paper *Improving the mental health of the population: Towards a strategy on mental health for the European Union* (European Commission, 2005).

6.2 Improving Access to Psychological Therapies (IAPT) - England

The Improving Access to Psychological Therapies (IAPT) programme was developed to provide psychological treatments for people with depression and anxiety and it is included within the national policy “Achieving better access to mental health services by 2020” in England (Department of Health, 2014). The IAPT began in 2006 in England with the aim to develop talking therapies services as routine first-line treatment alone or combined with medication, to address both the high prevalence and burden of these disorders and the number of untreated individuals (Clark et al., 2009).

At the beginning, the programme was first targeted at people of working age only in demonstration sites (Doncaster and Newham, UK), but in 2010 was opened to adults of all ages across England.

The IAPT approach is based on four main principles:

1. better access to services;

2. clinical improvement and recovery;
3. improved social and economic participation, including employment for working age people;
4. increased patient choice and satisfaction

Adopting a stepped care organizational model, the programme offers two intensity levels of care, low and high, depending on symptoms severity and patients' preferences (Hepgul et al., 2016). More than 3,700 therapists and psychological wellbeing practitioners received a specific training, offered as continuing professional development.

The adult IAPT programme has resulted in over three million people entering treatment since it started in 2008 with more than 685,000 people moving to recovery (up to the end of September 2015). Overall recovery rates were 45% in the last quarter of 2011, showing a relevant improvement over the duration of the programme (www.england.nhs.uk/mentalhealth/adults/iapt/).

6.3 The Mental Health Crisis Care Concordat - England

This is an England-wide national agreement between the different agencies and services involved in the care of people experiencing, or at risk of experiencing, a mental health crisis. It has been included in a broader English governmental policy addressed to improve mental health system in England achieving better access to mental health services by 2020 (Department of Health, 2014). Launched in February 2014, the Concordat focuses on improving the quality and availability of help and support for acute mental health crises, as well as prevention and recovery (Gibson et al., 2016).

The four main aims of the Concordat are:

1. Access to support before crisis point (people with mental health problems can get help 24 hours a day)
2. Urgent and emergency access to crisis care (health crisis is treated with the same urgency as a physical health emergency)
3. Quality of treatment and care when in crisis (dignity, respect and good therapeutic environment are considered essential components of the treatment)

4. Recovery and staying well (prevention future crises and referral to appropriate services are relevant goals of the routine practice)

Twenty-seven national bodies came together and signed up the Concordat, representing health, the police, social care, national and local government and the third sector organizations. In 2014, an evaluation of the work being undertaken to implement the national Mental Health Crisis Care Concordat statement in England has been commissioned. A total sample size of 603 online survey were retrieved in order to understand the experience of crisis care from the perspectives of service users and carers, and examine any change in their experiences over time. Data on additional results are available from: <http://www.crisiscareconcordat.org.uk/resources/>

6.4 Open dialogue (OD)– Finland

The Open Dialogue (OD) is a network-based approach to care of psychoses, pioneered in Finland in the rural area of Western Lapland since the mid 1990s (Seikkula et al., 2006).

The Open Dialogue adopted an organizational model that ensure provision of immediate mental health care: mental health clinics arrange the first meeting within 24 hours of the first contact, in addition to this, a 24-hr crisis service exists through mobile teams. Therapeutic interventions responses to the specific needs of each person were used in a flexible way and since meetings were usually organized at the patient's home, with the consent of the family.

Research identified several milestones of this approach:

- strong engagement of social and family network;
- psychological continuity of care;
- responsibility of entire treatment process by the multi-professional team.

Studies have shown that the OD approach leads to a reduction in hospitalization, in the use of medication and recidivism when compared with standard treatments. In one five-year study, for example, 83% of patients had returned to their jobs or studies or were looking for a job, 77% did not have any residual symptoms (Seikkula et al., 2006).

Currently national pilot projects involving the OD approach are underway in Poland (Klapcinsky, 2015) and England with the involvement of peer support workers as experts in the training and process

(Peer Supported Open Dialogue, available from: <https://www.kmpt.nhs.uk/research-and-development/open-dialogue.htm>).

