EU COMPASS FOR ACTION ON MENTAL HEALTH AND WELLBEING

ANNUAL REPORT (2018)

SUMMARY AND ANALYSIS OF KEY DEVELOPMENTS IN MEMBER STATES AND STAKEHOLDERS

This report has been prepared by the EU Compass consortium, Nova University (José Miguel Caldas de Almeida, Diana Frasquilho, Joana Zózimo), Trimbos Institute (Ionela Petrea, Charlotte Steenhuis) and Finnish Association for Mental Health (Johannes Parkkonen).

Funded by the European Union in the frame of the 3rd EU Health Programme (2014-2020)

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This report (D13 2018) was produced under the EU Health Programme (2014-2020) in the form of a service contract with the Executive Agency (Chafea) acting under the mandate of the European Commission. The content of this report represents the views of the contractor and is its sole responsibility; it should in no way be taken to reflect the views of the European Commission and/or Chafea or any other body of the European Union. Neither the European Commission nor Chafea do not guarantee the accuracy of the data included in this report, nor do they accept responsibility for any use made thereof by third parties.

Acknowledgements

We would especially like to thank the Member State representatives and stakeholders who dedicated their time to completing the Member State and Stakeholder surveys which provided us with the information needed to complete this report.

List of abbreviations

Chafea: Consumers, Health, Agriculture and Food Executive Agency
CME: Continuous medical education
DALY: Disability adjusted life years
DG SANTE: Directorate General for Health and Food Safety of the European Commission
EU: European Commission
MS: Member State
WHO: World Health Organization

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EXECUTIVE SUMMARY

This is the third 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 in 2017 by Member States and Stakeholders, the assessment of the progress made towards the objectives of the European Pact for Mental Health and Wellbeing and the Framework for Action on Mental Health and Wellbeing, and recommendations for the future. The report is based on the analysis of information that was collected through the EU Compass survey and presented in the EU Compass scientific position paper on community based mental health care.

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 last year.

Activities in legislation in 2017, reported by Member States, were focused on the update or improvement of national mental health legislation, as well as in the development of new legislation in areas related to the rights of people with mental disorders and the improvement of mental health care. Several countries developed new national mental health strategies, and others implemented new strategies with a focus on children and youth mental health and on mental Health in all policies.

Regarding the organization and quality of services, a significant part of the achievements reported by Member States in the past year are related to the development of new community based mental health services, in some cases as part of a deinstitutionalization process. Some countries created services and programmes for specific groups (e.g., children and juvenile drug users).

All countries reported new developments in promotion and prevention plans and programmes. Many addressed the prevention of mental disorders in general as well as stigma against mental illness. Important advances took also place on suicide prevention, work-based programmes, school-based programmes and depression prevention.

Progress in the involvement of patients, families and NGO´s in the development of mental health initiatives of different types is reported by some countries, and the results of the survey show that Member States are increasingly adopting the Mental Health in All Policies (MHiAP) framework, several countries reporting innovative activities in this area.

The impact of policies is still not assessed in a significant number of countries. However, some Member States reported encouraging progress in this area.

The main key mental health activities developed in 2017 reported by the responding stakeholders were: training, endorsing advocacy and raising awareness, providing care, performing research and dissemination, acting on prevention and promotion, and establishing collaboration and networking.

Lack of funding and organizational challenges – for example, lack of human resources — were the main challenges the stakeholders' representatives faced in 2017.

Non-governmental organizations (e.g. national and international associations and foundations) and academia (e.g. universities and research centres) were the partners most frequently reported by responding stakeholders, followed by professionals and users, county councils and municipalities, health services and policy makers and socio-cultural centres.

Overall, some progress towards the policy objectives of the Joint Action on Mental Health and Wellbeing was made in 2017, particularly in the updating and implementation of national mental health strategies, the development of new services, the launching of new promotion and prevention programmes, and the adoption of mental health in all policies approach. These advances, however, did not occur in a homogeneous way. On one hand, in some areas (for instance, in monitoring and development of information systems, improvement of quality of care, development of e-mental health) little or no progress has been made. On the other hand, while some countries reported initiatives that denote an effort to systematically implement a coherent mental health policy aligned with the Joint Action recommendations, others reported that in 2017 little or nothing had been done with this purpose.

The findings reported in the EU Compass scientific paper on provision of community based mental health care show that, when compared with traditional hospital-based services, Community mental health teams (CMHT´s) are associated with lower admission rates, better quality of care, and increased service user satisfaction.

It also show, in the last decade, the development of newer models of community-based services that proved to be effective, and various emerging approaches that, although still with an underdeveloped evidence-base due to difficulties relating to experimental design or their relative newness, already represent promising advances in community mental health care.

In relation to mental health in primary care, available evidence show that the collaborative care model is clearly superior to standard care in the treatment of high-prevalence disorders, such as depression and anxiety.

All these advances in knowledge contributed to the development of a large set of innovative community-based mental health care practices that have diversified and improved the quality of care in Europe during the last decade.

Based on the analysis of the advances registered in 2017 towards the objectives of the EU Joint Action on Mental Health and Wellbeing, and taking into consideration the difficulties and insufficiencies found in this process, new recommendations are presented in this Report, which complement the recommendations included in the Framework for Action.

INTRODUCTION

This Report is the second annual activity report of the EU Compass for Action on Mental Health and Wellbeing. Based on the 2017 Activity Reports of Member States and Stakeholders, which can be seen in Annexes, and taking into consideration relevant information from other sources, the Report includes a summary of the mental health policy related key activities developed in the last year by Member States and Stakeholders, an analysis of the developments to tackle the priority areas selected this year — providing community based mental health care and development of integrated governance approaches — implemented in 2017, as well as recommendations for the future.

The Report has three main objectives. First, to provide all people interested in mental health policy development in EU with an opportunity to better understand the mental health activities developed in the last year by Member States and relevant stakeholders in the EU, the reasons behind them, the progress made in their implementation and the achievements resulting from them. Second, to assess the progress made towards the objectives of the European Pact for Mental Health and Wellbeing and the Framework for Action on Mental Health and Wellbeing. Third, to identify the areas in which there was not enough progress and suggest strategies that should be prioritized in the future in these areas.

We hope that this Report will attain these objectives. We also hope that it will contribute to the dissemination of the policy recommendations included in the EU Framework for Action on Mental Health and Wellbeing and to promote a fruitful exchange of information on implementation activities and good practices in Member States.

METHODOLOGY

To assess the progress made across EU Member States in the last 12 months we analyzed information collected through annual online surveys completed by Member States' and stakeholders' representatives between September and November 2017. We also took into consideration data and information presented in the EU Compass scientific paper on community-based mental health care and in the Joint Action on Mental Health and Wellbeing publications.

Instrument

Development of the questionnaire

The development of the survey and its dissemination was led by the Finnish Association for Mental Health (FAMH), together with the other Consortium members and with input from the DG Santé and Chafea. The surveys were in accordance with guidelines set forth in a contractual agreement with DG Santé and Chafea. Indicators and questions were based on existing structures and frameworks, from the surveys used for collecting data on interventions in the Joint Action on Mental Health and Wellbeing and the World Health Organization's 2008 guide, which documented good practices in health. The development of the indicators and questions used for the survey involved extensive rounds of consultations between DG Santé, the Compass Consortium and the group of governmental experts in mental health. The survey was piloted with a panel of stakeholders, which allowed the Consortium to adjust the survey so to optimize user friendliness, clarity, readability and relevance.

The surveys were built using the web-based tool *Webropol*, which provides a user-friendly template allowing users to complete their survey online. Access to the survey was provided through a web link sent to Member State's and stakeholders' representatives via email. The *Webropol* tool allowed users to save their data for later completion if desired.

Structure of the surveys

The Member State and stakeholder surveys included open and closed-ended questions. The Member States' survey included 26 questions and was more in-depth than the stakeholders' survey, which was made of 14 questions.

The Member States' survey was divided into five parts:

- Part A covered background information;
- Part B covered updates on key developments that have been implemented since the previous EU Compass survey (2016, 2017) or that will be initiated by March 2018;
- Parts C and D focused on two of EU Compass themes (providing community-based mental health services and developing integrated governance approaches);
- Part E gives an opportunity to list relevant documents concerning mental health and wellbeing produced since 2016 that were not priorly mentioned.

The stakeholders' survey was comprised of 14 questions, and was divided into five parts.

- Part A addresses basic information on the organization;
- Part B focuses on the key activities carried out in the organization, with questions on the objectives of the organization, key activities and achievements, partners involved, target groups, available resources, strengths of the organization's activities, challenges faced in carrying out those activities, and whether or not these activities were evaluated;
- Part C and D focused on two of EU Compass themes (providing community-based mental health services and developing integrated governance approaches) and includes a number of questions addressing the extent to which action is taking place;
- Part E gives an opportunity to list relevant documents concerning mental health and wellbeing known to the respondent, produced since 2016 and that were not priorly mentioned.

Data collection

Mapping out respondents and Sampling

Respondents for the annual activity surveys were mapped out by NOVA University of Lisbon and other members of the EU Compass consortium. The identification of Member State's representatives to fill in the survey was determined after consulting the Group of Governmental Experts and, when requested, sub-national public authorities. The questionnaire was sent out to representatives from 28 Member States, as well as Turkey, Norway, and Iceland. Non-governmental stakeholders were identified in the fields of health, social affairs, education, workplaces and justice, as well as civil society groups. Existing lists developed for the Joint Action as well as lists of relevant stakeholders of the EU Compass Consortium partners were consulted and used. The total number of stakeholders identified through this process was XXX, all of whom were invited to take part in the survey. In addition, the web link was placed on the EU Compass website.

Data collection process

Member States' and stakeholders' representatives were invited to participate in the surveys via e-mail containing a private web-link to the online survey, from August to December 2017. To maximize response rates, a reminder system was used, wherein reminders via email were sent out to non-responders. Member States'

representatives that failed to respond to the survey by November 2017 were individually approached via email or phone call. Moreover, during the EU Compass's Awareness-raising and training workshops, the EU Compass representatives requested the representatives from the Member States who have not responded to do so. The initial deadline to fill in the Member States survey was 30th October 2017; however, the deadline was extended until the 2nd of December 2017 to increase the response rate.

Response rate

Of the 28 Member State representatives and three additional countries invited to participate in the Member States' survey, 26 representatives[1] completed the survey. Only five Member States' representatives [2] did not respond.

Of the stakeholders invited to complete the survey, 23 completed the survey.

Data analyses

Raw data from the survey respondents were exported from *Webropol* to an Excel spreadsheet, IBM SPSS Statistics and PDF documents. All data from stakeholders was similarly exported.

All data were checked for any inconsistencies or missing data and were cleaned.

All quantitative data analyses were performed using SPSS (Statistical Package for the Social Sciences), version 21. This package was used to carry out descriptive statistics (e.g. frequencies and cross-tabulations) on mainly binary and categorical data.

Qualitative data from both surveys were cleaned, and the researchers read and re-read the written answers and prominent answers and themes were identified as answer variables and analyzed.

[1] Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Finland, France, Germany, Greece, Hungary, Iceland, Rep. Ireland, Italy, Lithuania, Luxembourg, Netherlands, Norway, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Turkey and United Kingdom.
[2] Denmark, Estonia, Latvia, Malta and Poland.

KEY DEVELOPMENTS IN ACTIVITIES ON MENTAL HEALTH AND WELLBEING BY MEMBER STATES IN THE LAST YEAR

Legislation

Important steps were taken in 2017 to update or improve national mental health legislation in several Member States. In Finland, for example, a profound renewal of the mental health legislation is currently in progress, while in Romania amendments to the Mental Health Law (Rules of implementation 488/2016) allowed the creation of a mental health strategy for children and adolescents, and in Slovenia a working group was appointed in November 2016 to prepare amendments to the Mental Health Act.

Two countries developed new legislation in areas related to the rights of people with mental disorders. Spain developed new legislation regarding rights and autonomy of patients. Hungary, after signing the Convention on the Rights of Persons with Disabilities, included psychosocial disability in the group of disabilities, and awarded to the national NGO´s working in this area the same status other disability organizations already had, which contributed to enhance governmental financing. The UK implemented legislative changes through the Policing and Crime Act to ban the use of police cells as places of safety for people under 18 detained under sections 135 and 136 of the Mental Health Act 1983. 10. On the other hand, an independent review of the Mental Health Act 1983 led by Sir Simon Wessley to ensure that it remains fit for purpose and to improve the rights of people was launched. An interim report of the review will be published in spring 2018.

Other countries developed new legislation contributing to the improvement of mental health care. This occurred in Cyprus, where new legislation on Community Mental Health Care has been submitted for approval by the Parliament. Its primary aim is the development of community residential health facilities for persons with mental health issues, either by the private sector, or NGO's or Municipalities, after obtaining approval from Mental Health Services. Slovenia, on its side, adopted an Act Regulating the Integrated Early Treatment of Preschool Children with Special Needs. Early childhood intervention in primary health care centers is intended for all children who are subject to a developmental risk or developmental disability. The aid covers the period between the moment of prenatal diagnosis and the moment that the child reaches the age at which school is compulsory. It includes the entire process from the earliest possible identification and detection up to the moment of training and guidance assessment. The Act introduces a family representative and a representative of a non-governmental organization, who can be involved in a multidisciplinary team by providing support, counseling and assistance from their own experience in early childhood development or pre-school development.

Mental health policy and plans

Significant achievements were registered in several countries in the development of national mental health strategies.

In the last quarter of 2017, France was working in the elaboration of the new National Health Strategy, which includes an official national mental health strategy. The document is currently available online for public consultation and comments.

In Bulgaria, a new version of the National Mental Health Program and Plan of Action for the next 6 years period is also under preparation.

In Iceland, the Mental Health Policy and Action Plan (2016-2020), which was passed through congress in April of 2016, is being actively implemented and monitored. The Public Health Policy, which was passed through congress in October of 2016, is also being actively implemented and monitored. The Action Plans for both policies have received funding and this will be budgeted for the plans in the coming years. Both plans involve collaboration between cross-sectoral partners, focus on interventions as well as prevention and wellness promotion.

A national strategy for mental Health, with a focus on children and youth and mental Health in all policies was launched in Norway, in August 2017.

In Slovakia, a new Programme for Mental Health was created with the involvement of cross-sectoral partners (e.g., the League for Mental Health and patient's organizations), reinitiating the Mental Care Health Reform.

Slovenia adopted in April 2016 a new Resolution on the National Health Care Plan 2016–2025, which included, in the chapter dedicated to Mental Health, the adoption of a national mental health program, amendments to the Mental Health Act, a healthcare cooperation protocol with providers in the field of social protection and education, the development of integrated community treatment programs and support for people with chronic mental health problems, guidelines for programs and services to be carried out by non-governmental organizations, volunteers, family members and others, and the development of the model of the national network of services for the mental health of children and adolescents. In October 2017 the Ministry of Health launched a new working group for the drafting of a National Mental Health Program. In May 2016 the Ministry of Health also adopted a Strategy for dementia until 2020. In 2017 the Ministry launched a public tender with the purpose to co-finance education programs for the management of dementia for the years 2017 and 2018.

