

# **EU COMPASS FOR ACTION ON MENTAL HEALTH AND WELLBEING**

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## **SUMMARY AND ANALYSIS OF KEY DEVELOPMENTS IN MEMBER STATES AND STAKEHOLDERS**

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## Executive summary

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).

This is the first annual activity report of the EU Compass for Action on Mental Health and Wellbeing. It includes a summary of the key mental health activities developed over the past year by Member States and stakeholders, an assessment of the progress made towards the objectives of the European Pact for Mental Health and Wellbeing and of the Framework for Action on Mental Health and Wellbeing, and recommendations for the future. The report is based on an analysis of the information collected through the EU Compass survey and presented in the relevant EU Compass scientific papers.

The analysis of activities developed by Member States and stakeholders shows that significant progress was made towards some of the objectives of the European Pact and the Framework for Action over the past year.

Many countries developed or updated their mental health legislation, particularly in areas related to the regulation of coercive measures, quality of care, and integration of people with disabilities. Most policy developments were centered on the development of new strategies, particularly in fields related to child and adolescent care, dementia, suicide prevention, quality of care, and the delegation of care to municipalities due to decentralization.

National funding available for mental health increased in several countries, namely for children's and young people's mental health, Alzheimer's disease, suicide

prevention, e-mental health, research, alternative services for forensic hospitals, and eating disorders.

The reorganization of services continued, particularly through actions related to deinstitutionalization and the creation of new community-based services (e.g. mobile teams, day centers, and crisis intervention centers), and psychological support in primary care. Improving information systems, developing monitoring programs, creating quality indicators and indicators of quality have been also important goals to several countries.

Important advances have been achieved in promotion and prevention programs, in areas such as fighting stigma, suicide prevention, work-based programs, school-based programs, and programs on alcohol and other addictions. Another area in which we can see significant progress is the participation of users, families and non-governmental organizations in mental health policy and services development.

Significant developments also took place in the 'mental health in all policies' approach, both at the national and the EU level. Several countries reported multi-ministerial collaboration initiatives and new programs involving non-health sectors such as education and employment, among others.

The most significant area in which stakeholders developed their activities was the provision of mental health services. Other important areas of stakeholder activity were education and training, advocacy, and mental health promotion programs.

The actions most frequently developed by Member States for tackling depression and promoting resilience in the past year were actions related to improved recognition of depression by medical professionals and subsequent referral and treatment, followed by actions providing families and/or high-risk groups with support or tools to build resilience and reduce stress. The most common activities developed by stakeholders with this same objective included improving public awareness of depression and access to care, support that builds resilience and reduces stress, implementation of self-help and/or self-management tools, and service delivery on depression.

In order to improve access to care, the majority of Member States developed activities related to the reorganization of services, focusing on the integration of mental health and psychological assistance in primary care, development of crisis intervention centers and mobile teams. With the same purpose, stakeholders reported actions to improve public awareness and access to care for depression, as well as public campaigns aimed at destigmatizing depression and other mental illnesses, and at improving early detection.

Based on this assessment, the following recommendations should be taken into consideration:

**Legislation and policy:** The updating of mental health legislation remains an important challenge. New steps will have to be taken to integrate the new concepts

introduced by the Convention on the Rights of Persons with Disabilities into national mental health laws, and to give human rights issues the position they deserve in public mental health. More concerted efforts are also needed in order to ensure the sustainable and effective implementation of policies contributing to the promotion of mental health, and the prevention and treatment of mental disorders.

**Information systems:** Developing and improving information systems should be a priority for all Member States. New indicators on the use of services are needed to better monitor the shift toward comprehensive community care. New indicators on the outcomes of interventions and policies are also needed to measure their impact.

**Financial and human resources:** In most countries, more financial resources and a more rational use of existing ones are needed. Financial incentives should also be set in place in order to facilitate the transition to community-based approaches in mental health. New efforts are also needed to develop human resources prepared to support the development of these new approaches.

**Promotion of mental health:** A stronger and more systematic investment should be made at both the national and the EU level to develop strategies and programs that contribute to fighting stigma and which promote the mental health of people in all stages of life. New programs involving non-health sectors such as education, work and employment, among others, are needed, in the context of a mental health in all policies approach.

**Prevention and treatment of depression and other common disorders:** In relation to the prevention of depression and promotion of resilience, further efforts are specifically needed in raising awareness, developing self-help and/or self-management tools, enhancing surveillance for depression, and promoting the use of e-mental health tools.

**Access to mental health care:** Regarding care for common mental disorders, more attention should be paid to cooperation between the social and health sectors, training for primary health care professionals, and development of community-based services. Vigorous efforts should also be made to address the gap that exists between psychotherapy and other psychosocial interventions.

With respect to care for people with severe mental disorders, the transition from institutions to comprehensive community-based care remains a key priority in the EU. Significant progress was made in clinical care. It is now necessary to also pay attention to the importance of high quality supported housing, meaningful activities (paid or unpaid), the role of peer support workers, and the significant importance of helping people to sustain or create strong social networks in their communities, as these are all part of person-centered, recovery-focused mental health services.