Moreover, a pilot implementation (funded by the Centre for Disease Control) of the OD approach is under experimentation in Italy in eight mental health departments under the scientific coordination of the National Research Council, which carries out the evaluation (available from: <http://www.istc.cnr.it/projects/ongoing>).

6.5 Program for integration between Primary Care and Mental Health Services – Emilia Romagna, Italy

This Program was started in 2000 as an effort of the Health Government of Emilia-Romagna Region to coordinate a number of bottom-up initiatives of primary care-mental health cooperation (Menchetti et al., 2006). Over the last decade a region-wide collaborative network, composed by representatives of local health authorities, mental health and primary care departments, academic and scientific institutions has been developed.

Two main objectives were identified:

1. to improve the quality of treatment for patients with common psychiatric disorders in primary care;
2. to modify the pathways of care, supporting the management of common psychiatric disorders in primary care and focusing mental health services' activities towards severe or difficult-to-treat cases.

The framework of this program was inspired by the stepped care model proposed in the NICE guidelines for depression and anxiety (NICE, 2004; 2009). Regional recommendations for depression were developed and disseminated. A series of educational started from a regional-level “training for trainers” course, and continued at local level. Trainers were selected among key professionals: Primary Care Physicians (PCPs) were chosen among group coordinators, trainers for the Italian Society of Primary Care Medicine, and PCPs with mental health care background; psychiatrists involved in the project were selected among those having previous experience with primary care sector (Rucci et al., 2012).

The project achieved the following results:

- Implementation of innovative experience of psychiatric consultation-liaison services for primary care across the Region.
- Region-wide training events that involved approximately 150 professionals (PCPs and mental health professionals) from all the 9 local health trusts of the Region.
- Development of a regional guideline for the management of common mental disorders between primary care and mental health services (2007).
- The project impact has been evaluated through a cluster-randomised trial. 227 adults with an onset of depressive symptoms were recruited by primary care physicians of eight health districts from September 2009 to June 2011 and compared with patients who accessed to usual care. At three months (n=210), the proportion of patients who achieved remission was higher in the collaborative care group. When considering only patients with minor/major depression, collaborative care appeared to be more effective than usual care (Menchetti et al., 2013).

6.6 Permanent Access to Mental Health Care (PASS Psy) - Paris, France

In 2010 the Hospital and Care Organization Direction of Paris funded the *Réseau Psychiatrie Précarité* to create 40 experimental teams named PASS Psy (*Permanence d'Accès aux Soins de Santé Psychiatrie*). This model has been subsequently adopted by many services across France (Averiller&Meruel, 2011).

Each PASS Psy team is composed by social workers, nurses and general practitioners, and it is located in the same offices of the Mental Health and Social Exclusion service (*Santé Mentale et Exclusion Sociale, SMES*). The scope of the PASS Psy project was to help- people with complex health and psychosocial needs related to social disadvantage to easily access an integrated service providing mental health healthsocial care.

The main objectives were:

1. To foster social rights of people with mental disorders facing the risk of social exclusion;
2. To help people with mental disorders to easily access care through the integration of psychiatric emergency teams with primary care;

3. To strengthen coordination and collaboration between mental health services, primary care, social services to foster continuity of care and patients' rights;
4. To set up a permanent cross-professional network including all actors and stakeholders involved in social and health care at community level.

A provisional qualitative evaluation of PASS psy, included in the evaluation of the national mental health plan, concluded that PASS psy teams were mainly implemented in urban areas, adopted an outreach model, provided effective crisis intervention and were able to contact a population with high numbers of low-income males, homeless and migrants usually not served by mainstream traditional services.