As mentioned in the 2017 EU Compass Report, the Swedish government has adopted a national strategy for mental health for the period 2016-2020. The strategy is based on five focus areas that have been identified as the main challenges in relation to promotion of mental health and wellbeing and combating mental ill health: 1 - Preventive and promotional efforts; 2 - Accessible services; 3 - Vulnerable groups; 4 - Participation and rights;

and 5 -Organization and leadership. Each focus area covers people of all ages – children, young people, adults and the elderly – as well as girls and boys, men and women. Suicide prevention is also a recognized priority. One of the key elements in achieving the Government's goals and supporting the implementation of the national strategy is an agreement between the Government and the Swedish Association of Local Authorities and Regions (SALAR). In the 2017 Agreement on Support for Targeted Measures for Mental Health, the Government provided a total of 885 million SEK (approx. 91 million Euros) for targeted measures for mental health, while 780 million SEK (approx. 80 million Euros) are provided to local authorities and regions to continue the work towards long-term sustainable efforts to promote mental health and mental wellbeing, and to improve services for individuals suffering from mental health problems. The governmental action plan gives the regions/local authorities autonomy on how the money should be distributed in the regions but all work is based on the 5 focus areas that the government has proposed.

Organization and quality of services

A significant part of the achievements reported by Member States in the past year are related to the transition from institutional mental health care to community- based care.

Belgium, a country that had already mentioned in the previous EU Compass reports important achievements in this transition to community-based care, reported now new advances in the development of a second wave of reforms, focused on child and adolescent care and in forensic care of adults.

In Czech Republic, several projects related to the mental health care reform in which the country is engaged were launched in 2017. These included a project aiming at fighting stigma, a project focused on promoting a multidisciplinary approach in the treatment of mental disorders, a project focused on building new Community Mental Health Centers, and a project on deinstitutionalization that includes changes in legislation, quality measures and transformation of psychiatric hospitals.

In Italy, the process to close down all Forensic Hospitals in the country has been completed, and the Ministry of Health has further developed research on quality of community care.

Luxembourg initiated a reorganization of ambulatory psychiatric services in order to improve support to patient suffering from mental disorders and to support their integration in society trough three different axes: living, leisure time an work. This county has also increased access of refugees to counseling.

In Hungary an expansion of governmental financing of community mental health services was made as part of social service provision (169 service providers covered 8701 clients in June 2017). The Government is also committed to the deinstitutionalization of 5 long-term care institutions (3 for people with disabilities and 2 for

psychiatric patients). The supported living program has been launched with home-care services offered for 660 people by EU funds, which will be expanded to 10.000 people in the planning period of 2017-2020.

In Netherlands, the Dutch Healthcare Authority has published a report on the state of mental healthcare in the country. One of the Authority's conclusions is that a shift has taken place from specialized to basic/primary (mental) care: more patients are treated in basic/primary (mental) care rather than in specialized care. Moreover, waiting list times are often too long, especially in which concerns patients with autism spectrum disorders or personality disorders. Therefore, a national approach to solve waiting lists in mental healthcare has been launched. The ministry, insurers, caregivers and local authorities have written an action plan. Regional taskforces including all stakeholders have been established in order to minimize waiting times for patients by the summer of 2018. An independent research institute (Trimbos) has published a report about the state of the deinstitutionalization in the mental healthcare sector. The current policy is aimed at improving quality of care and decreasing costs by treating patients in outpatient/community based facilities or at home instead of intramural care. The conclusion of the report is that deinstitutionalization has started but the outpatient capacity is not increasing accordingly.

Several countries reported achievements made possible through projects funded by the EU.

In Croatia, the first part of "Ensuring Optimal Health Care for People with Mental Health Disorders (Twinning project with Netherlands; implemented by Trimbos Instituut; funded by the EU) has been completed in April 2017, and the second part (Technical Assistance; also funded by EU) has started.

The Hungarian Government has set the structural development of mental health services as an important target via funding by EU structural funds EFOP/VEKOP. Within these projects, the infrastructural improvement of child and adolescent psychiatry, addictions and mental hygiene service systems (6 bil. Ft), the conditional advancement of psychiatric out-patient services (4 bil. Ft), the development of a secured psychiatric unit (2,7 bil. Ft) and the infrastructural improvement of psychiatric and addictions departments (in which 14 acute psychiatric wards will receive support) will be achieved.

In Cyprus, the European Early Promotion Programme, aiming at promoting mental health and early intervention for families with children aged 0-2 years old, is being implemented. It refers to families with children aged 0-2 years old and it's carried out by Health Visit Officers, who are appropriately trained by skilled mental health personnel.

Services and programmes for specific groups were also launched in some countries.

In Cyprus an Inpatient Unit for Juvenile drug users with serious behaviour problems began to operate in the General Hospital of Nicosia since early 2017. In the Netherlands, an integral approach/policy to increase the

quality of care for people who are (temporarily) confused or disturbed has been launched. The causes for the state of confusion can be very diverse and the problems and needs of these people are often of a wide variety. Therefore an integrated approach is required involving several policy areas (housing, care, employment, debts, well being) and several stakeholders. A national team stimulates and facilitates (local) stakeholders to create networks between different caregivers and institutions involved in the care for people with confused behavior.

Some countries reported achievements in promotion of quality. For instance, in order to gain more insight in the quality of care, Routine Outcome Measurements have been implemented in the Dutch mental healthcare sector. Caregivers are contractually obligated by insurers to have at least 50% of their patients fill in a pre and post treatment questionnaire. Data are pseudonymously collected and analyzed, and it will be evaluated if these data are indeed useful to judge quality.

Prevention/promotion

European funding also contributed to the development of mental health promotion projects. This happened in Hungary, where a grant of 1,18 Billion Forint was awarded, in the framework of the Norwegian Financial Mechanism, to the development of capacity and methodology in favor of public mental health promotion. Also in Hungary, the Youth Aware of Mental Health Program, YAM, a school based universal intervention, targeting pupils aged 14-16 years, is ongoing. And in 2017, within the framework of Baby-Mother-Father Perinatal Mental Disorders Services program, a new official guideline was developed in intersectoral cooperation, providing support for treatment of perinatal and postnatal depression. Implementation of the program is ongoing in Saint John Hospital as a pilot in Central and Eastern Europe.

In the area of suicide prevention, a Commission for Suicide and Violence Prevention was created in 2016 at the Parliament of the Republic of Lithuania, while in the Netherlands a regional program has been launched to prevent suicide. In these regional experimental setups, all local stakeholders (schools, caregivers, municipalities) work together to prevent suicide. The UK updated the Cross-Government Suicide Prevention Strategy for England to strengthen delivery of its key areas for action and expanded its scope to address self-harm as an issue in its own right. Every local authority in England will have a multi-agency suicide prevention plan in place by the end of the year. This followed an inquiry into suicide prevention in England by the Health Select Committee. The Government published its response to the Committee in July.

The UK also initiated a programme to deliver Mental Health First Aid training in schools, launched the first National Mental Health Prevention Concordat in England for local authorities to work across all local authorities and build mental health prevention into their local Strategic Joint Needs Assessments for local communities, and commissioned an independent review of mental health in the workplace in England.

In Netherlands, a national 'depression campaign' has been launched to create awareness and to break the stigma of mental illness. This campaign will run for multiple years.

In Norway, the Programme for Public Health in the Municipalities 2017-2027 is a national framework of joint effort on mental health promotion and drug prevention at the municipal Level

In Spain, the Regions are developing new initiatives on promotion and prevention, involving partners of different sectors.

Mental health in all policies

Several countries reported further advances in the mental health in all policies approach. For example, in 2016 and 2017, the Austrian health target #9 “To promote psychosocial health in all population groups” has been elaborated by an intersectional and multidisciplinary workgroup following this approach. Three strategic aims and a bundle of actions shall contribute to enhance mental health promotion, prevention, support, treatment and anti-stigma work.

In Croatia a National Framework for Screening and Diagnostics of Autism Spectrum Disorders has been prepared by the Ministry of Health, Ministry of Social Politics and Youth, Ministry of Science, Education and Sports, with participation of users' organizations, which is now in the acceptance procedure.

In France a National Council for mental health was created in October 2016, supported by commissions working on priority areas: suicide prevention, children and young adults well-being, implementation of stakeholders' collaboration in the territories, precariousness and vulnerabilities.

In 2017 the Norwegian Government introduced an inter-ministerial national strategy on mental health, which states the shared responsibility in promoting good mental health in all policies. The Norwegian strategy for mental health is signed by the ministers of Local Government and Modernisation Children and Equality - Education and Research - Labour and Social Affairs Culture - Justice and Public Security Health and Care Services. In addition to this National strategy, Norway is gradually implementing a Program for Public Health in the municipalities, starting in 2017. The program is focusing on providing knowledge on what works in mental health promotion at the local levels, and how to work across sectors to improve mental health among children and young people. Drug prevention is also an important part of the program.

In the UK, the Government published its response to the Five Year Forward View for Mental Health in England in January 2017 to set out how it will implement its recommendations across government. The Prime Minister also set out a wide range of mental health reforms which included a review of mental health in the workplace, a review of the Mental Health Act 1983 and delivering Mental Health First Aid training in schools. An Inter-

Ministerial Group on Mental Health was also established to oversee this work, which brings together senior Ministers across government to progress the mental health agenda. It should also be noted that in the UK equalities legislation requires non-health sector policies to take into the account the needs of people with protected characteristics, which includes people with mental health needs, and the Government has put parity of esteem for mental and physical health into legislation.

E-health

Regarding the use of new information technologies, Bulgaria reported a new online portal for suicide attempts that is active and works since 2016, as well as an Educational internet platform for General practitioners in the field of mental health that is active since 2016, while in Finland the availability of digital mental health services has significantly improved.

PROVIDING COMMUNITY-BASED MENTAL HEALTH SERVICES

Organization and coordination of community-based mental health services

The majority of Member States' representatives (92%) referred to having their mental health services organized by catchment areas in all or some parts of the country. The level of coordination most reported was fairly good and some coordination. A small percentage reported very high coordination (Fig.1 and 2). It should be noted that more than 40% of the countries where services are organized by catchment area in all parts of the country refer to have less than fairly good coordination, a fact that supports the idea that fragmentation of care continues to be a serious problem in many countries.

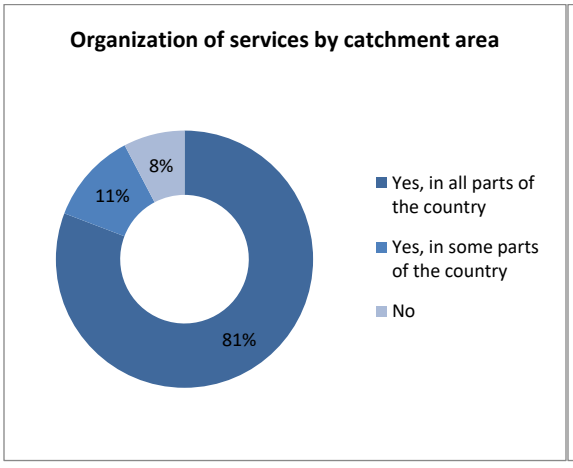


Figure 1

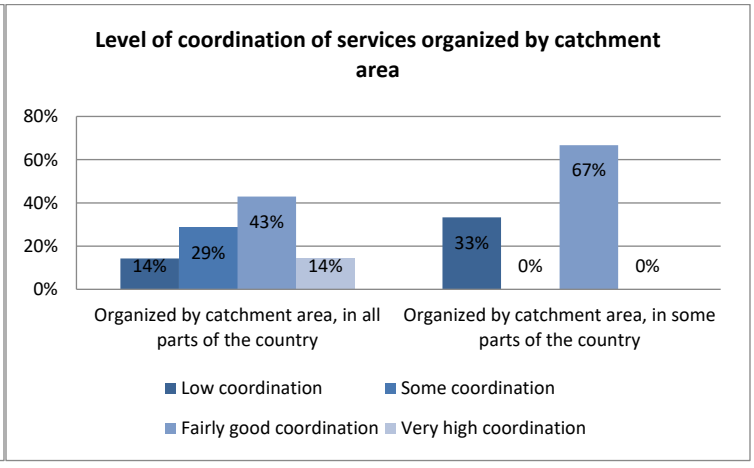
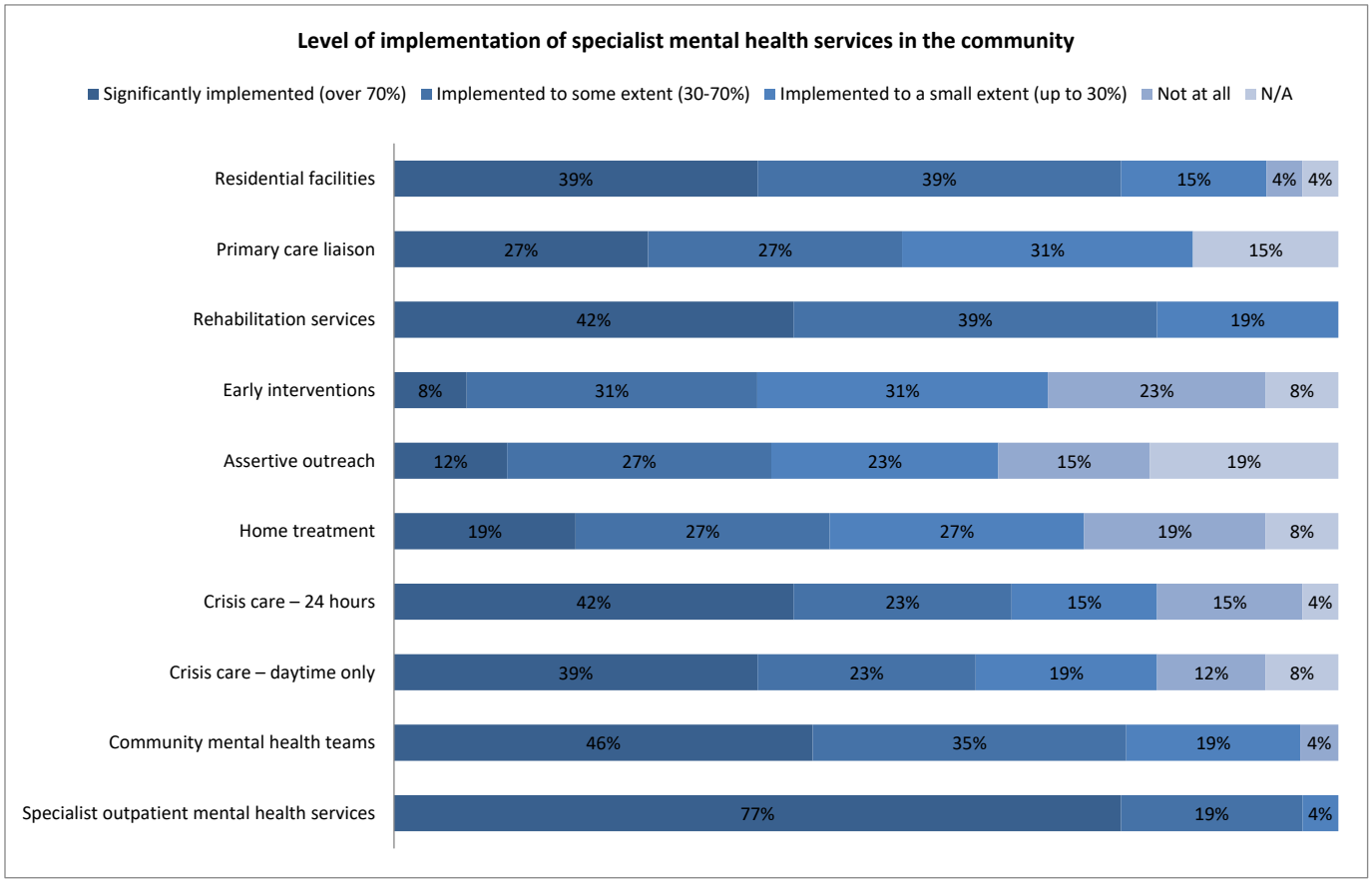


Figure 2

Level of implementation of specialist mental health services in the community

Member states' representatives reported having significantly implemented specialist outpatient mental health services (77%), followed by community mental health teams (46%), 24 hours' crisis care (42%), rehabilitation services and residential facilities (39%). The specialist mental health services in the community that Member States' representatives most reported not having implemented or to have implemented in a small extent were



primary care liaison, early interventions and assertive outreach (Fig.3).