## Introduction

Mental health studies and surveys have revealed that mental disorders are highly prevalent in Europe and impose a major burden on individuals, society and the economy. Mental health problems are also a key reason for losses of productive human capital, due to their association with high rates of presenteeism and absenteeism, which represents a significant share of the EU's burden of disability (European Commission, 2016a). Positive mental health and wellbeing contribute to improved social cohesion, economic progress and sustainable development in the EU.

To address these challenges, the European Commission launched, in 2005, the Green Paper "Improving the mental health of the population: Towards a strategy on mental health for the European Union" (European Commission, 2005), which helped highlight the relevance of mental health for the EU, the need for a strategy at the EU level, and its possible priorities.

The debate sparked by the Green Paper led to a process that resulted in the launching of a European Pact for Mental Health and Wellbeing in 2008 (European Commission, 2008), and the establishment of the Joint Action on Mental Health and Wellbeing under the EU Health Program in 2012.

The Joint Action for Mental Health and Wellbeing, which started its work in 2013 and involves 25 Member States as well as Iceland and Norway, shows that significant advances have already taken place in Europe in public mental health. Many countries have developed or initiated some type of mental health reform in the past few decades, and most countries' psychiatric services have undergone important transformations. At the same time, prevention and promotion programs involving cross-sector cooperation have been increasingly integrated in mental health strategies.

Nonetheless, important challenges remain to be effectively addressed (European Commission, 2016b). In order to respond to these challenges, the Framework for Action on Mental Health and Wellbeing, launched in Brussels on January 22, 2016, defined five main objectives (European Commission, 2016a), aligned with the priorities previously defined by the WHO (2013a, 2013b):

- Ensure the setup of a sustainable and effective implementation of policies contributing to the promotion of mental health and the prevention and treatment of mental disorders;
- Develop mental health promotion and prevention and early intervention programs, through the integration of mental health in all policies and multi-sectoral cooperation;
- Ensure the transition to comprehensive mental health treatment and high quality care in the community that is accessible to all, emphasizing the availability of mental health care for people with mental disorders, the



coordination of health and social care for people with more severe mental disorders, and integrated care for mental and physical disorders;

- Strengthen knowledge, the evidence base, and the sharing of good practices in mental health; and
- Partnering for progress.

In order to support Member States in reviewing their policies and sharing experiences to improve policy efficiency and effectiveness through innovative approaches, while taking into account specific needs at the local, regional and national levels, the Framework for Action also includes general and specific recommendations for each objective, both to Member States and to the European Commission.

The implementation of these recommendations will be a key challenge for the mental health sector in the next few years. With this in mind, the Commission established the EU Compass for Action on Mental Health and Wellbeing in order to create a mechanism for the dissemination of the policy recommendations resulting from the Joint Action and to promote the exchange of information on implementation activities and good practices among Member States.

The EU Compass provides Member States as well as stakeholders with an opportunity to share annual reports about their activities on mental health, the reasons behind the activities, the progress made in their implementation, and the achievements resulting from them.

This Report is the first annual activity report of the EU Compass, and in it the reader can find a summary of the key mental health policy-related activities developed over the past year by Member States and stakeholders, and a critical analysis of the developments implemented in the past year to tackle depression and/or promote resilience and improve accessibility to mental health care, as well as recommendations for the future.

## Methodology

To assess the progress made across EU Member States over the past 12 months we analyzed information, data and good practices that had been collected and identified through the EU Compass survey and presented in the relevant EU Compass scientific papers. We also took into consideration data and information presented in the Joint Action on Mental Health and Wellbeing and in WHO reports.

The EU Compass survey was carried out with the collaboration of national representatives of the Member States and European working groups, including relevant experts, policy makers and other stakeholders.

The questionnaires for Member States and stakeholders used in the survey were divided into two distinct sections: baseline questions and theme-specific questions. More detailed information on the development, structure and contents of the questionnaires can be seen in Annex 1 (Sections of the Questionnaires) and Annex 2 (Report: “Information and data collected on annual activities of Member States and stakeholders”)

Data collection took place between February and May of 2016. Completed questionnaires were submitted by web-based survey tools and checked for any inconsistencies or missing data. The questionnaires were sent out to 28 Member States, as well as Norway, Iceland, and Turkey (a country that is regularly invited to EC activities), and to 620 non-governmental stakeholders in the realm of health, social affairs, education, workplaces, justice, and civil society.

Of the 28 Member State representatives and three additional countries invited to respond to the Member State questionnaire, 22 responded (Austria, Belgium, Bulgaria, Croatia, Denmark, Estonia, Finland, Hungary, Iceland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Portugal, Romania, Slovakia, Slovenia, Spain, Turkey, and the United Kingdom). Of the 620 stakeholders invited to fill in the survey, 60 responded.

