Mental health Systems in the European Union Member States, Status of Mental Health in Populations and Benefits to be Expected from Investments into Mental Health

European profile of prevention and promotion of mental health (EuroPoPP-MH)

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Abbreviations

ADHD – Attention deficit hyperactivity disorder

CBT – Cognitive behavioural therapy

CMEPSP - Commission on the Measurement of Economic Performance and Social Progress

CSDH - Commission on Social Determinants of Health

EAAD - European Alliance Against Depression

HCQI - Current health care quality indicators

IAPT - Improving access to psychological therapies

ECHI - European Commission Health Indicators

EHIS - European Health Interview Survey

GDP - Gross Domestic Product

MHEEN - Mental Health Economics European Network

MHP – Mental Health Promotion

NGO – Non-governmental organisation

OECD - Organisation for Economic Co-operation and Development

PMI – Prevention of mental illness

SME – Small and medium sized enterprise

WHO – World Health Organisation

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Executive summary

Many people are affected by mental health problems and the impact and consequences are considerable. Prevention of mental illness and promotion of mental health have become important areas of focus among European Union (EU) policy makers. In December 2010, the Executive Agency for Health and Consumers (EAHC) of the European Commission's Directorate General for Health and Consumers commissioned this project to provide an up-to-date profile of mental health systems across European Members States and other countries, with a focus on prevention of mental illness and mental health promotion activities. The report comprises:

- a review of the relevant European literature;
- a series of 29 country profiles (EU Member States and other countries, Croatia[1] and Norway), and analyses of these;
- suggestions for strengthening systems to support prevention and promotion;
- economic and social benefits of investments in prevention and promotion;
- existing monitoring indicators to assess the quality of mental healthcare;
- future plans for prevention and promotion in Member States and other countries;
- discussion and policy recommendations for Member States and the European Commission.

Data were collected on the types of prevention of mental illness and mental health promotion activities in each participating country and focused on three settings: schools, the workplace and long-term residential facilities for older people.

Status of mental health in the European Union

Recent estimates of the prevalence of mental illness show that this remains high. Mental illness accounts for 26.6% of total ill-health and is associated with a three-fold increase in the number of work days lost compared to not having a mental illness over the past 12 months (Wittchen et al., 2011; Wittchen & Jacobi, 2005).

Organisation of mental health care in the EU

The literature documents the shift from institutional-based (or long-stay) mental healthcare to community-based services. The evidence suggests that community mental healthcare is a more effective form of care (Caldas de Almeida & Killaspy, 2011; Semrau et al., 2011).

[1] The report was completed prior to Croatia's accession to the EU (which took place 1 July 2013) and so referred to as a candidate country given this was its status at the time.

Prevention and promotion in the EU

Significant developments in mental health promotion and prevention of mental illness have taken place over the past decade in Europe. There are several important sources of information for effective prevention of mental illness and mental health promotion programmes (e.g. DataPrev[2]). Recent publications demonstrate the cost savings that can be made following investments in preventing mental illness and mental health promotion programmes (Czabała et al., 2011, McDaid & Park, 2011, Knapp et al (2011), Matrix Insight, 2012). There is, however, a notable gap in the literature on cost-effective interventions for older people generally and for those in long-term care facilities.

Analysis of country profiles – key findings

- Eleven countries continue to provide long-stay hospital care, some of which are still in transition towards community based mental health services.

- The number of inpatient psychiatric care beds and admissions varies considerably between countries.

- Community mental health services in different forms were present in almost all countries. However, only eight countries had a comprehensive range of community-based services, including specialist services such as early intervention or assertive outreach.

- Variations and gaps in mental health services were found. The uneven distribution of services was a particular problem for several countries with relatively well-developed community based services. Other countries reported a lack of even basic community services such as outpatient clinics, and child and adolescent psychiatric services.

- All participating countries provided examples of prevention of mental illness and promotion of mental health initiatives; 381 initiatives were reported, 62.7% of which were prevention programmes mostly in schools (41.8%). There were relatively fewer mental health promotion activities (16.8%), of which 62.5% were also in schools. Work-based programmes mostly combined prevention and promotion (28.2% of 78 combined programmes). Only 6.6% of all reported initiatives targeted older people.

Strengthening systems to support prevention and promotion

The key issues emerging from the survey of 81 prevention and promotion experts centred on the implementation of initiatives including the lack of political commitment, clear action plans or mandates for implementation, availability of financial resources and trained personnel to deliver programmes.

[2] http://dataprevproject.net/

Feasible and practical indicators

There are many key indicators and minimum datasets currently maintained across participating countries. The most commonly reported mental health indicators were: type and number of healthcare facilities (17 countries), diagnosis of people using psychiatric facilities, usually inpatient services (16 countries), and workforce or numbers of mental health professionals (15 countries). Service use/activity data was the next most frequent indicator (14 countries).

Future plans for prevention and promotion activities

All participating countries have to some extent implemented prevention and mental health promotion activities. Some are more advanced than others, depending on their policy commitment and investments, infrastructures and resources.