A more detailed analysis of the data shows that almost 23% of the countries have not implemented at all or have only implemented to a small extent both specialist outpatient mental health services and community mental health teams. In other words, a quarter of the countries still concentrate all mental health care on institutional care.

We can also see that while 77% of the countries have significantly implemented specialist outpatient care, only 46% have significantly implemented community mental heath teams. This strongly suggest that although most countries were able to develop ambulatory mental health care, in many cases this is not carried out by multidisciplinary community-based teams. Taking into consideration that these teams have proved to be a fundamental part of a modern and effective mental health system, these data indicate that a lot has yet to be done in the transformation of mental health care in the EU.

The fact that only 27% of the countries reported a significant implementation of liaison with primary care confirm the large gap that exist in the coordination between specialist and primary care services, a gap that has a profound impact on the provision of mental health care of good quality.

Community Mental Health Centres

About half of the representatives could not provide information on the rate of Community Mental Health Centres (CMHC) available in their countries (Fig.4). The other half (with results ranging from 2014 to 2017) presents a rate of CMHC per 100.000 that goes from 0,17 up to 5,70.

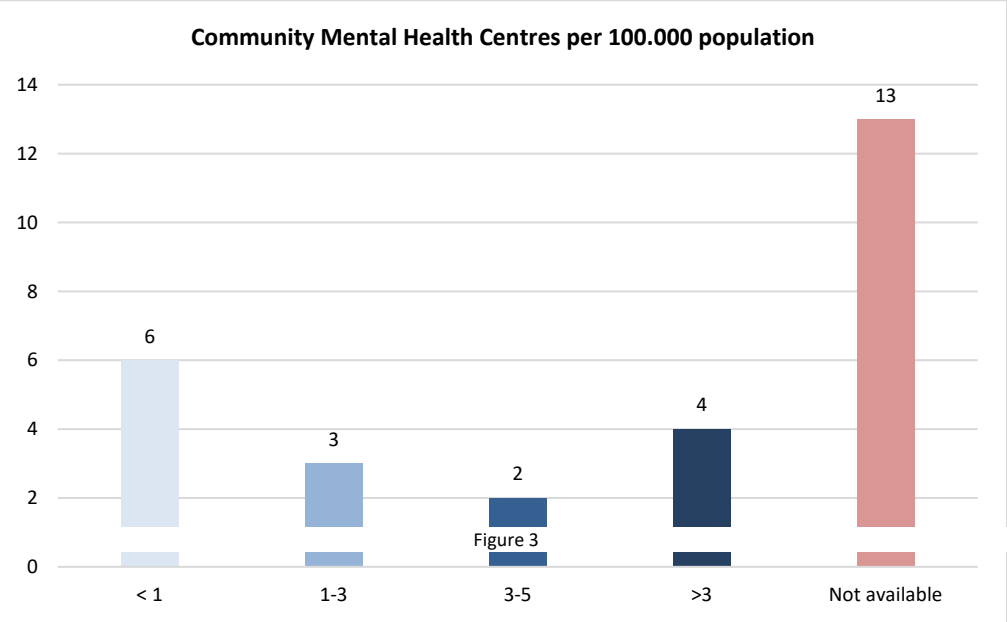


Figure 3

Country	Rate
Bulgaria	0,17
Turkey	0,20
Romania	0,38
Croatia	0,54
Hungary	1,20
Cyprus	2,84
Lithuania	4,00
France	5,50
Slovenia	0,20
Greece	0,49
Italy	3,84
Netherlands	5,70
Norway	2,9
Not available*	13

Table 1

* Austria; Belgium; Czech Republic; Finland; Germany; Iceland; Ireland; Luxembourg; Portugal; United Kingdom, Slovakia; Spain; Sweden

The survey included questions about the rates of annual patients treated in CMHC. However, only 11 countries were able to report this information (Table 2).

Rate of annual patients treated in Community Mental Health Centres		
Country	**Rate per 100.000 population**	**Rate per 100.000 population by sex (if available)**
Bulgaria	285,71	data not available
Cyprus	6276	data not available
Finland	3,02	Reported proportion of women 58%, and men 42%
France	22236	data not available
Hungary	1300	data not available
Ireland	4,625	data not available
Italy	20,2	21,00 Male

Netherlands	5829	data not available
Norway	Child and adolecents: 5080. Adult: 468	data not available
Slovenia	0,01	40% male; 60% female
Turkey	79	Women: 65; Men: 91

Table 2

This data show that, in many EU countries, there are no community mental health centres. There are also reasons to believe that this denomination is used for quite different kinds of services. While in some countries mental health centres are community-based services that are responsible for providing all basic mental health care in a determined catchment area, including some beds, community mental teams, psychosocial rehabilitation programmes, mental health promotion and liaison with primary care, in other countries mental health centres only include ambulatory care or even only promotion/prevention programmes.

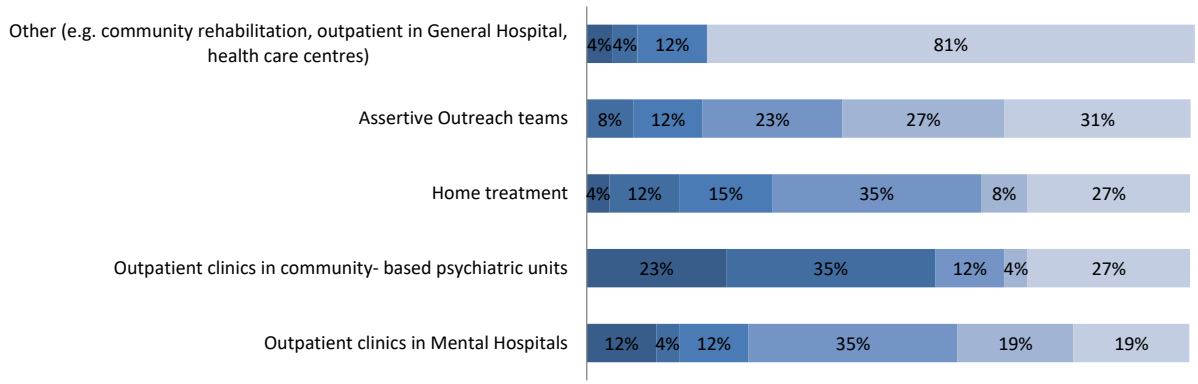
Proportion of patients with severe mental illness receiving routine follow-up community care upon discharge from inpatient services in the following settings

Member States' representatives reported that the higher proportion of patients with severe mental illness receives routine follow-up in outpatient clinics in community-based psychiatric units, and outpatient clinics in mental hospitals. Settings such as home treatment, assertive outreach teams and other are providing fewer proportion of follow-up community care to people with severe mental illness (Fig.5).

A more detailed analysis show three important facts. First, nowadays mental hospitals still are responsible for follow-up care in all or the majority of patients after discharge in 16% of the countries, and only in 19% of the countries mental hospitals have no more any follow-up intervention. In other words, mental hospitals have certainly lost a central role in the provision of ambulatory care in the majority of countries, but this did not happen in all countries. Second, in 58% of the countries, the majority of patients receive now follow-up care in outpatient clinics in community based psychiatric clinics. Third, home treatment and assertive outreach teams continue to have a significant role only in a small number of countries.

Proportion of patients with severe mental illness receiving routine follow-up community care upon discharge from inpatient services by settings

Figure 4



Proportion of unemployed people who receive social welfare benefits or pensions because of disability due to mental health problems in the last available year

National data on the proportion of unemployed people who receive social welfare benefits or pensions because of disability due to mental health problems is available only in seven countries — Finland, France, Germany, Netherlands, Slovakia, Slovenia, Spain (Table 3). In the case of Finland data refers to the "*number of persons on disability pension due to a mental health or substance abuse disorder (ICD-10 F-category) between 16-64 years".* Justifications for the lack of information on this issue unavailability in most of the countries range from "*There is no special calculation for unemployed people"* (Croatia) or "*Waiting the answer from the Ministry of Labour and Social Justice"* (Romania), which reflected the overall reality that these data are "*Not collected in the health sector"* (Italy). Accordingly, 19 countries did not report data.

Country	Proportion	Year of Data
Finland	3,13%	2015
France	28%	2009
Germany	37%	2016
Netherlands	43%	2013
Slovakia	30%	Not available
Slovenia	30%	2016
Spain	17,9%	2015

Table 3

Level of implementation of recommendations to provide community-based mental health services in 2015-2017

Figure 6 shows the level of implementation of the recommendations to provide community-based mental health services as reported by the Member States' representatives.

A great proportion of the recommendations were reported to **have been implemented before 2015**, such as:

- Establish or increase the number of psychiatric units in general hospitals;
- Mobilise in all places a shift from long-stay psychiatric hospitals to a system based on general hospital and community mental health services;
- Shift the focus of specialised mental health care towards community-based services.

The **most implemented recommendations after 2015** were:

- Develop and update mental health policies and legislation;
- Ensure that community psychosocial support is available for people with severe mental disorders;
- Promote the social inclusion of people with long-term mental disorders;
- Ensure quality of care improvement and the protection of human rights across all parts of the system;

- Promote the active involvement of users and carers in the delivery, planning and reorganisation of services;
- Develop self-help and users and carer groups.

The recommendations that were **the least implemented** were:

- Improve the use and effectiveness of monitoring mechanisms of mental health services;
- Stopping new admissions to psychiatric institutions, or 'closing the front door';
- Integrate mental health in primary health care;
- Reallocate resources, both human and financial, away from mental hospitals/psychiatric hospitals to community services.

Overall, we can see that, in most countries, the basic transformations of the transition from psychiatric hospitals to community- based care have started and occurred before 2015. In the last few years, the areas of interest of countries have moved to updating policies and legislation, ensuring better quality of care, promoting social inclusion and more involvement of users and carers.

Interestingly, according to the representatives of most countries, the recommendations that were the least implemented include some of the actions that proved to have a more important role in the process of deinstitutionalization and development of community care – e.g., stopping new admissions to psychiatric institutions, integrate mental health in primary health care; and reallocate resources, both human and financial, away from mental hospitals/psychiatric hospitals to community services. If this interpretation is correct, it seems to indicate that the development of community care is being made more as something that is added to the existing institutional care than something that is replacing the last one in a coordinated manner.

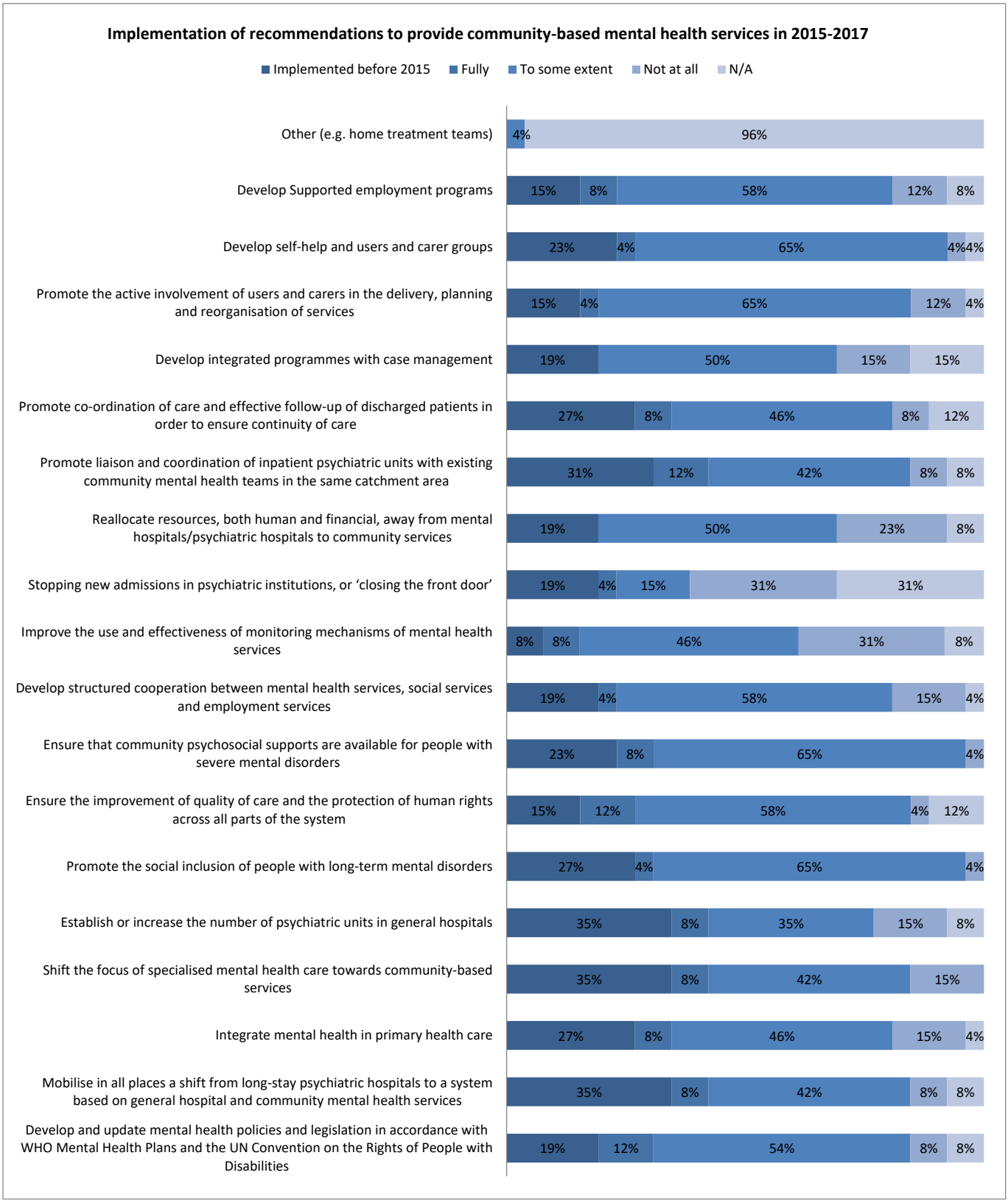

Implementation of recommendations to provide community-based mental health services in 2015-2017
Implemented before 2015
Fully
To some extent
Not at all
N/A
Other (e.g. home treatment teams)
4%
96%
Develop Supported employment programs
15%
8%
58%
12%
8%
Develop self-help and users and carer groups
23%
4%
65%
4%
4%
Promote the active involvement of users and carers in the delivery, planning and reorganisation of services
15%
4%
65%
12%
4%
Develop integrated programmes with case management
19%
50%
15%
15%
Promote co-ordination of care and effective follow-up of discharged patients in order to ensure continuity of care
27%
8%
46%
8%
12%
Promote liaison and coordination of inpatient psychiatric units with existing community mental health teams in the same catchment area
31%
12%
42%
8%
8%
Reallocate resources, both human and financial, away from mental hospitals/psychiatric hospitals to community services
19%
50%
23%
8%
Stopping new admissions in psychiatric institutions, or 'closing the front door'
19%
4%
15%
31%
31%
Improve the use and effectiveness of monitoring mechanisms of mental health services
8%
8%
46%
31%
8%
Develop structured cooperation between mental health services, social services and employment services
19%
4%
58%
15%
4%
Ensure that community psychosocial supports are available for people with severe mental disorders
23%
8%
65%
4%
Ensure the improvement of quality of care and the protection of human rights across all parts of the system
15%
12%
58%
4%
12%
Promote the social inclusion of people with long-term mental disorders
27%
4%
65%
4%
Establish or increase the number of psychiatric units in general hospitals
35%
8%
35%
15%
8%
Shift the focus of specialised mental health care towards community-based services
35%
8%
42%
15%
Integrate mental health in primary health care
27%
8%
46%
15%
4%
Mobilise in all places a shift from long-stay psychiatric hospitals to a system based on general hospital and community mental health services
35%
8%
42%
8%
8%
Develop and update mental health policies and legislation in accordance with WHO Mental Health Plans and the UN Convention on the Rights of People with Disabilities
19%
12%
54%
8%
8%