Raw data from all the questionnaires was extracted and transferred into an Excel spreadsheet and re-checked to ensure that the correct information was received and entered. All data analyses were performed using SPSS (Statistical Package for the Social Sciences), version 23. This package was used to carry out descriptive statistics (e.g. frequencies and cross-tabulations) on mainly binary and categorical data.

## Key developments in mental health and wellbeing activities by Member States over the past year

### Legislation

New activities related to mental health legislation took place in more than half of the countries. In some cases the activities focused on the assessment of the needs for reform of the existing mental health legislation (e.g. Finland), or on the preparation of new legislation (Slovakia). In other cases, the activities aimed at integrating new concepts into existing legislation. This was the case in Lithuania, which introduced the term 'limited ability' from the Convention on the Rights of Persons with Disabilities into its Civil Code.

Some countries revised their existing legislation or drafted new legislation in order to regulate coercive measures and address problems related to security (Denmark); while others addressed problems related to the detention, neglect, maltreatment and abuse of minors (Slovakia); or changed their legislation in order to regulate admission procedures (Slovenia) or the closure of forensic mental hospitals (Italy). New legislation transferring the responsibility for children's and adolescent mental health care to the municipalities, as well as on long-term health care and the integration of people with disabilities into the labor market, was also approved in the Netherlands.

We can conclude that the new developments in legislation were primarily focused on problems related to security, abuse, detention and forensic issues. The fact that concepts from the Convention on the Rights of Persons with Disabilities were integrated into the national legislation of at least one country deserves to be mentioned, as this is an issue that most countries will have to address, and which will require significant debate in the near future.

### Policy

More than 80% of Member States reported policy-related activities in the last year. Slovakia developed activities aiming at the preparation of a national mental health program, Belgium updated its national mental health strategy and made new agreements concerning the reform of children's and adolescent care, Iceland approved a national mental health policy, and Denmark published a report entitled "A modern, open and inclusive effort for people with psychiatric illness", which lays the groundwork for how best to direct efforts of helping people with mental disorders.

Suicide prevention was the objective of new policy and legislative measures in several countries. In Lithuania it allowed for the creation of a suicide prevention bureau at the State Mental Health Center, while in the Netherlands the national suicide program was continued and a research program was initiated. The Netherlands

also promoted initiatives to improve the quality of care, fight stigma, and promote the participation of children in regular schools, irrespective of mental health and behavioral problems.

Measures to give mental health the attention it deserves were developed in Luxembourg, where, for the first time, mental health was included among the missions of the Directorate of Health, as well as in Norway, where a recent White Paper on Public Health (2015) stated that parity for mental health within public health is a priority, and a White Paper on Primary Health requires municipalities to have expertise of psychologists at their disposal.

## Funding

Eighty percent of the countries developed activities related to funding. In 2016 Belgium increased its available funds for new initiatives in mental health. The same happened in Denmark, where new funding was allocated to the area of psychiatry, namely to improve psychiatric wards and reduce the coercive measures used; in Italy, where funding was allocated to alternative services for forensic hospitals and to research; in Slovakia, to support the treatment of eating disorders and Alzheimer's disease, and to fight stigma; and in the UK, where the Government announced a significant investment in mental health over the next five years, and an additional investment in the treatment of children's and young people's mental health and eating disorders. In the Netherlands, the total budget increased by 1%, with an increase in the budget for general practice psychological assistance, with specific funding for programs on suicide prevention, e-mental health, and scientific research, despite a decrease of the total budget available for youth care and social support. These developments show encouraging signs of an increasing awareness of the importance of mental health, but much more will have to be done in all countries in order to overcome the historical disparity between mental health and other areas of health.

## Organization of services

The vast majority of the countries reported activities related to the organization of services this past year. Most of these activities were focused on the creation and/or development of community services. In Belgium a reform of mental health care for adults included an increase in the number 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 services for people with mental disabilities. In Lithuania, the network of day centers was expanded and crisis intervention centers were created. The Netherlands reported a significant decrease in the number of beds and an increase in the number of general practitioners who

contracted with a psychological assistant. Norway also invested in employing psychologists in municipalities and developed the project Mental Health Care Now, which is based on the British program on improving access to psychological interventions.

Several countries have dedicated special attention to improving information systems and developing monitoring programs. Quality indicators were developed in Belgium, while Italy developed indicators of process and quality, and supported the improvement of an information system based on service activities.

### **Measuring the impact of policies**

All Member States reported activities that measured the impact of policies and/or the emerging development of new needs over the past year.

In most countries the impact of policies and the emergence of new needs were measured through regular monitoring ensured by the Ministry of Health or other official agencies, continuing the work done in previous years. Yet several countries (e.g. Estonia, Lithuania, the Netherlands, Portugal, Spain and Turkey) reported new initiatives that were initiated or planned in the past year.