Conclusions

Our findings show the variety of activity in mental health across Europe over the past decade. The implementation of prevention of mental illness and promotion of mental health initiatives has progressed since the EU and WHO policy initiatives launched in 2005. Investment in prevention and promotion activities is essential, together with improvements in the access and quality of mental healthcare for the people who need it.

Key policy recommendations

Recommendations for Member States

1. Ensure commitment and leadership to population mental health and well-being
2. Strengthen mental health promotion and prevention of mental illness
3. Promote mental health and well-being partnership action
4. Promote the transition towards mental health services that are integrated into the community and ensure a better distribution of and access to services
5. Promote quality of care, data collection and defining indicators
6. Empower users, informal carers and civil society

Recommendations for the European Commission

1. Continuing a leadership role on mental health and well-being
2. Promoting exchange and cooperation between Member States
3. Integrating mental health into the EU's own policies
4. Working with stakeholders
5. Improving the availability of data on the mental health status in the population and defining, collecting and disseminating good practices

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1. Introduction and Objectives

1.1 Introduction

This report was commissioned by the Executive Agency for Health and Consumers at the end of 2010 and commenced January 2011. The project had a wide remit to profile mental health systems across 27 European Member States and two other countries, Croatia and Norway. The report was completed prior to Croatia's accession to the EU (which took place 1 July 2013) and so referred to as a candidate country given this was its status at the time.

A core theme of the project concerns the extent to which prevention and promotion policies and initiatives have permeated health and related systems within each country. This status report attempts to provide an update of mental health systems across Member States and other countries, the status of mental health in the population, and an overview of developments in mental health promotion and prevention of mental illness (in terms of the benefits expected and future directions).

1.2 Policy context

Burden and associated costs of mental illness

In any one year, the proportion of the European Union's population suffering from a mental disorder is 38.2% (164.8 million people) (Wittchen et al., 2011). The most common diagnoses are anxiety disorders (14.0%), insomnia (7.0%), depression (6.9%), somatoform disorders (6.3%), alcohol and drug dependence (>4%), attention-deficit and hyperactivity disorders (ADHD, 5% in younger age groups) and dementia (1% in people aged 60-65 and 30% in those aged 85+ years). Although the overall prevalence of mental disorders appears not to be increasing, compared to figures from a comparable study carried out in 2005 (Wittchen & Jacobi, 2005), the rate remains significantly and persistently high.

Mental disorders impact on a person's emotional, financial and social circumstances, as well as affecting their families and social network. The cost or burden of mental illness is therefore far reaching. Across 30 European countries, the total cost of disorders of the brain is estimated at 798 billion Euros for 2010 (Gustavsson et al., 2011). This figure includes mental, neurological and neurodegenerative diseases of the brain. The proportion attributable to direct healthcare costs (37%) was greater than that attributed to indirect non-medical costs (e.g. social services) (23%). However, the proportion

attributable to indirect costs in terms of a person's loss of production were even higher at 40%.

Equally important are the social costs associated with mental illness. Stigma and discrimination, for example, are widely reported as enormously detrimental. A study in 27 countries, including those of Europe, examined the global pattern of both experienced and anticipated discrimination in those with schizophrenia. Nearly half of 729 participants (47%) had experienced discrimination in making or keeping friends; 29% (of 724) had experienced discrimination in finding a job, and 29% (of 730) discrimination in maintaining employment (Thornicroft et al., 2009). The authors identify two important discrimination domains – personal relationships and work – and found that over half the participants anticipated, but did not experience, discrimination.

Access to mental health care for those who need it is crucial, yet the gap in accessing these services is notably wide. Examining six European member countries, Alonso et al. (2007) found that for people drawn from representative samples of the general adult population with a 12-month prevalence of mental disorder, just under half (48%) reported no formal use of mental healthcare. A fear of being labelled with a mental health problem also leads to delays or avoidance of seeking treatment or help (Wahlbeck & Huber, 2009), with the possibility that symptoms of mental illness could continue or worsen as a consequence.

People with mental illness are also at greater risk of physical illness and have higher levels of disability and earlier mortality. This in part is due to lifestyle and treatment-specific factors such as use of antipsychotic medication. Moussavi and colleagues (2008), in a worldwide study of 60 countries including 26 from the European region, found people with depression had much poorer health scores than those with other chronic diseases such as angina, arthritis and diabetes, even after controlling for a number of important confounders. There is evidence to show that people with severe mental illness and comorbid physical health problems are less likely to receive standard levels of care for metabolic, cardiovascular, viral, respiratory and other disorders (De Hert et al., 2011). On average 26% of people with mental illness in Europe are provided with treatment. For those with physical illness, over 75% receive treatment (Wahlbeck & Huber, 2009). This is a staggering difference and often rooted in discrimination.