Figure 5

Further comments regarding the implementation of the recommendations mentioned above:

Further comments to the implementation of the recommendations were varied. Three countries' representatives (Czech Republic, Romania, and Slovenia) declared to be "(…) working to improve the implementation of recommendations". Two other said that their countries were undergoing a deinstitutionalization process, with the "number of beds in long-stay units constantly being reduced" (Croatia) or that "some psychiatric hospitals were closed until 2011" (Portugal). The representative from Croatia also added that mechanisms to monitor quality of MH care services are due to be implemented by 2018. The representative from Bulgaria mentioned not having had developments in the period of 2015/17, and the representative from Ireland stated the difficulty to answer the question due to the regional discrepancies in implementation. Finally, Iceland's representative described their efforts to make primary care the entry point for the treatment of mental health problems; the importance that has been given to destigmatization through the financing of psychological support; specific training on mental health in primary care; and the creation of interdisciplinary community teams for outreach.

Barriers to the level of impact on implementation of the recommendations to provide community-based mental health services in 2015-2017

In terms of barriers to implementing the recommendations to provide community-based mental health services (Figure 7), the bigger constraints are due to inadequate/insufficient funding (92%), poor cooperation between health and social care (85%), lack of consensus among stakeholders (81%), and low political support (77%), thus confirming the conclusions obtained on this issue in the Joint Action.

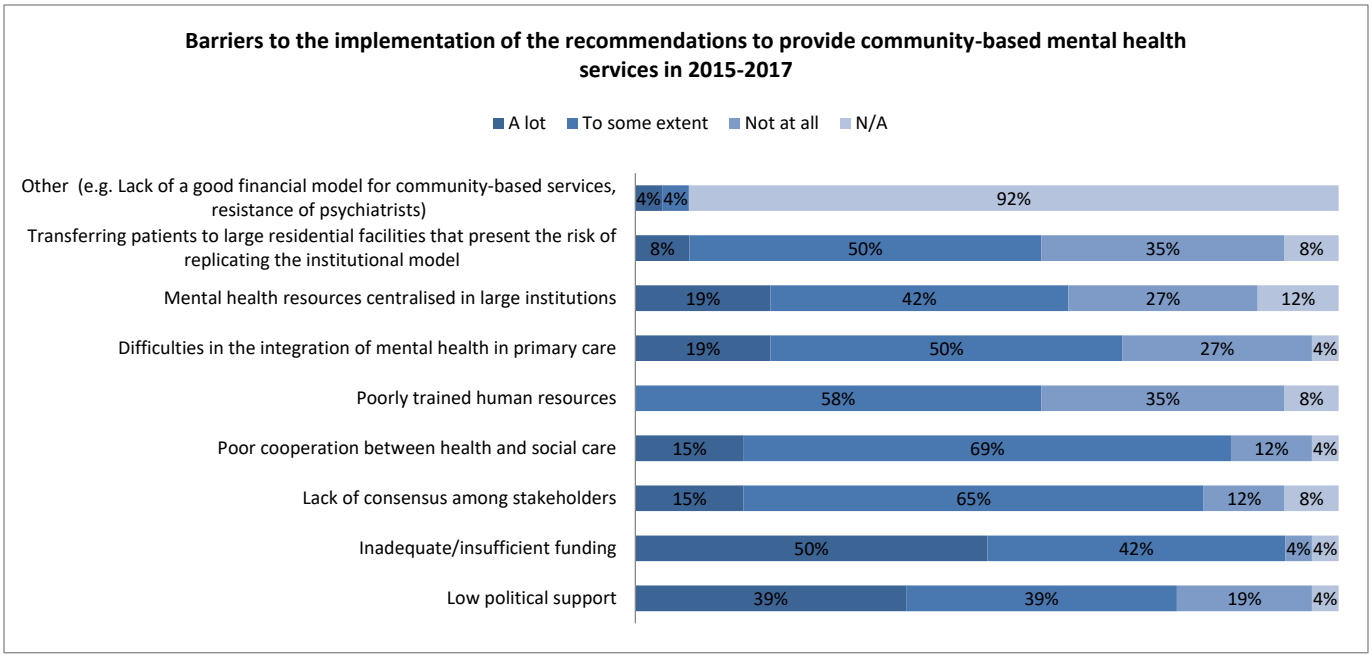


Figure 6

DEVELOPING INTEGRATED GOVERNANCE APPROACHES

How mental health is taken into account in non-health sectors' policies and practice.

When analysing responses[3] to the question of how mental health (MH) is taken into account outside of the Health Sector, i.e. with the aim of identifying how mental health concerns are integrated in other policies, many barriers are reported (Fig.8). The main one is low political support in developing policy, but even more in effectively implementing the policies designed for MH or MHiAP. This is also formulated in terms of it *not being a priority* or remaining in a theoretical plan, which is proven by a correspondent lack of funding mentioned by four countries. One clarifying quote comes from Bulgaria: "Mental health problems are not among the priorities of non-health sectors' policies as well as for the health sector. There is no special interest to reform the existing institutional model of mental health care which reflects on the attitudes in the non-medical sector."

Nonetheless, even though the non-effectivity of MHiAP is mentioned in different ways by a considerable number of the 26 countries represented in this questionnaire, still almost half of them (12) mentioned different initiatives that show there is some degree of implementation. For example in Finland: "The *Let's Talk* method (developed in the Effective Child & Family Programme) is being implemented in the whole country as part of the Government Key Project «Programme to address child and family services». KiVa school (kivaprogram.net) [exists in] 90% of all comprehensive schools, [with] actions against bullying, since 2006. Mental Health skills are part of the new core curriculum for basic education since August 2016. *Time Out!* (tampub.uta.fi/handle/10024/66805), [is a] psychosocial support program targeted at those conscripts exempted from military or civil service, from 2004. *Good Hunting Mate! Talk about your worries*, early identification and intervention at hunts (theseus.fi/handle/10024/55410), from 2011. *Mental Health First Aid* is being disseminated in the whole country as part of the Government Key Project «Health and wellbeing will be fostered and inequalities reduced». The aim is to disseminate *Mental Health First Aid* to professionals working with people in different fields. The Finnish Defence Forces have provided their personnel with the Mental Health First Aid training in the Karelia Brigade. PALOMA -project develops methods to promote mental health of the refugees and asylum seekers."

Fifteen countries mentioned having policy and specific plans addressing MH issues and ten have programs to put them in practice (or are designing programs to put them in practice in the future). These plans are mostly targeted, but there are also countries addressing MH problems in a universal way, i.e. developing political

[3] To see full responses please go to Anex 1 ou to D2 – link.

measures to promote better MH for everyone. Austria is one of these countries: “In 2016 and 2017 the Austrian national health target #9 ‘To promote psychosocial health in all population groups’ has been elaborated by an intersectional and multidisciplinary workgroup following a mental health in all policies approach (more than 40 institutions/organizations were involved). Three strategic aims and a bundle of actions shall contribute to enhance mental health promotion, prevention, support, treatment and anti-stigma work. The 10 Austrian health targets were developed with the aim to prolong the healthy life years of all people living in Austria in the coming 20 years (until 2032), irrespective of their level of education, income or personal living condition.” Overall, many answers are more focused in specific-health measures than in an integrating MH in other policies.

As for the geographical significance of these policies, some of the answers mentioned not only a national focus but also a regional implementation or development of MH measures and even responsibility. Finally, we would like to draw attention to the small number of countries’ representatives mentioning data collection for specific MH indicators. We cannot conclude that there are not more countries doing this collection, only that this was not mentioned more frequently among the member states as a way of supporting the assumption of mental health as a priority. The lack of specific data on MH has already been reported, for example, about the rate of Community Mental Health Centres. Please see the graphic below for more info:

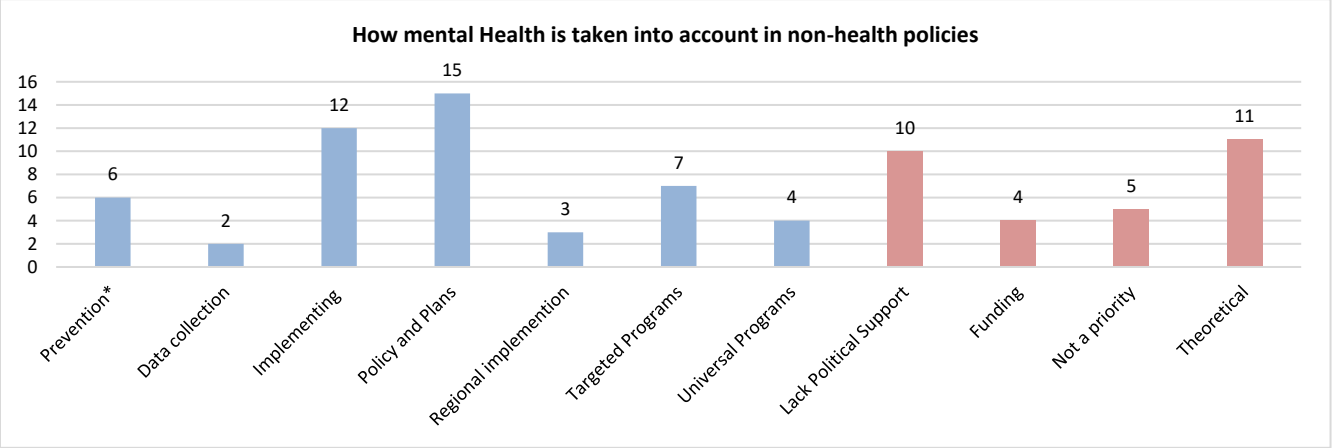


Figure 7
*namely Awareness Campaigns or Training

National programmes/strategies for developing integrated governance approaches (or MHiAP):

More than half of the countries' representatives reported having national programmes or strategies for integrated governance approaches compared to 29% who reported not having (Fig.9). In addition, countries' representatives referred that the strategies were implemented in *some* to *all or almost all* regions or local authority areas.

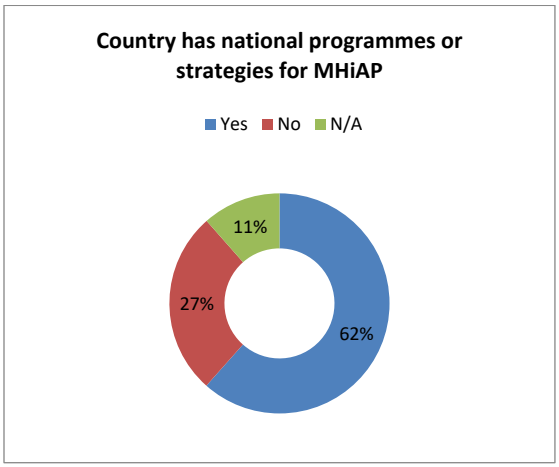


Figure 8

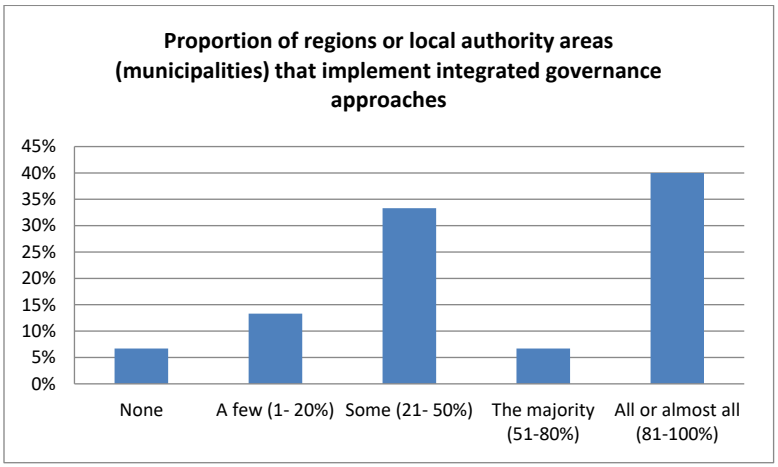


Figure 10

Yes= Austria, Belgium, Bulgaria, Croatia, France, Iceland, Ireland, Italy, Netherlands, Norway, Romania, Slovakia, Slovenia, Sweden, Turkey, United Kingdom. **No=** Czech Republic; Finland; France; Germany; Greece; Hungary; Iceland; Ireland; Italy; Lithuania; Luxembourg; Netherlands; Portugal

Further description of these programmes

When asked to describe further what these programmes entail[4], the diversity of answers is evident: the dispersion of answers is big, meaning that countries might be looking for solutions according to their specific national context. Still, ten representatives mentioned types of intersectionality, be it in terms of inter-ministry coordination or non-governmental coordination between institutions from different sectors; seven gave examples of targeted programs (mostly in schools and work environment)[5], and six reported the official involvement of non-health actors in governing mental health issues.

It is important to emphasize the small number of countries' representatives mentioning the involvement of users and families in the design of the programmes or in governance initiatives, like mental health committees in Belgium: "Catchment areas are governed by committees, including partners from non-health sectors and

[4] To see full responses please go to Anex 2 ou to D2 – link.

[5] Like in Slovakia: "programme Zippy's friend- for children, psychoeducation's programmes, Days of mental health days of "forget-me-not"".

representation of patients and their families." The decentralization of mental health governance was also an emergent theme, although not much reported, in the initiatives conducted by or at local level, as in France: "A new development in mental health governance: from 2017, mental health stakeholders have to elaborate together "territorial mental health programmes", the territory being defined as being adequate for the relevant coordination of health, social and medico social actors (e.g. a French department). Local mental health councils are also being developed all over France, at suburban or urban or rural levels."