### **Mental health intersectoral activities involving the fields of health, social affairs, education, justice, workplaces, patient, family and civil society**

Several countries reported prevention projects based on the cooperation of health with social affairs and other sectors. For instance, a prevention package for mental health as well as a campaign aimed at increasing knowledge of mental illness was developed in Denmark, while the Netherlands developed the initiative “Everything is Healthcare”, aimed at the development of an effective approach on prevention in general for the coming years. In Hungary, promotion and prevention initiatives were initiated, and in Spain each region is developing regional promotion and prevention plans. In the Netherlands, the strategic exploration on the prevention of depression was carried out, while in Austria and Luxembourg suicide prevention programs were continued. In Lithuania, the Netherlands and Portugal, national programs on depression and suicide prevention were planned or initiated. Several countries initiated programs on the prevention of alcohol and other addictions (e.g. Austria, Lithuania and Luxembourg).

Several countries reported activities jointly developed by the health and justice sectors. One very innovative example in this field is a program developed in Italy leading to the closure of forensic mental hospitals. The introduction of concepts from the Convention on the Rights of Persons with Disabilities into the Civil Code, reported by Lithuania, shows that albeit still subtle, the impact of this convention on legislation is starting to be felt in Europe.

Projects related to schools were reported by some countries, namely Slovakia, which developed an educational project at schools (“The Second Step”), which addresses problems associated with violence, bullying and hyperactivity, and which aims to develop empathy between children, communication skills, good social relationships, solidarity in the classroom, and the collaboration of schools with families. Another project in Slovakia led to the creation of a public portal for counseling services, sharing theoretical contributions and good practices within the field of educational counseling.

Work-based programs were initiated in Norway (focusing on the prevention of mental illness) and Croatia (research and education on psychosocial risks at the workplace), while in the UK the Department of Health and the Department of Work and Pensions developed the Joint Health and Work Unit to support people with mental illnesses in obtaining and retaining employment.

Programs addressing other specific issues were also reported. In Finland, one Government program includes the intention to initiate a national program to promote mental health and prevent loneliness and social exclusion, while the Netherlands developed a steering committee for the societal participation of people with mental illnesses.

It should also be noted that projects against stigma associated with mental disorders were continued or initiated by a significant number of countries (among others Estonia, Italy, Latvia, the Netherlands and the UK).

The involvement of patients, families and non-governmental organizations in mental health policy and care is being increasingly promoted by Member States. More than 70% of the countries reported developments in this area. In Belgium, patient and family organizations were involved in the reform of mental health care. In Slovenia, representatives of patients, families and non-governmental organizations participated in the preparation of the Mental Health Law. In Denmark, non-governmental organizations and the regions have been involved in psychiatric strategic planning, and patients, families and non-governmental organizations have been involved in various projects. In Finland, collaboration between non-governmental organizations and the Ministry of Social Affairs and Health in the field of mental health promotion has intensified, especially in the preparation of a long-term program for the promotion of health and wellbeing.

In Spain, under the strategic line of involving patients and families in the Mental Health Strategy, a workshop was organized with users and their families to discuss and draft actions for improving the conclusions of the Joint Action on Mental Health and Wellbeing. In Turkey, patients, families and non-governmental organizations have become involved in the services now that community-based mental health centers have started being established. In the UK, patients and families

participated in the development of the revised Mental Health Act 1983 Code of Practice, and in the Mental Health Taskforce.

The ‘mental health in all policies’ approach has been increasingly adopted by Member States. Finland, the country that led the work package on Mental Health in All Policies (MHiAP) within the Joint Action on Mental Health and Wellbeing, developed many initiatives to promote the concept of mental health in all policies within Finland and throughout Europe, and organized a regional EU conference on this theme with the participation of national representatives of different policy sectors.

In Austria, a key principle for the development and elaboration of the Austrian Health Targets is the ‘mental health in all policies’ approach, and the Safety and Health at Work Act promoted in this country is an important step in the promotion of mental health and the prevention of mental disorders in the workplace.

In the UK, Public Health England established the National Prevention Alliance with cross-sector membership to promote mental wellbeing in other non-health policy areas, and endorsed a national awards scheme to encourage employers to develop mental wellbeing policies. In addition, the Department of Health worked with the Department of Work and Pensions to ensure that staff in job centers are aware of mental health issues, such as depression and suicide risk.

In Norway, the most recent White Paper on public health (2015) pointed out mental health as one of three prioritized areas, and the chapter on mental health was developed through multi-ministerial collaboration. The country’s grant scheme “Mental Health in Schools” aims to strengthen the field of mental health in schools with a focus on a better learning environment, increased competence, wellbeing, mental health literacy and collaboration between services for children and youth.

Lithuania was actively involved in the work package “Mental Health in All Policies” within the Joint Action on Mental Health and Wellbeing project, and organized a high-level roundtable discussion on mental health in all policies, with the participation of representatives from different sectors including the Lithuanian Parliament, the President’s office, and the social, education and justice sectors.