6.7 Pilot project for developing a model for community mental health service (CMHC) in Blagoevgrad (Bulgaria)

The pilot community mental health centre (CMHC) in Blagoevgrad (Bulgaria) was inaugurated in 2005 as a part of the wider project "Mental Health Project for south-eastern Europe" financed by WHO with the effort to bring the region closer to the norms and aspirations of the European Union. The Centre provides services to the region's population in relation to early detection of psychiatric disorders and psychotic states, diagnostic assessments and development of therapeutic plan. Early training of the personnel was provided by team of specialists in community psychiatry from the New Bulgarian University (Sofia) in close cooperation with the Medical College in Blagoevgrad.

The total number of personnel employed in the existing psychiatric dispensary is 68 - 8 doctors, 2 psychologists, 1 social worker, 1 occupational therapist, 30 nurses and 26 non-medical staff. The outpatient unit includes a day-care centre and an outpatient service that is the basis for the newly established pilot community mental health center (CMHC) (WHO, Regional Project Office of the Mental Health Project for South-Eastern Europe, 2005). The Centre provides a variety of programs for psychosocial rehabilitation and re-socialization aiming to bring people back into the community and fully integrate them so they are able to work and live independently.

The following type of services are delivered at the CMHC: outpatient care, including consultation, diagnostics, short and long -term treatment, home visits and crisis interventions, group and individual rehabilitation, and social rehabilitation programs; inpatient care - acute treatment; forensic psychiatric consultations.

The CMHC also developed connections with other mental health and health services, local regional hospital and specialists in private practice in other regions in Bulgaria. Linkages with community organizations and NGOs have been established through years (i.e. Global Initiative in Psychiatry, Open Society Foundation, Organization of Parents Against Dependency, Red Cross, Regional Youth Centre, etc.)

In more than 5 years of its establishment the center offers complex of psychosocial services in the community, creating conditions for comprehensive care for persons with mental disabilities during their day life. The basic principles established in the CMHC in Blagoevgrad were disseminated in the development of similar centers in the country. One of these successful projects is located in Sofia, “Slatina” District. It is a mutual project of Global Initiative on Psychiatry and the Sofia Municipality (WHO, 2012).

6.8 Andalusian Public Foundation for Social Integration of People with Mental Illness(FAISEM)

As a result of the regional Andalusian reform, in 1993 a public foundation, called FAISEM was jointly funded by the four government departments (health, social affairs, employment and economy and finance) to provide social support services for people with severe mental disorders in the community.

FAISEM manages a network that mainly includes residential facilities, occupational and vocational activities addressed to mental health (MH) users already in contact with local MH services with the aim of promoting social inclusion citizenship and recovery.

Residential programs include boarding homes for 10-20 users, supervised housing for a maximum of 10 users who required moderate level of assistance and Home support service consisting in regular visits to the user’s own home or family home.

A relevant activity offered by FAISEM is the employment programme that include vocational opportunities, service of employment guidance and support tailored on mental health users’ individual needs. Training and technical support for social enterprises providing job opportunities for initial work experience is also provided by specialized FAISEM teams.

In 2006, with regard to employment programmes, 425 people worked in social firms, 52.5% had a mental health disorders, 76% were mainly men with an average age of 37 (25% under the age of 30), 80% had a diagnosis of schizophrenia or other severe mental illnesses (Valmisa Gómez de Lara et al., 2008).

In 2007, in the FAISEM's housing programme (boarding houses, apartments and home support):

- 1,819 places were available;
- 68.6% of the people hosted in these residential resources were males with an average age of 46 (ranging between 19 and 87 years of age) and single (80.3%);
- 85.9% of the people attended housing programme were diagnosed with schizophrenia, 5.0% had emotional disorders, 4.0% had personality disorders, 2.4% suffered from learning disability, 1.8% had other diagnoses.

7. Conclusion

Although data routinely collected by European Union and World Health Organization give some indications on access to mental health care in Europe, the bulk of information is provided by a number of population-based and service-based epidemiological studies. However, research is sparse, cross-country comparisons including European countries are limited and the evidence is not particularly strong. Considering these limitations, we can conclude that access to mental health care in European Union is far from being satisfactory.