Finally, five representatives reported the low implementation of National Programmes for MHiAP. Croatia describes very clearly what also happens, perhaps, in other countries: "There is a national strategy where the integrated approach in mental health care is described. Actually, no real legislative changes are done to support these intentions. They entail health, social, labour, education, justice and some other sectors cooperation; covering all topics and recommendations given in modern mental health care. Unfortunately, they are often not implemented." Further information can be found in Figure 11.

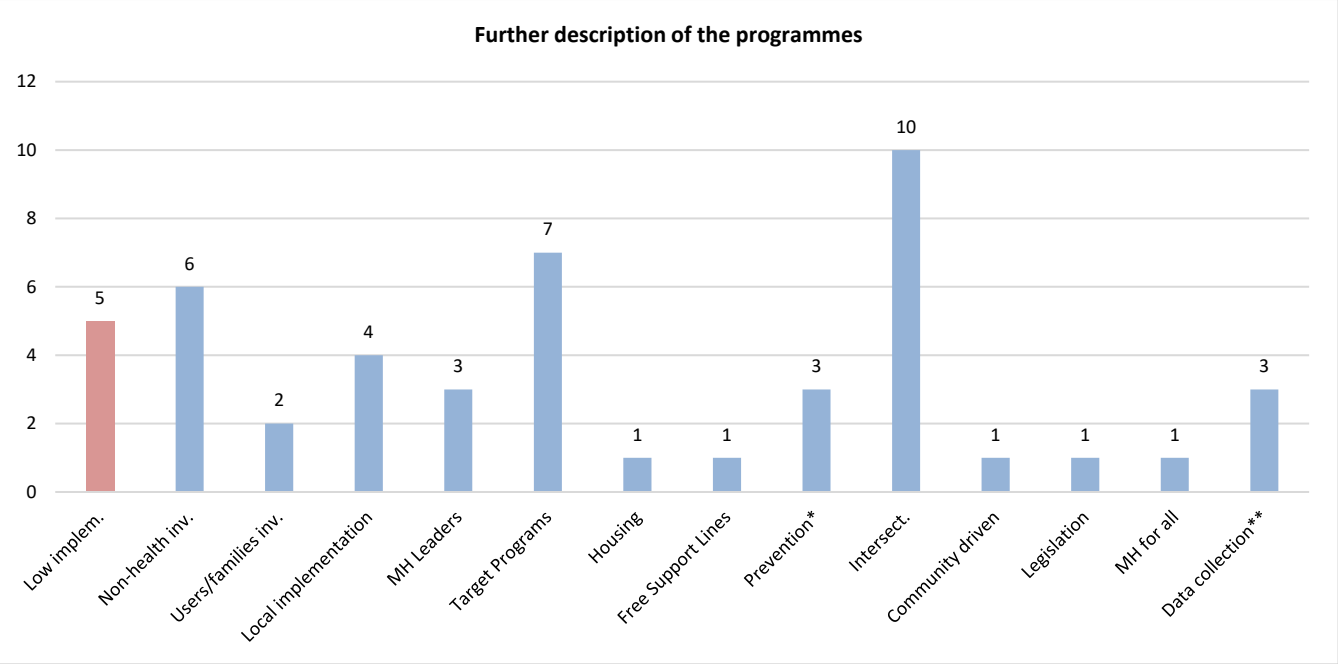


Figure 11

***namely Awareness Campaigns | **including a concern with indicators' standardization**

Recommendations to develop integrated governance approaches (or MHiAP) that have been implemented in 2015-2017

The **most implemented recommendations** to develop integrated governance approaches reported by Member States' representatives were:

- Enabling the Mental Health in All Policies approach by building mental health literacy and better understanding of mental health impacts;
- Action on social determinants of mental health;
- Set up multi-stakeholder policy forums to initiate and develop mental health promotion policies and initiatives;

The recommendations that were highly reported to **have not been implemented** were:

- Improve provision of sector-relevant information on impact of policy decisions on public mental health;
- Utilise tools such as joint budgeting
- Implement public monitoring or audit of the mental health and equity effects of policy actions

Further information can be found in figure 12.

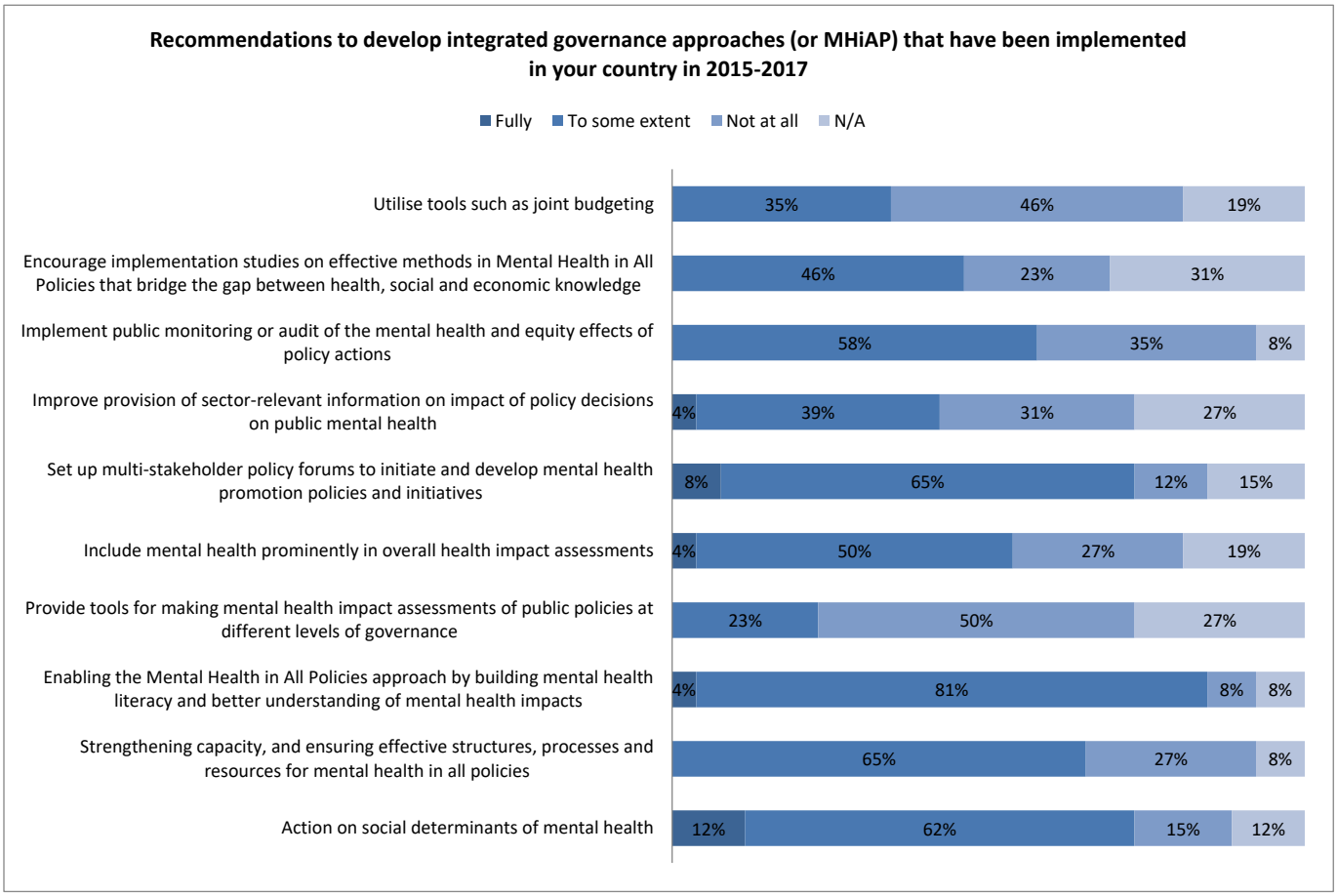


Figure 12

Barriers that impacted on the implementation of recommendations to develop integrated governance approaches (or MHiAP) in 2015-2017

Figure 13 shows the main barriers to implementing the recommendations to develop integrated governance approaches as reported by the Member States' representatives. The main barriers that impacted to some extent or a lot this implementation were:

- Lack of available tools;
- Low political support;
- Inadequate/insufficient funding;
- Poor cooperation between health and other sectors;
- Problems with joint budgeting;
- Lack of knowledge/understanding of MHiAP/integrated governance.

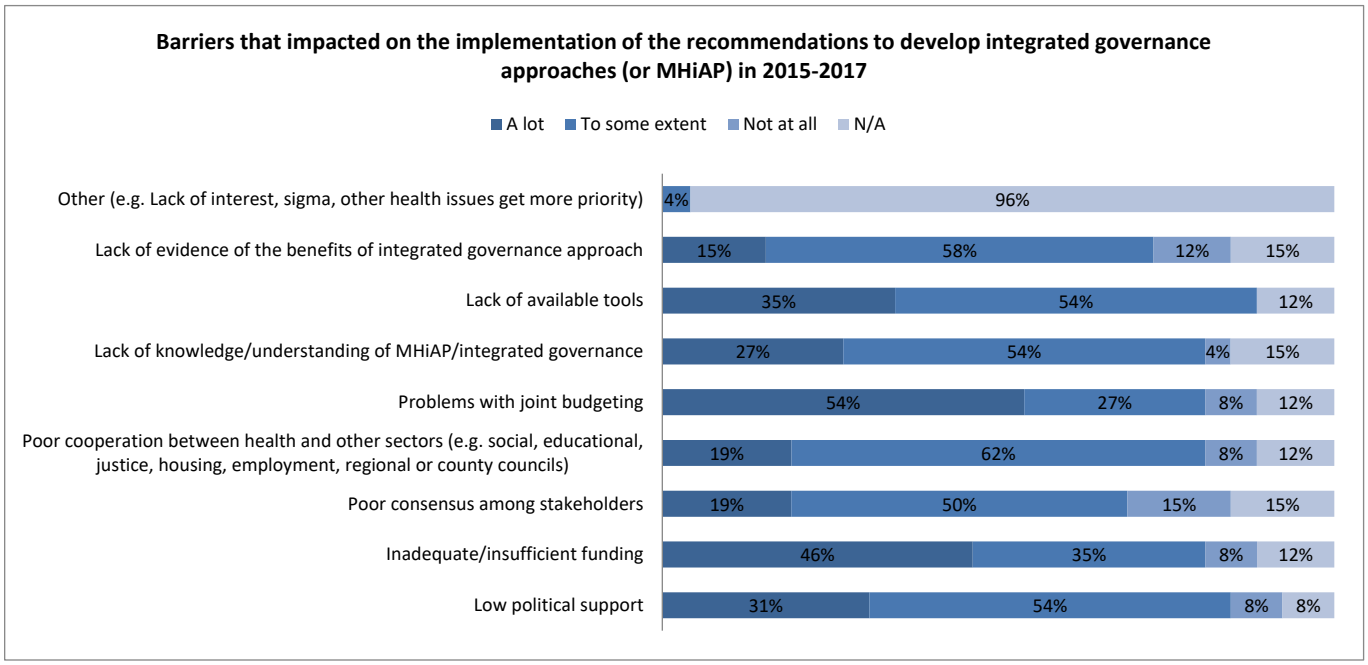


Figure 13

FURTHER INFORMATION REGARDING DEVELOPING INTEGRATED GOVERNANCE APPROACHES (OR MHIAP)

Evidence of financial benefits of developing integrated governance approaches to mental health

Most of the countries representatives considered that there is no evidence of the financial benefits of developing a Mental Health in All Policies approach (which may account for its low implementation rate). N.A. accounts for "Information not available"(Fig.14). Also, five countries did not answer to this question, hence the total number of answers being 21. However, between the countries that recognised the evidence of the financial benefits of this approach, particularly interesting are the answers from the UK and Norway (see these countries reports in the Annexes).

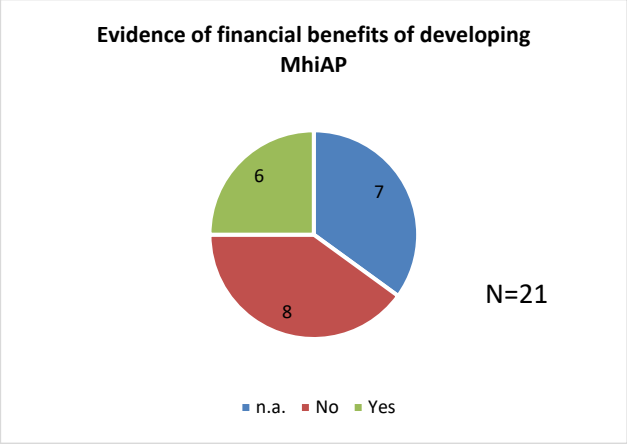


Figure 14

Responsible entities for funding activities to develop integrated governance approaches to mental health

Mental Health in All Policies is mostly funded at the National or Regional/Federal levels. "Various" category includes: National Insurance Fund; Inter-Departmental; national lottery, international funding (e.g. EU); donations, etc. To be noted that 3 countries mentioned not having funding for MHiAP. Please find more information below:

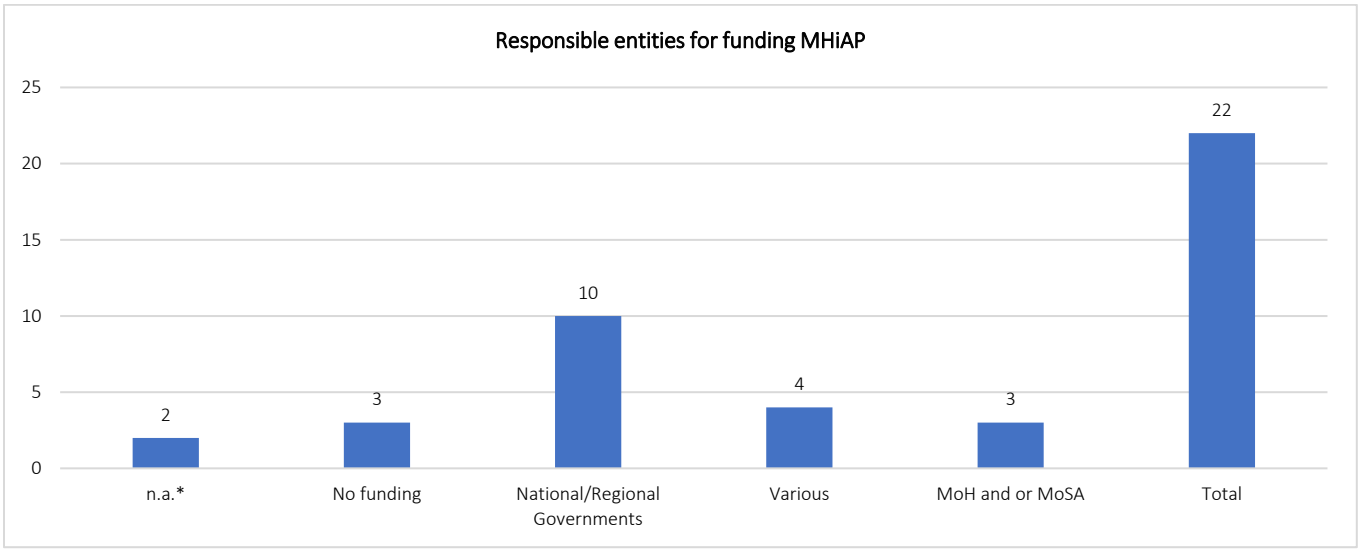


Figure 15

**n.a.* includes "do not know"

Responsible entities for implementing integrated governance approaches to mental health

As for the responsibilities in implementing Mental Health in All Policies (Fig. 16), the main actors responsible for it are the Central, Regional or Federal governments, depending on the country, either by themselves or in collaboration (9 countries). The "Integrated" category brings together the countries where different sectors work in an integrated way, as expressed in the countries' answers "This depends on the program" (Netherlands); and a mix of "Ministry of Social Affairs and Health, National Institute for Health and Welfare, municipalities" (Finland). Please find more information in figure 16.