Since 2006, Spain’s Ministry of Health has employed strategic coordination targeting the collaboration of regional governments with social services, prisons, education, housing, employment, etc. Furthermore, social services and penitentiary institutions are represented in the Institutional Committee of the Mental Health Strategy.

In the Netherlands, two new initiatives were started: a project of the Ministry of Social Affairs and Labor to raise awareness, prevent stigmatization, and help solve mental health issues in the workplace, and “Fitting Education”, a program of the Ministry of Education to increase the inclusion of children with mental health and behavioral problems in regular schools.

In Turkey, coordination with the Ministry of Family and Social Policies is going on in the context of the development of community-based mental health services and the establishment of safe homes and workplaces for people with mental disorders.

### **Monitoring the mental health status of the population or particular population groups**

Almost all countries reported new developments associated with monitoring the mental health status of the population or particular population groups.

Belgium has a national health survey, which includes an important section on mental health, with questions on suicidal thoughts, suicide attempts, depression, anxiety and sleep disorders. It also developed the “Health Behaviors of School-Aged Children” survey. Estonia also developed such a survey. In Italy, a broad study was conducted, funded by the Ministry of Health, on the prison population, including suicidal behavior. A population-based study on the prevalence and socio-demographic characteristics of self-reported suicidal behaviors was published in Latvia. In the Netherlands, the Netherlands Mental Health Survey and Incidence Study, a psychiatric epidemiological longitudinal study in the general population aged 18 to 64, was continued. In Norway, a cross-national data collection scheme designed to conduct youth surveys at the municipal level has been financed through the national budget since 2015. In addition, the Directorate of Education carries out an annual online user survey among students. In Portugal, a new national case register for suicide events was launched. In the UK, the Mental Health Minimum Data Set publishes annual data on mental health status, the Adult Psychiatric Morbidity Survey publishes data every 7 years (most recently in 2016) on mental health in England, and the Office for National Statistics publishes annual data on suicide and self-harm.

### **Prevention of depression and promotion of resilience**

The actions most frequently developed by Member States to tackle depression and/or promote resilience over the past year were those related to improving the recognition of depression by medical professionals and subsequent referral and treatment, followed by actions providing families and/or high-risk groups with support or tools to build resilience and reduce stress. Collaborative activities with the educational and labor sectors for better public education and awareness of depression, and for better access to support, as well as the use of routine screening tools for depression among general practitioners and psychiatrists were also reported by many Member States. Other activities, such as raising awareness about depression, implementing self-help and/or self-management tools, enhancing surveillance for depression, and particularly implementing evidence-based e-mental health tools for combating depression, were less frequently developed by Member States.



## Improving accessibility to mental health care

As mentioned elsewhere in this report, several countries developed activities which indirectly contribute to improving access to care. These include Slovakia's preparation toward a National Mental Health Program, and Belgium's updating of its National Mental Health Strategy and new agreements concerning the reform of children's and adolescent care.

The majority of countries reported activities related to the reorganization of services contributing to this same objective.

Austria increased the availability of mental health care in its primary care package. The representative from Austria also noted that over the past decade the number of inpatient and outpatient psychiatric services has increased, while the number of large state hospitals has decreased. With regard to the development of community-based mental health services closer to people's homes, this had already been developed earlier in most regions (more than 10 years ago), but this is an ongoing process.

In Belgium there was an increase in the number of psychiatric beds in general hospitals, with an additional 117 beds since 2014, as well as a development of mobile teams.

In Denmark there were several changes in inpatient and outpatient mental health care in general hospitals. In Finland there was a development of housing and employment support for people with mental disorders in the past year, and self-help and self-management tools were implemented. Iceland's new Mental Health Policy and Action Plan contains specific actions to increase access to mental health services in primary care, increase support for families, and increase psychologists among primary care staff. There was also an increase in community mental health services for people with severe mental disorders. Norway provided continuous financial support to its municipalities to increase the number of psychologists.

Lithuania increased the number of mental health centers and of services in psychiatric hospitals (psycho-social services, day centers, art therapy), and expanded the network of day centers. Estonia developed the training of mental health nurses, added funds for primary care to hire more nurses, and created four children's mental health centers as well as services for children with learning difficulties or behavioral problems.

In the Netherlands there was an increase in the available budget for psychological assistants to general practitioners. With regard to the development of inpatient and outpatient mental health care in general hospitals, there was an ongoing reduction of the number of beds and an increase in ambulatory mental health care facilities. There was also an increase in the provision of local community teams, and some progress in the implementation of e-mental health interventions.

In Turkey the number of community-based mental health centers increased.

In the UK the Government promoted changes in various areas. Regarding access to psychological therapies, the national target of ensuring that 15% of people could benefit from access to services was attained. An investment was made in Liaison Psychiatry Services in order to ensure that people who arrive at emergency services with mental health problems are referred to appropriate services. Through the Crisis Care Concordat, every local area now has a local crisis care action plan to provide support to people in the community before they reach a crisis point. The Department of Health and the Department of Work and Pensions established a joint Health and Work Unit to support people with mental health problems in obtaining and retaining employment. The Department of Health established a Mental Health Housing Forum to identify evidence and good practices to improve the provision of suitable housing for people with mental health problems. The Department of Health is also working with the Department of Communities and Local Government to assess the mental health issues associated with wider Government policies on housing, homelessness, and people with complex needs.