Coverage is better for severe mental disorders, such as psychoses, and much worse for depression and common mental disorders. For many European countries no sound data have been found, but the available information suggest huge differences across countries, requiring thorough investigations. Even among people accessing care, treatment coverage is inadequate and quality of treatments often low. Few information is available on barriers to treatments, although probably a mix of attitudinal and structural barriers are operating to hinder access to effective care.

Structural barriers may be more important in countries with limited health coverage and less developed community care, attitudinal barriers are important everywhere. However, trends in containment of health costs can raise the role of financial barriers even in countries with universal health coverage.

Low perception of need is an important attitudinal barrier and may be related to stigma, conflicting illness models between users and professionals, and limited responsiveness by services to patients needs and expectations. Although there are suggestions that in some countries attitudinal barriers to

treatments are decreasing, more efforts are required in this direction (Evans-Lacko et al., 2013). Moreover, greater acceptance of professional help for mental health problems may be associated to changes to the worse of the attitudes towards people with mental illness (Schomerus et al., 2012). The lack of coverage is especially relevant for psychological and psychosocial treatments, despite indication from guidelines about evidence-based care models.

8. Principles and Recommendations

The conclusions of this report require that the European Union and the Member States develop and implement policies and services to address pitfalls and gaps in European health care systems, in order to improve access to care for people with mental disorders. To achieve this, we propose the following set of principles and recommendations:

Principles:

1. **Protection of human rights:** People with any mental disorder should be protected from all types of discrimination and stigmatisation, and their rights and opinions considered and respected in any care setting, including the right to the choice of providers and to good quality care.
2. **Accessibility:** People with any mental disorder should have easy and affordable access to care targeted to their specific mental health problems.
3. **Equity:** Access to care should be insured to people in need regardless of their place of residence, social and economic circumstances, gender, race, type of problem.
4. **Quality:** The care provided should be of good quality, including evidence-based approaches and considering the users' preferences.
5. **Participation of all stakeholders:** People with mental disorders and, if appropriate, members of their family and interpersonal network, should be actively involved in planning and delivery of services that they receive. They should be considered as important partners in the provision of mental care and receive training and education if needed. All key agents of the community (e.g. municipalities, social, education and cultural associations, NGOs, self-help groups), should be actively consulted and involved as well.
6. **Focus on primary care.** Primary care is the main entry point to treatment and an important source of help for people with mental disorders. Therefore, it is a key component of the mental health

system. The development of mental health services relies on the effective role of primary care. This has to be recognized by providing training opportunities and resources to primary care workers and ensuring their links with specialist services.

Key recommendations:

1. To establish a consensus on clear operational definitions of any meaningful aspect of mental health indicators, mental health services and patterns of care to be used in routine data collection.
2. To commit the member states to improve the quality of mental health-related data reporting.
3. To implement Europe-wide projects to monitor mental disorder prevalence and access to care.
4. To implement studies on physical, economical and cultural barriers to care and on strategies to address them.
5. To identify treatment gaps and improve integration between social, educational and health services.
6. To foster capacity of primary care workers to effectively identify, treat and refer mental disorders, disseminating effective models of integrated treatments, including drugs, psychological interventions and psychosocial support strategies in primary care, especially focused on depression.
7. To strengthen the ability of specialist mental health services to promote easy and early access of people with psychoses or at risk of psychosis, by providing a user-friendly access to care.
8. To increase the availability of multidisciplinary teams, if necessary by including professionals with psychological and psychosocial skills in primary care.
9. To implement studies on relationships among costs, quality and outcomes to obtain a complete assessment of mental health system performance.
10. To implement Europe-wide programs to increase knowledge of mental health problems within the context anti-stigma and empowerment-building strategies.
11. To commit member states to include in health coverage the access at no cost to psychological interventions and psychosocial rehabilitation packages.

12. To promote a consultation with the organization of consumers and carers to reach a consensus with professionals about user-friendly service organization models and evidence-based treatments in agreement with users' illness models and expectations.
13. To commit member states to promote the participation of all stakeholders, including users, carers and community agents in service planning, monitoring and delivery at all levels.

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