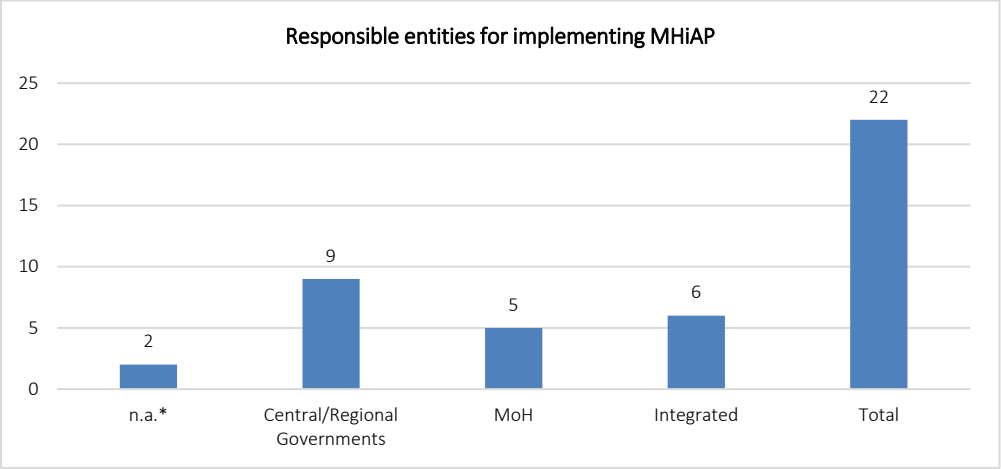


Figure 16

*includes "do not know" and "no implementation"

Sectors and professionals involved

When looking at the sectors and professionals involved in MHiAP, the majority refer collaboration between various ministries or sectors in society, including Health and other areas (11). Four countries report having an inter-ministerial strategy, which does not mean different sectors or levels of intervention, beyond the ministries, are included. Finally, three countries specify the Ministry of Health and or the Ministry of Social Affairs (Figure 17).

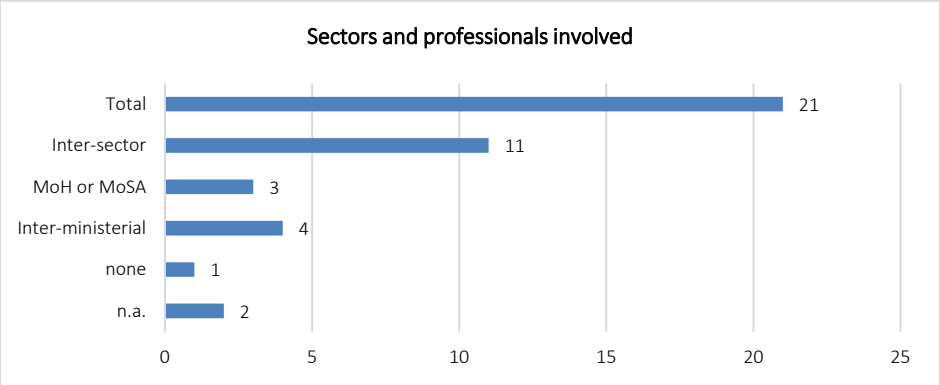


Figure 17

Focus on targeted or universal approaches

Most of the representatives reported their countries to have either targeted approaches or both approaches, depending on the issue (n=6), and only one country stated having a universal approach (Fig.18).

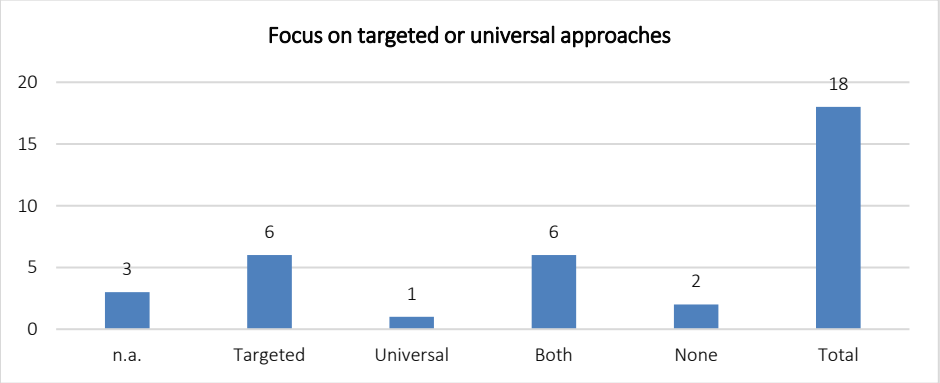


Figure 9

*Includes "having no information on this"

Is there citizen/public involvement in implementing integrated governance approaches to mental health

Finally, most of the member states' representatives reported citizen or public involvement in implementing integrated governance approaches to mental health in their countries (Fig. 19). Only four countries say this involvement do not exist, and five others did not provide information in this issue.

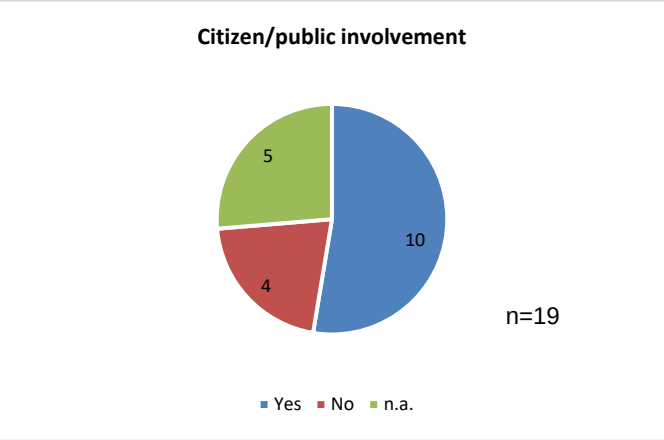


Figure 19

KEY DEVELOPMENTS BY STAKEHOLDERS

INFORMATION ABOUT THE STAKEHOLDERS' ORGANIZATIONS

Status and Sector

The great majority (70%) of the stakeholders' organizations belong to the third sector, i.e. are non-governmental. A quarter of the stakeholders' organizations are governmental or university based, and only 4% belong to the private sector. Around 65% of the organizations work in the health sector and social sector. Other important sector includes education, human rights and other such as labour sector, youth, arts and culture sector.

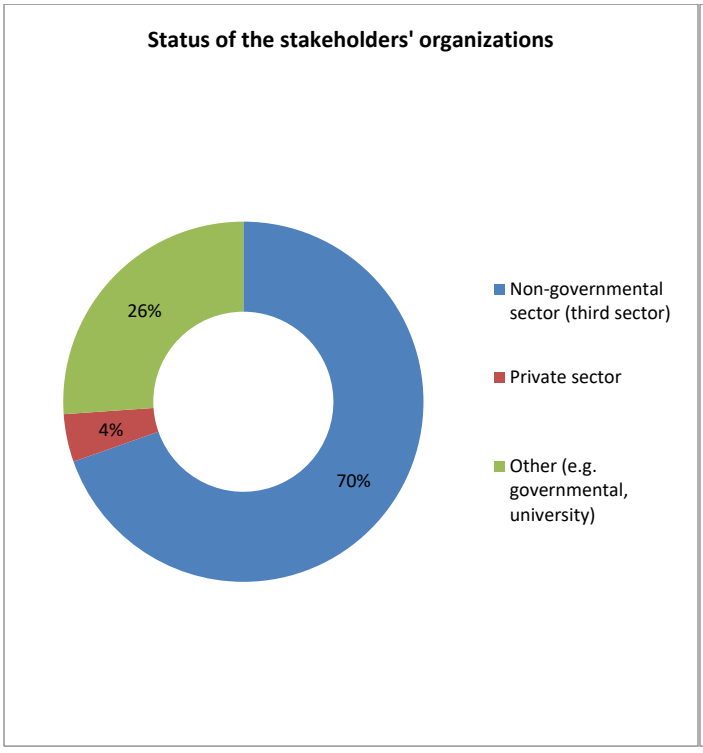


Figure 20

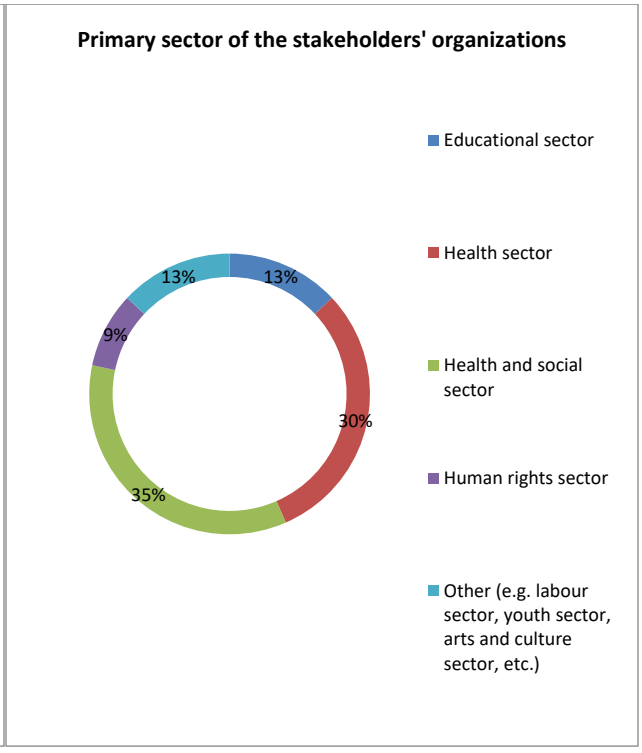


Figure 21

Basic information about the organisations

When asked to further describe their organization, many respondents mentioned activities related to gathering data on mental health issues, as well as doing formal research. The following most mentioned two themes are education and being a network of stakeholders or organizations. Improving quality of life is also an important theme, namely not only as a matter of mental health but also with a focus on physical health (two of the organizations are representative of physiotherapists specialised in mental health issues). Finally, working as advocates either promoting mental wellbeing, non-labelling or to influence policy are *other* valuable information that the organizations shared with us.

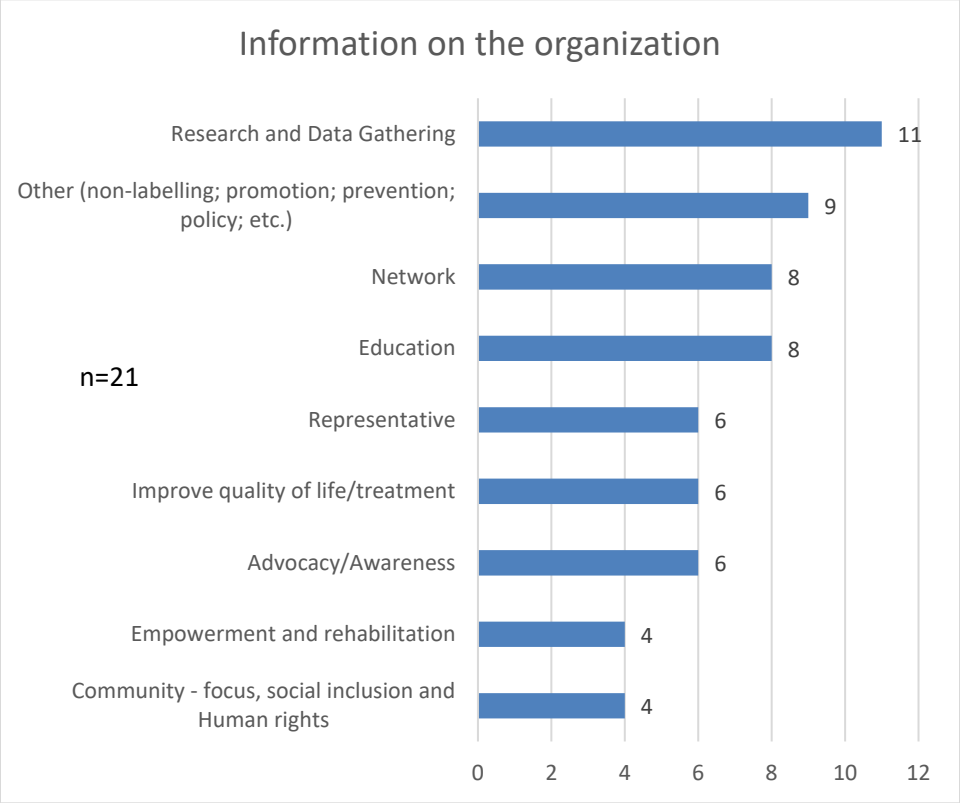


Figure 22

STAKEHOLDERS' ACTIONS IN MENTAL HEALTH IN 2017

Reasons why the organizations work on mental health

Stakeholders provided written information on the reasons why they acted on mental health during 2017. The main reasons were to promote health, to provide care, to support research and/or training and to promote advocacy. Notwithstanding, nine out of the 23 respondents did not provide information.

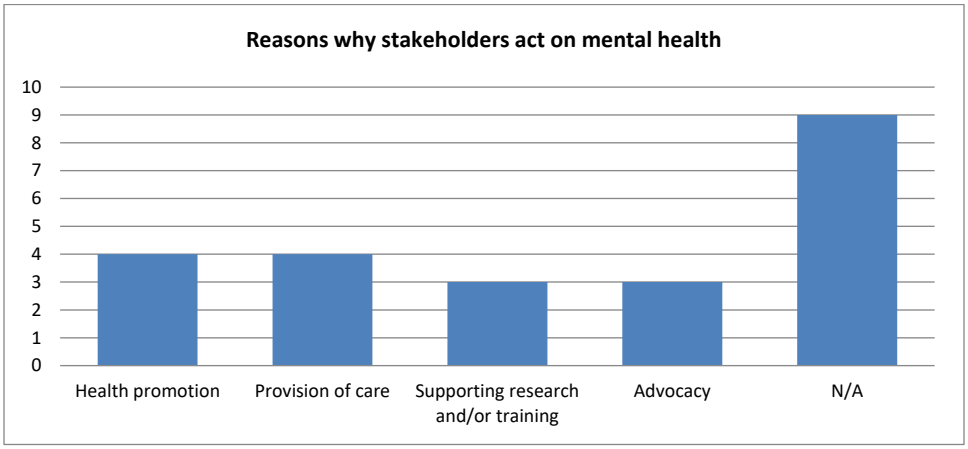


Figure 23

How mental health is related to the core objectives of the organisations

Regarding how mental health is related to the objectives of the organizations, about half of the stakeholders responded that mental health is the main goal of their organizations' work and 13% stated that mental health is one of the core objectives of their work. Nonetheless, around 40% of the stakeholders did not provide information about this matter.