In Spain and Italy the national mental health strategies include several important actions to improve access to mental health care, but their implementation depends on regional governments, which makes it difficult to assess the progress made.

## Key developments in activities on mental health and wellbeing by stakeholders over the past year

An analysis of the reports made by stakeholders shows that the provision of care related to mental health was, by far, the mental health-related action most frequently reported over the past year. This was followed by the promotion of education and training, advocacy and empowerment, supporting mental health policy development, sharing information and building partnerships, and mental health promotion initiatives. The activities that were least reported and that need further development are anti-stigma work and prevention activities.

The majority of the stakeholders reported having provided services related to mental health care. These actions included diagnostic and referral services, psychosocial and educational interventions, rehabilitation and community interventions, housing and occupational support, short-term crisis support, and online support.

Many stakeholders reported having promoted education and training for further professional development and continuous medical education. Many stakeholders also reported advocacy actions to promote mental health policy development, including advocating better access to evidence-based treatment, formulating recommendations and guidelines for promoting mental health (e.g. workplaces and schools), and advocating for mental health in all policies.

A number of actions for sharing information and building partnerships were reported by the stakeholders. Examples given ranged from dissemination of work at scientific conferences to the development of networks between users, professionals and other local mental health associations. The most common activities reported were related to the promotion of mental health, wellbeing and resilience. There were reports of actions targeting vulnerable groups such as elderly people, school-aged children and families, with a special focus on mental health literacy and capacity building.

Only a few stakeholders reported participation in research projects focusing on mental health and wellbeing, actions against stigma, and prevention activities. Prevention actions were focused on vulnerable groups (e.g. families and youth) and the determinants of mental health (e.g. monitoring the effects of austerity and the economic crisis).

Regarding prevention of depression, the most common activities by stakeholders were: a) improving public awareness of depression and access to support; b) support to build resilience and reduce stress; c) implementation of self-help and/or self-management tools; d) service delivery for depression; and e) influencing policy. The actions least commonly reported and which therefore need

further development were: service development, research on depression, and development of good practices and quality standards.

The majority of the stakeholders reported having undertaken actions to improve public awareness and access to care for depression. Some of the actions reported included intersector collaboration (e.g. education, social and labor sectors), and public campaigns to promote the destigmatization of depression and other mental illnesses and to improve early detection.

A large number of stakeholders also reported having provided mental health care to people with depression. It should be noted that counseling and psychotherapy were by far the most common actions, followed by mental health literacy programs and depression prevention programs.

Many stakeholders also reported actions to improve policy, promote education, and raise awareness of depression among service users and their caregivers.

## Findings and good practices on prevention of depression and promotion of resilience

The EU Compass scientific paper on the prevention of depression and promotion of resilience (Annex 3) describes a significant number of programs that proved effective in preventing depression in different settings and promoting resilience.

It describes several good practices related to the prevention of depression in schools that were successfully implemented in Europe. For instance, the European Union co-financed the SUPREME project ([www.supreme-project.org](http://www.supreme-project.org)), an intervention website for mental health promotion and suicide prevention, which was able to reduce symptoms of depression at 2 and 4-month follow-up. Also other programs carried out in schools, consisting of cognitive-behavioral therapy elements, information-giving on mental health and wellbeing, and social competence training, proved to be effective in preventing depression among children and adolescents (Corrieri et al., 2014).

Regarding prevention of postpartum depression, the most promising interventions were found to be intensive, individualized postpartum home visits provided by trained public health nurses or midwives, lay-based telephone support lines, or interpersonal psychotherapy treatment (Brugha et al., 2011).

For people with comorbid depression and somatic health conditions, interventions such as behavioral activation or motivational approaches that encourage self-management and/or healthy lifestyle approaches proved to be effective in diverse settings, such as in primary care, the workplace, and in social and community settings (Naylor, 2012). Training primary health care professionals in cognitive-behavioral or motivational approaches also resulted in a demonstrable reduction of symptoms of depression among people with long-term conditions (Corbière et al., 2009, Henderson et al., 2011).

For the prevention of depression among older people, stepped-care approaches including therapeutic options for more complex needs such as problem solving therapy proved to be effective in the Netherlands (van 't Veer-Tazelaar et al., 2009).

In relation to the promotion of resilience, the scientific paper mentioned above considers that the existing evidence base for resilience training programs shows a modest but consistent effect in improving mental health outcomes in the short term. It also concludes that resilience-based programs should be nested in settings like schools, and training programs for teachers on promoting resilience through their classroom approaches and teaching methods should be implemented.