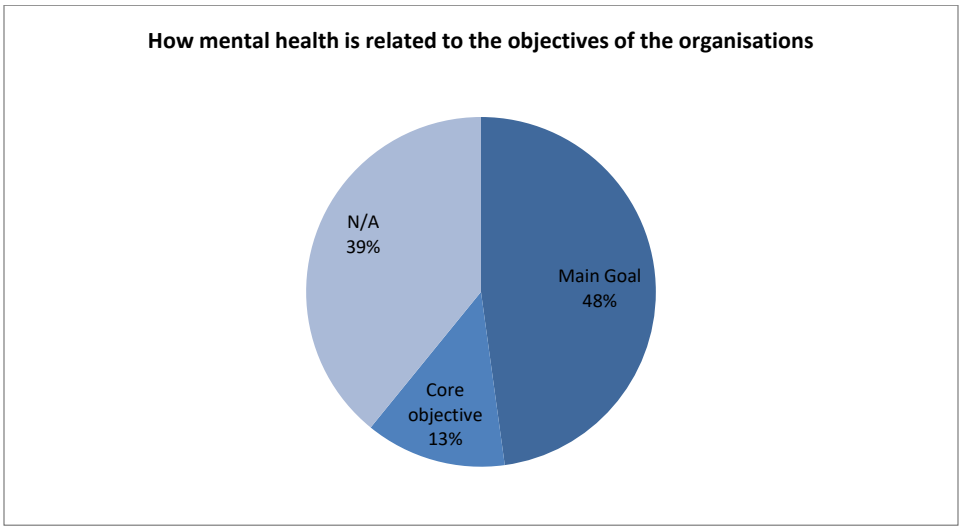


Figure 24

The key mental health activities of the organisations

The main key mental health activities developed in 2017 reported by the responding stakeholders were: training, endorsing advocacy and raising awareness, providing care, performing research and dissemination, acting on prevention and promotion, and establishing collaboration and networking.

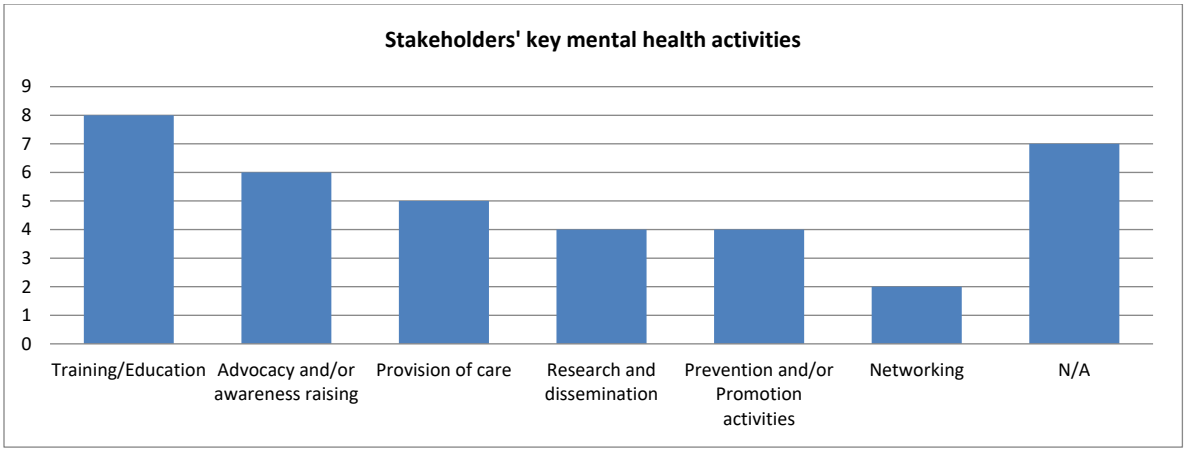


Figure 25

The key partners involved in the actions in mental health implemented in 2017

Figure 27 shows the main partners that collaborated with the stakeholders' organizations in the actions in mental health implemented in 2017. Non-governmental organizations (e.g. national and international associations and foundations) and academia (e.g. universities and research centres) were the most frequent reported key partners involved. Moreover, four organizations stated to work in close collaboration with professionals and users, three organizations reported partnerships with county councils and municipalities, two with health services (e.g. hospitals and health centres), and two other reported participation of policy makers and socio-cultural centres.

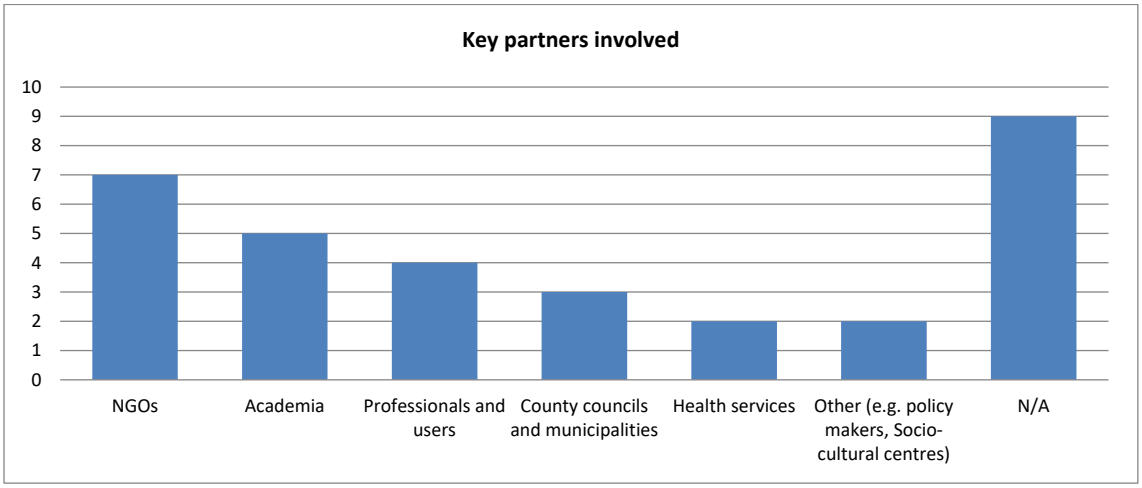


Figure 27

Organization's target group

The main target of these organizations is what we named "target beneficiaries" due to the diversity of organizations answering the questionnaire. These include elderly people with psychosocial disabilities, people with physical illnesses, particularly cancer patients, or young people under 11-35. The second major target group are mental health professionals, which include not only *health professionals* but also other MH experts, be it in social work or pedagogy. "Other" category includes many important groups, such as families and the general public.

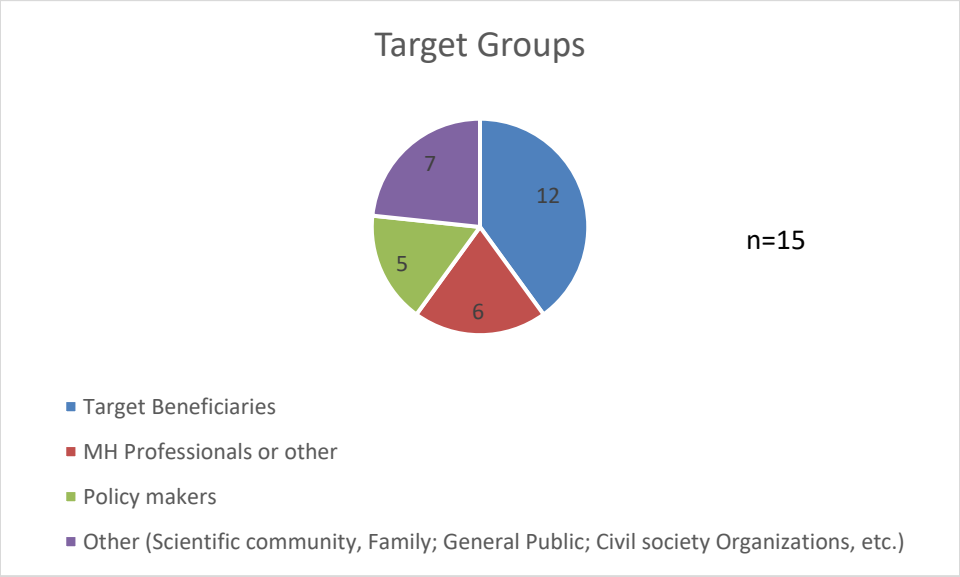


Figure 28

Resources available for the organizations' work

Regarding the resources available for the organizations to perform their work, the majority works with self-raised funds, such as research grants, services provided or funded projects. Volunteer and personal dedication work are also mentioned.

Figure 29

Strengths of the organizations' activities

In line with what have been said before, the main strength appointed is the collection of data on mental health, followed by characteristics connected to accumulated work experience and integrating the users, clients or beneficiaries of the organization's activities in their many sides, not only as recipients but also as participants in the organization.

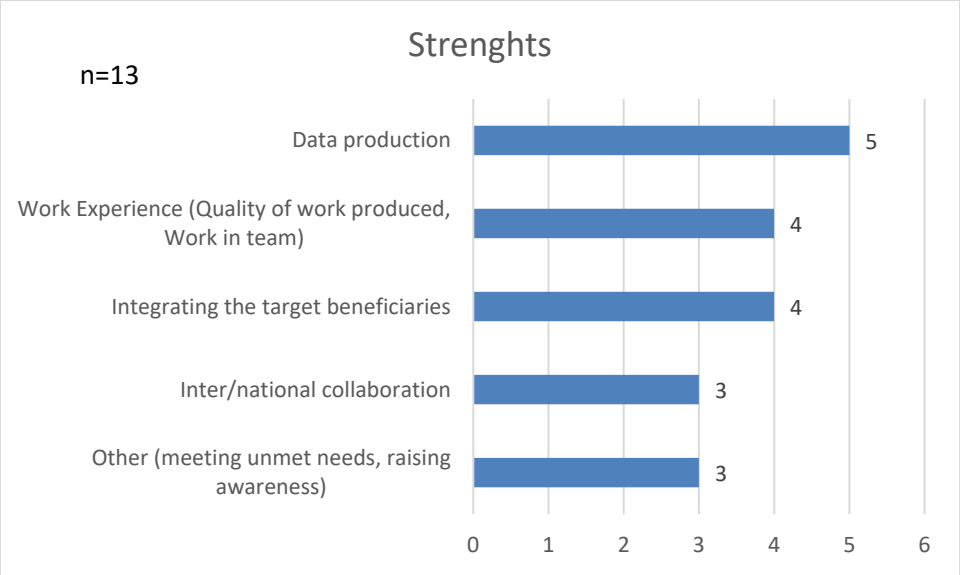


Figure 30

Challenges met

About the challenges the stakeholders' representatives have been facing, the main one is related to lack of funding and organizational challenges – for example, lack of human resources. Stigma is also reported by three respondents.

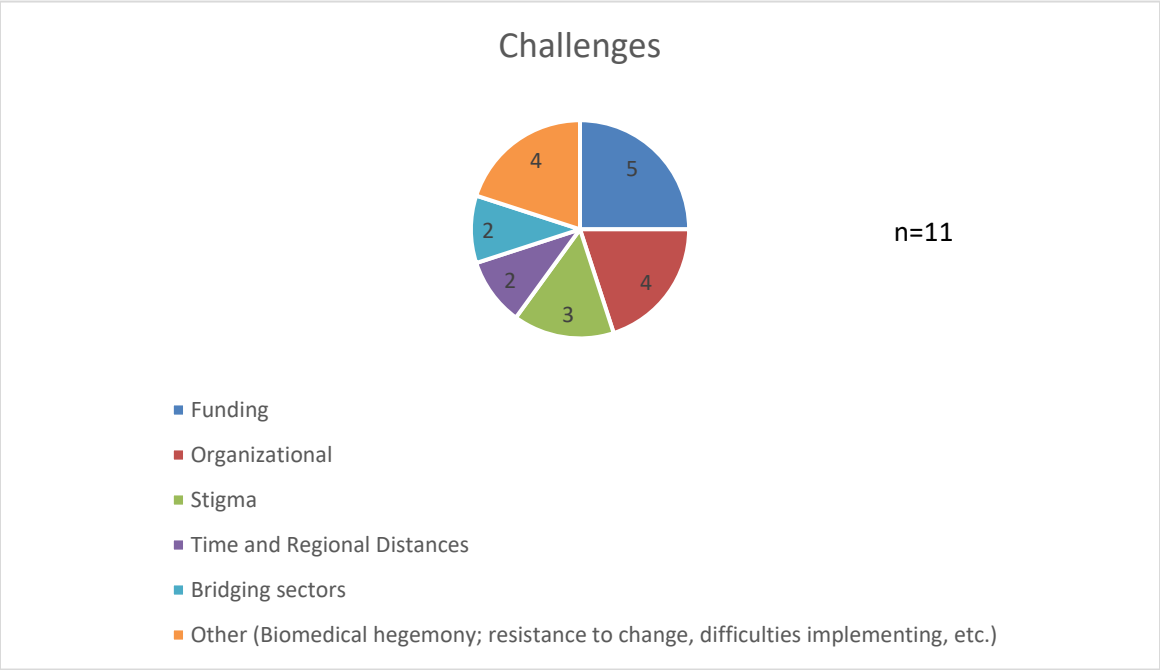


Figure 31

Activities' evaluation

As for the evaluation of the stakeholders' activities, the majority of stakeholders (6) answered 'yes' to this question. Four are evaluated through academic indicators as publications or research programmes' evaluation. The other two stakeholders say they are evaluated through the impact and feedback of their activities.

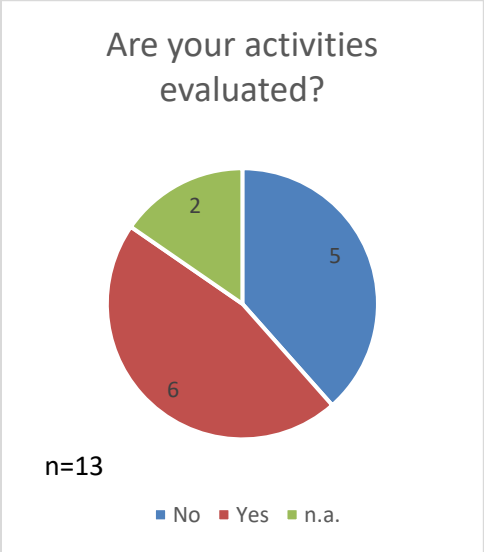


Figure 32

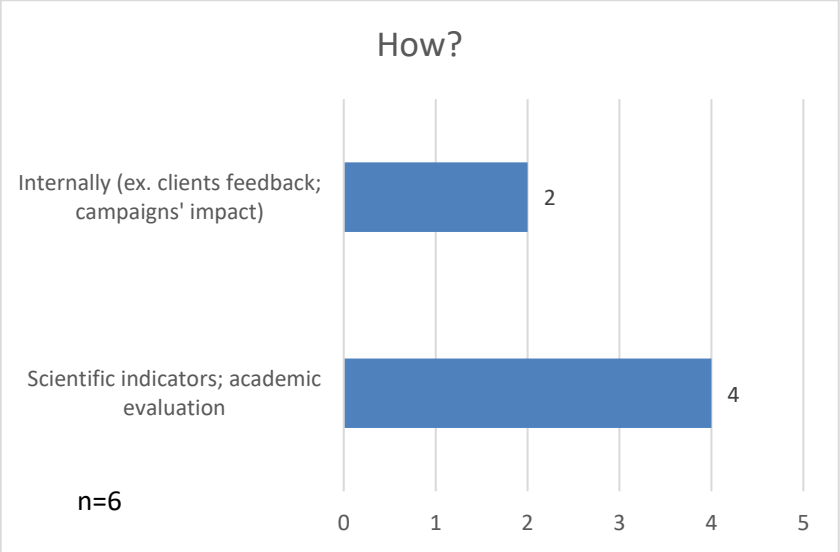


Figure 33

7. FINDINGS AND INNOVATIVE PRACTICES IN COMMUNITY MENTAL HEALTH CARE

As the EU Joint Action Report on the Transition to Community Care showed, community care is associated with continuity of care, greater user satisfaction, increased adherence to treatment, better protection of human rights, and the prevention of stigmatization. It also contributes to improved access to services, enables people with mental disorders to maintain family relationships, friendships, and employment while receiving treatment; so facilitating early treatment and psychosocial rehabilitation (Caldas de Almeida et al, 2015). For this reason, according to the WHO mental health care pyramid (WHO, 2003, 2007), specialist community mental health services are a core component of mental health systems, ensuring in coordination with general hospital inpatient units the fundamental specialized responses to the mental health care needs of a population.