## Findings and good practices on access to mental health care

According to the conclusions of the EU Compass scientific paper on access to mental health care (Annex 4), access to mental health care is far from satisfactory in the European Union. Although the research in this field is still not very strong, the wide range of documents from different sources analyzed in this scientific paper allowed for the identification of important gaps in access to mental health care.

A World Health Organization (WHO) report estimated a median treatment gap in Europe of 45% for major depression, 40% for bipolar disorder and 18% for schizophrenia (Kohn et al., 2004). According to the WHO Mental Health Surveys the treatment gap for severe disorders ranged from 34% (Portugal) to 69% (Bulgaria). The figures for the moderately severe sample ranged from 63% (Spain) to 83% (Romania), while for mild disorders the differences were from 79% (France) to 86% (Romania) (Wang et al., 2011). A population-based Italian study reported a treatment gap for schizophrenia of 36% in a region of 10 million people, a result which confirms that even in a system based on universal health coverage and community care, the treatment gap for severe mental disorders is significantly high (Lora et al., 2012b).

Regarding access to specific treatments, the scientific paper on access to mental health care states that in a Finnish study by Hämäläinen et al. (2009) the rates of depressed people receiving antidepressant drug treatment was 36%, and in the German study by Bramesfeld et al. (2007) this figure was 40%. 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 the low rate of 11% for people treated in primary care, in contrast to a much higher rate in specialist settings (46%).

Data from the WHO Mental Health Surveys show that in 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. 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.

Regarding adequacy of treatment, the rate of patients who received minimally adequate treatment (defined by considering drug or psychological therapies), although proportionally increasing with the severity of the disorder, was relatively high only in Germany and the Netherlands (67%). In other countries the treatment rate for serious disorders ranged from 30% in Romania to 58% in France.

Research reviewed in the scientific paper on access to mental health care showed that structural barriers may be more important in countries with limited health coverage and less developed community care, while attitudinal barriers (particularly low perception of need) are significant everywhere.

A diversified range of good practices in this field were identified in the Joint Action report on transition to community-based care and in the EU Compass scientific paper on access to mental health care. As can be seen in more detail in Annex 4, some of these good practices, such as the “European Alliance Against Depression” (Hegerl et al., 2008) and the “Program for Integration Between Primary Care and Mental Health Services” in Emilia Romagna, Italy (Menchetti et al., 2013), are based on the cooperation of specialized services with primary care physicians to optimize diagnosis and treatment. Other good practices were developed to provide psychological treatment to people with depression and anxiety (Clark et al., 2009), or to ensure better access to care for people experiencing (or at risk of experiencing) a mental health problem (Department of Health, 2014). Finally, several programs have succeeded in improving the access of people with severe mental disorders to integrated care in the community, e.g. the “Open Dialogue” in Finland (Seikkula et al., 2006), the “Permanent Access to Mental Health Care” in Paris, France (Arveiller and Mercuel, 2011), the “Pilot Project for Developing a Model for Community Mental Health Service” in Blagoevgrad, Bulgaria (WHO, 2012), and the “Andalusian Public Foundation for Social Integration of People with Mental Illness” (FAISEM) in Spain (Valmisa Gómez de Lara et al., 2008).

## Progress towards the policy objectives of the European Pact for Mental Health and Wellbeing and the Framework for Action of the Joint Action on Mental Health and Wellbeing

The analysis of activities developed by Member States and stakeholders shows that significant progress was made towards some of the objectives of the European Pact and the Framework for Action during the last year.

Many countries developed or updated their mental health legislation and policies. Changes in legislation were mostly focused on the regulation of coercive measures, problems related with detention, security concerns, quality of care, and the integration of people with disabilities. Some countries started integrating new concepts introduced by the Convention on the Rights of Persons with Disabilities into their legislation. However, it should be noted that this is not yet a general concern in Europe.

Most policy developments were centered on the development of new strategies, particularly in fields related to children's and adolescent care, dementia, suicide prevention, quality of care, and the delegation of care to municipalities due to decentralization.

National funding available for mental health increased in several countries. The areas receiving additional funds include children's and young people's mental health, Alzheimer's disease, suicide prevention, e-mental health, research, alternative services for forensic hospitals, and eating disorders.

The reorganization of services continued, particularly through actions related to deinstitutionalization and the creation of new community-based services (e.g. mobile teams, day centers, and crisis intervention centers), and provision of psychological support in primary care. Improving information systems, developing monitoring programs, and creating quality indicators have also been important objectives pursued by several countries.

All countries reported new developments in their promotion and prevention plans and programs. Many addressed the prevention of mental disorders in general as well as stigma against mental illness. Important advances took place in suicide prevention, work-based programs, school-based programs, programs on alcohol and other addictions, and programs supporting people with mental illness to obtain and retain employment. Innovative initiatives in other areas should also be mentioned: for instance, prevention of loneliness and social exclusion, and the enhancement of societal participation of people with mental illnesses.

Another area in which we can see significant progress is in the participation of users, families and non-governmental organizations in the development of policy and services. In many countries these stakeholders were regularly involved in the



preparation and revision of legislation, the development of strategies and plans, and the implementation of the Joint Action recommendations.

The large majority of Member States improved the monitoring of the mental health status of their populations or of particular population groups, based on national health surveys, the Health Behavior in School-Aged Children survey, and population studies on suicide or mental health problems in prisons.

The impact of mental health policies and plans was measured in most countries, not only through the regular monitoring ensured by the national Ministry of Health, but also through new initiatives. This made it possible to measure the impact of national mental health plans and programs. The evaluation of emerging new needs was also developed in some countries.

Significant developments in the 'mental health in all policies' approach were achieved over the past year, both at the national and the EU level. Several countries reported new programs involving non-health sectors such as education and employment, among others, and multi-ministerial collaborative initiatives were promoted in several countries.

Provision of mental health services is the area in which stakeholders developed their activities in a more significant way. The majority of these activities were diagnostic and referral services, psychosocial and educational interventions, rehabilitation and community interventions, housing and occupational support, short-term crisis support, and online support. Other important areas of stakeholder activity included education and training, advocacy, and mental health promotion programs.

According to Member States, the strengths of the current mental health situation include good coordination of mental health care, collaborative care between mental health (both in specialized and in primary care services), strong political commitment and the development of innovative community services, while the main weaknesses are insufficient financial and human resources and insufficient intersectoral cooperation.

## Recommendations

The Framework for Action includes general and specific recommendations to Member States and to the European Commission on how to support the implementation of the policy actions needed to improve the mental health of the populations in the EU countries. Because the analysis of the information collected from Member States and stakeholders summarized in this Report highlights several important aspects of the mental health situation in Member States, new recommendations, complementing the recommendation of the Framework for Action, can be formulated in the following areas:

### Legislation and policy

The updating of mental health legislation remains an important challenge. New steps will have to be taken to integrate the new concepts introduced by the Convention on the Rights of Persons with Disabilities into national mental health laws, and to give the human rights issues the position they deserve in public mental health. More concerted efforts are also needed in order to ensure the sustainable and effective implementation of policies contributing to the promotion of mental health, as well as the prevention and treatment of mental disorders.

### Information systems

Developing and improving information systems should be a priority for all Member States. The truth is that the responses to the survey clearly show that many Member States either did not provide data or do not have data on a significant range of questions.

New indicators on the use of services are needed to better monitor the shift toward comprehensive community care. New indicators on the outcomes of interventions and policies are also needed to measure their impact.

Although past experiences have proven that reaching agreement at the EU level regarding a basic dataset for all Member States is difficult, the Member States and the European Commission should nonetheless undertake further efforts to reach this important goal.

### Financial and human resources

In most countries, more financial resources and a more rational use of the existing resources are needed. Although a tendency to increase the funding available to mental health can be seen in some EU countries, the lack of parity between mental health and other areas of health continues to be a serious issue in most countries.

Financial incentives should also be put in place in order to facilitate the transition toward community-based approaches to mental health care.

New efforts are also needed to develop human resources prepared to provide high quality mental health care, and to support the development of new approaches that are indispensable in responding to the needs of the EU population.

### Promotion of mental health

Despite the important advances that have already taken place in mental health promotion, much more has to be done in this area. A stronger and more systematic investment should be made, at the national and EU levels, to develop strategies and programs contributing to fighting stigma and promoting the mental health of people in all stages of life. New programs involving non-health sectors such as education and employment, among others, are needed, in the context of a ‘mental health in all policies’ approach.

### Prevention and treatment of depression and other common disorders

With regard to the prevention of depression and the promotion of resilience, further efforts are specifically needed in:

- Activities for raising awareness about depression and recovery from depression among service users and their caregivers (e.g. through education);
- Implementation of self-help and/or self-management tools including, but not limited to, e-health;
- Enhancing surveillance for depression;
- Promotion of the use of e-mental health tools; and
- Tailored websites for resilience building.

Regarding access to care of people with common disorders, the analysis of the information collected through the survey confirms that the barriers that need more attention include insufficient funding and a lack of cooperation between the social and health sectors, along with insufficient human resources, a lack of training for primary health care professionals, and a lack of community-based services. Vigorous efforts should also be undertaken to address the gap that exists in relation to psychotherapy and other psychosocial interventions.

### Care and social inclusion of people with severe mental disorders

With regard to care for people with severe mental disorders, the transition from institutions to comprehensive community-based care remains a key attention priority in the EU, as shown by the average number of beds that continue to exist in Member States’ largest psychiatric hospitals, together with the limited development of

crisis intervention, supported housing, and other psychosocial interventions reported by most countries. Significant progress was made in clinical care. It is now necessary to also pay attention to the importance of high quality supported housing, meaningful activities (paid and/or unpaid), the role of peer support workers, and the significant importance of helping people to create and sustain strong social networks in their communities, as these are all part of person-centered, recovery-focused mental health services.

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