The literature review carried out by the EU Compass scientific paper on "Community-based mental health care" (see Annexes) confirms these advantages, and shows that, when compared with traditional hospital-based services, Community mental health teams (CMHT´s) are associated with lower admission rates, better quality of care, and increased service user satisfaction.

In the last decade, newer models of community-based services have emerged. The critical review carried out by the EU Compass scientific paper show that these new models made possible important advances in the provision of mental health care in several domains.

In relation to mental health in primary care, the Liaison Primary Care and the Collaborative Care models, created to overcome the insufficiencies usually found in the coordination of care between primary care and specialist mental health services, proved to be both associated with improved patient satisfaction and treatment adherence, and all available evidence show that the collaborative care model is clearly superior to standard care in the treatment of high-prevalence disorders, such as depression and anxiety. This means that strategies to decrease the huge gap found in the treatment of common mental disorders must pass by scaling up collaborative care.

Regarding new approaches with community mental health teams, Assertive Community Treatment (ACT) and Intensive Care Management (ICM) proved to be associated with reduced hospitalizations, increased patient retention and improved social functioning. Yet, it should be noted that the effectiveness of these more intensive

and systematic interventions appears to be dependent on context; and more recent studies suggest that their effectiveness is less evident when standard community services are well developed and well resourced.

Early intervention services (EIS) proved that it is possible to ameliorate the individual and economic consequences of psychotic illness through the early identification of individuals at high-risk of developing psychosis, or those in the early stages of the illness. On the other hand, available evidence supports the advantages of various alternatives to inpatient treatment that have been proposed — e.g., crisis outreach and intervention in the community, day hospitals and short-term residential, crisis houses.

In the area of rehabilitation interventions, IPS outperformed standard vocational services across all vocational outcomes an in some non-vocational outcomes, such as quality of life and occupational engagement.

Various emerging approaches, although still with an underdeveloped evidence-base due to difficulties relating to experimental design or their relative newness, already represent promising advances in community mental health care. These include Flexible Assertive Community Treatment (F-ACT), Recovery-oriented services, Shared decision making / collaborative care-planning, Peer support, and Personal budgets.

All these advances in knowledge contributed to the development of a large set of innovative community-based mental health care practices that have diversified and improved the quality of care in Europe during the last decade. Examples of these innovative practices in various domains — e.g. , collaborative care, integrated programmes based on case management and assertive community approaches, mobile teams, peer support, Individual placement programmes, deinstitutionalization strategies, among others — have been described in the EU Joint Action Report on Community Care (Caldas de Almeida et al, 2015) as well as in the previous EU Compass Annual Reports, the EU Compass Scientific Papers on Access to Care (Barbato et al, 2016) and Community Based Mental Health Care (Killaspy et al, 2018), as well as in the EU Compass Good Practices in Mental Health and Wellbeing Booklet ( ).

PROGRESS TOWARDS THE POLICY OBJECTIVES OF THE JOINT ACTION ON MENTAL HEALTH AND WELLBEING

Important steps were taken in 2017 to update or improve national mental health legislation in several Member States (e.g., Finland, Romania and Slovenia). Three countries (Hungary, Spain and UK) developed new legislation in areas related to the rights of people with mental disorders. Other countries developed new legislation contributing to the improvement of mental health care. This occurred in Cyprus, where new legislation on Community Mental Health Care has been submitted for approval by the Parliament, and in Slovenia, where an Act Regulating the Integrated Early Treatment of Preschool Children with Special Needs was adopted.

Significant progress was made in several countries in the development of national mental health strategies. In the last quarter of 2017, France was working in the elaboration of the new National Health Strategy, which includes an official national mental health strategy, and in Bulgaria a new version of the National Mental Health Program and Plan of Action for the next 6 years period was also under preparation. In Iceland, the Mental Health Policy and Action Plan (2016-2020) has been actively implemented and monitored. In Norway, a national strategy for mental Health, with a focus on children and youth and mental Health in all policies was launched in August 2017. In Slovakia, a new Programme for Mental Health was created with the involvement of cross-sectoral partners, and in October 2017 the Ministry of Health launched a new working group for the drafting of a National Mental Health Program. In Sweden, the Government allocated 170 million euros to support the mental health national strategy for the period 2016-2020.

Regarding organization and quality of services, a significant part of the achievements reported by Member States in the past year are related to the development of community based mental health. Belgium registered new advances in the development of a second wave of reforms, focused on child and adolescent care and in forensic care of adults. The Czech Republic launched in 2017, in the context of the national mental health services reform, projects aiming at fighting stigma, disseminating a multidisciplinary approach in the treatment of mental disorders, building new Community Mental Health Centers, and promoting deinstitutionalization through changes in legislation, quality measures and transformation of psychiatric hospitals. Italy completed the process to close down all Forensic Hospitals in the country. Luxembourg initiated a reorganization of ambulatory psychiatric services and enhanced access of refugees to counseling.

In Hungary the government increased financing of community mental health services, as part of social service provision, committed to the deinstitutionalization of five long-term care institutions, and launched, with EU funds, a supported living program with home-care services. In Netherlands, a report on the state of mental

healthcare in the country was published, a national approach to solve waiting lists in mental healthcare has been launched, and an independent research institute published a report about the state of the deinstitutionalization in the mental healthcare sector.

Some countries created services and programmes for specific groups. Cyprus created an Inpatient Unit for Juvenile drug users with serious behaviour problems, and the Netherlands launched an integral approach/policy to increase the quality of care for people who are confused or disturbed.

In relation to promotion and prevention, progress was made in several countries. That happened in Hungary, through the Youth Aware of Mental Health Program (a school based universal intervention), the Baby-Mother-Father Perinatal Mental Disorders Services program, and a project on development of capacity and methodology in mental health promotion that is supported by the Norwegian cooperation.

In the area of suicide prevention, a regional program on suicide prevention was launched in the Netherlands, while the UK updated the Cross-Government Suicide Prevention Strategy for England to strengthen delivery of its key areas for action and expanded its scope to address self-harm as an issue in its own right.

The UK also initiated a programme to deliver Mental Health First Aid training in schools, launched the first National Mental Health Prevention Concordat in England for local authorities, and commissioned an independent review of mental health in the workplace in England.

In Netherlands, a national 'depression campaign' has been launched to create awareness and to break the stigma of mental illness, in Norway the Programme for Public Health in the Municipalities 2017-2027 is a national framework of joint effort on mental health promotion and drug prevention at the municipal level, and in Spain the Regions are developing new initiatives on promotion and prevention, involving partners of different sectors.

Several countries reported further advances in the mental health in all policies approach. France created a National Council for mental health in October 2016, supported by commissions working on priority areas. In Croatia a National Framework for Screening and Diagnostics of Autism Spectrum Disorders has been prepared by the Ministry of Health, Ministry of Social Politics and Youth, Ministry of Science, Education and Sports, with participation of users' organizations. The Norwegian Government introduced an inter-ministerial national strategy on mental health signed by various ministries, which states the shared responsibility in promoting good mental health in all policies. And in the UK an Inter-Ministerial Group on Mental Health was established, which brings together senior Ministers across government to progress the mental health agenda.

Finally, some advances took place in the use of new information technologies: for instance, Bulgaria reported a new on line portal for suicide attempts and an Educational internet platform for General practitioners in the field of mental health, and in Finland the availability of digital mental health services has significantly improved.

Overall, we can say that some progress towards the policy objectives of the Joint Action on Mental Health and Wellbeing was made in 2017, particularly in the updating and implementation of national mental health strategies, the development of new services, the launching of new promotion and prevention programmes, and the adoption of mental health in all policies approach. These advances, however, did not occur in a homogeneous way. On one hand, in some areas (for instance, in monitoring and development of information systems, improvement of quality of care, development of e-mental health) little or no progress has been made. On the other hand, while some countries reported initiatives that denote an effort to systematically implement a coherent mental health policy aligned with the Joint Action recommendations, others reported that in 2017 little or nothing had been done with this purpose.

Regarding the two areas that received special attention this year (provision of community based mental health care and integrated governance approaches) the information obtained through the surveys allowed a more detailed analysis of the progress made since 2015.

The results of the survey show that the basic transformations that occurred in the EU in the transition from institutional to community based care occurred before 2011, in fact long before that date in many countries. These transformations consisted mostly in the development of specialist outpatient mental health care in the community, provision of inpatient treatment in psychiatric units of general hospitals, improvement of quality of care in the existing mental hospitals, and organization of mental health services in catchment areas. All this represented a huge advance in terms of access to care, quality of care and continuity of care. However, it is important to note that, although most countries (76%) have significantly implemented outpatient care, only 46% were able to develop ambulatory mental health care carried out by multidisciplinary community-based teams. If we consider these teams are a core component of a modern and effective mental health system, we have to conclude that a lot has yet to be done in the transformation of mental health care in the EU.

The fact that only 27% of the countries reported a significant implementation of liaison with primary care is also a very important finding because it confirms that the coordination between specialist and primary care services continues to be very limited, and the provision of collaborative care is still an exception in most countries.

Mental hospitals have certainly lost a central role in the provision of mental heath care in many EU countries. Yet, almost 23% of the countries have not implemented at all or have only implemented to a small extent both

specialist outpatient mental health services and community mental health teams, which means that a quarter of the countries still concentrate all mental health care on institutional care. On the other hand, although in 58% of the countries the majority of patients receive now follow-up care in outpatient clinics in community based psychiatric clinics, the truth is that community mental health teams continue to be underdeveloped in more than half of the countries, and other effective interventions (e.g., home treatment and assertive outreach teams) have a significant role only in a small number of countries.

As mentioned before, in the last few years the areas of interest of countries have moved to updating policies and legislation, ensuring better quality of care, promoting social inclusion and more involvement of users and carers. However, some of the recommendations that proved to have a more important role in the process of deinstitutionalization (for example, stopping new admissions to psychiatric institutions, integrate mental health in primary health care; and reallocate resources away from psychiatric hospitals to community services.) were among the last implemented, which seems to indicate that the development of community care is being made more as something that is added to the existing institutional care than something that is replacing the last one in a coordinated manner.

Regarding the development of the integrated governance approach, the fact that more than half of the countries' representatives reported having national programmes or strategies for integrated governance approach, show this approach is being increasingly adopted in the EU. Most of the examples reported involve coordination between ministries or non-governmental coordination between institutions from different sectors. Targeted programs (mostly in schools and work environment) are also frequent, and six countries reported the official involvement of non-health actors in governing mental health issues.

According to the results of survey, in order to implement recommendations to develop integrated governance approaches, Member States have mainly invested in building mental health literacy and better understanding of mental health impacts, actions on social determinants of mental health, and setting up multi-stakeholder policy forums to initiate and develop mental health promotion policies and initiatives. However, important recommendations, such as utilising joint budgeting, improving provision of sector-relevant information on impact of policy decisions on public mental health, and monitoring or audit of the mental health and equity effects of policy actions were among the least implemented ones.

The responses to the survey also show that lack of knowledge/understanding of MHiAP/integrated governance, low political support, inadequate/insufficient funding, poor cooperation between health and other sectors, problems with joint budgeting continue to be important barriers that need to be addressed in the future.

RECOMMENDATIONS

Taking into consideration the new information obtained through the 2017 survey, two different kinds of recommendations can be formulated: recommendations on two general areas (information systems and monitoring; Legislation and policy) that remain fundamental for mental health policy implementation, and recommendations on the two specific areas included in the 2017 survey.

Information systems and monitoring

- Promote EU joint cooperation to develop mental health indicators and mechanisms allowing measurement of performance of mental health services and the impact of mental health policies in Member States;
- Monitor the implementation of mental health policy across the EU.

Legislation and policy

- Contributing to initiate the debate and action that is needed, to integrate the new concepts introduced by the Convention on the Rights of Persons with Disabilities (UNCRPD) into national mental health laws;
- Promote actions to ensure that Member States that still don't have a national mental health strategy will have one and that all Member States will have a clear mental health action plan with measurable targets;
- Improve leadership and governance of the mental health system at all levels.

Community mental health care

- Develop/update mental health policy aiming at moving away from institutional care to integrated and well coordinated community based mental health care, including inpatient treatment in general hospitals and comprehensive community-based services for each catchment area, according to local and national needs;
- Promote actions that ensure the efficient use of available resources and those to be reallocated from long-stay psychiatric hospitals to community-based services;
- Integrate mental health in primary health care and scale up collaborative care;
- Promote the active involvement of users and carers in the delivery, planning and reorganization of services;

- Monitor and substantially improve the quality of care and respect of human rights for people who continue to reside in long-stay psychiatric hospitals; abolishing any practices that involve physical restraints;
- Develop a concerted effort to reduce and ultimately cease admissions to long-stay psychiatric hospitals;
- Develop facilities and programmes that have so far been underdeveloped in many EU countries, such as integrated programmes with case management, community rehabilitation services for complex cases, outreach or mobile mental health teams, E-Health, self-help and users and carer groups;
- Develop structured cooperation between mental health services, social services and employment services, to ensure that community-based residential facilities, vocational programmes, and other psychosocial rehabilitation interventions are available;
- Promote the use of the opportunities provided by the EU 2020 Strategy to improve the monitoring and evaluation of policies addressing the social exclusion of people suffering from mental disorders.

Integrated governance

- Promote actions to improve mental health literacy in the public sector and among the general public;
- Disseminate information demonstrating existing win-win situations, where objectives of different policy areas coincide to mutual benefit, and using language that is understandable to policy makers in different sectors;
- Enhance the inclusion of communities, social movements and civil society in the development, implementation and monitoring of “Mental health in all Policies”;
- Develop tools for implementation of “Mental health in all Policies”, such as tools for mental health impact assessment;
- Invest in the evidence and knowledge base of “Mental health in all Policies”;
- Promote the utilization of joint budgeting of mental health strategies involving different sectors;
- Improve monitoring and audit of the mental health and equity effects of policy actions.

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