Social determinants of mental health

The Commission on Social Determinants of Health (CDSH, formed by the WHO in 2005) brought together the evidence on social determinants and how to promote health equity in order to spur change in collaboration with policy makers, researchers and civic society (CSDH, 2008). The CSDH called for closing the health gap within a generation. Three overarching recommendations were put forward:

- improving daily living conditions, particularly the well-being of girls and women;
- tackling the inequitable distribution of power, money and resources in order to address health inequities and inequitable conditions of daily living; and
- measuring and understanding the problems and assessing the impact of action.

By examining the available research evidence, the CSDH has created an opportunity to see what mental health can contribute to understanding how material living standards and social position (or social economic status) influence health and mental health (Friedli, 2009). Employment and working conditions provide one example. Where positive, these provide financial security, social status, personal development, good social relations and self-esteem. Where a person's work experience is negative, this can adversely affect their physical and mental health. Investment in the early years of life is another example where significant gains can be achieved in reducing health inequities. Hence, care from pre-pregnancy through to the early days and years of life play an important role in building children's capacity (CSDH, 2008).

Mental health, well-being and happiness

Debates on mental well-being have had a fundamental influence on mental health policy in Europe. Published around the beginning of the current economic crisis, the report by Stiglitz and colleagues in 2008, commissioned by Nicholas Sarkozy during his tenure as as President of France, attempts to identify an alternative to Gross Domestic Product (GDP) (considered too narrow) to measure the economic and social progress of a country. The focus is on non-market activities, well-being rather than production, quality of life and sustainability (CMEPSP, 2008). The OECD Global Project on Measuring the Progress of Societies attempted a similar exercise (Hall & Giovanni, 2009).

Drawing on the CMEPSP's recommendations, the OECD developed the Better Life Initiative to help understand the factors that contribute to well-being and achieve greater progress for all (OECD Better Life Index) (OECD, 2011a). The 'How's Life' report (OECD, 2011b) describes the most important factors that shape people's lives and well-being. Forty countries worldwide were surveyed and it was found that well-being has increased on average over the past 15 years through better employment, housing, education, reduced exposure to crime and air pollution etc. The differences between countries are very significant. People with less education and lower incomes tend to have poorer well-being, more health problems and reduced life expectancy.

The New Economics Foundation (NEF, 2009) has also produced some influential work in this area. Their report on the national accounts of well-being in Europe examined two categories of well-being: personal (a person's own experiences of negative and positive emotions, vitality, satisfaction, resilience), and social (supportive relationships, trust and

belonging). These data were collected in a major 2006/2007 survey of 22 European countries and revealed some interesting findings:

- countries with high levels of personal well-being do not necessarily have high levels of social well-being, and vice versa – Denmark came top and Ukraine bottom;
- Scandinavian countries scored highest for overall well-being, with Central and Eastern European countries having the lowest scores;
- levels of well-being inequality vary greatly between European countries. Austria, for example, has many more individuals at both the high and low ends of the well-being scale;
- well-being profiles also varied considerably between countries. Portugal shows a mixed picture for each well-being component, but not Estonia, which had similar scores just above or below the European average.

Much of the literature on well-being has focused on adults, but some surveys have been conducted to gauge the levels of well-being in children (UNICEF, 2007; 2011). The 2007 survey of 21 OECD countries found that the UK ranked in the bottom third of the rankings for five of the six domains measured (e.g. material well-being, health and safety, educational, family and peer relationships). A subsequent study, commissioned by UNICEF, of Spain, Sweden and the UK shows a complex relationship between well-being, materialism and inequality. Time with family and friends and activities outside the home appear central to children's subjective well-being; material goods were used as social enablers rather than something that was directly linked to their own happiness (UNICEF, 2011).

As with the well-being agenda, the search for happiness (or life satisfaction) is also gaining momentum in wealthy countries with recognition that this is not simply achieved through increasing income. Improving happiness appears to be moving beyond something pursued at an individual level to becoming a matter of national policy (Sachs, 2012).

Recovery, person-centred approaches, stigma and social inclusion

The rise of recovery approaches in recent years has also made an impact on the well-being agenda. A European Social Network working group on Mental Health published a report which charts how health and social services are moving towards more person-centred approaches which are focused on recovery (ESN, 2011). These approaches for people with mental health problems are focused on the person themselves taking on as much control as possible by organising and choosing the services they need. Recovery is also about being considered as an individual with assets; in other words, an approach that emphasises a person's strengths rather than being solely problem-focused. This acts

as a means to improving a person's quality of life and a way of tackling stigma and discrimination. These are also issues which must be addressed if recovery approaches are to be successful. It promotes, therefore, a socially inclusive approach. Recovery is about regaining dignity and respect for a person with mental health problems. Rather than being in passive receipt of services, service users become actively involved in their care. This has, to some extent, been extended so that service users work alongside professionals to redesign and deliver mental health services, although it is generally acknowledged that there remains much more to achieve with this form of service user involvement.

Prevention and promotion - definitions and interventions

In an effort to reduce the burden of mental disorders, the WHO published two summary reports which describe some of the evidence base on the effectiveness of mental health interventions in terms of both prevention and promotion (WHO, 2004a; 2004b). These documents highlight the need for these interventions, and aim to assist Member States in selecting and implementing appropriate policies and programmes to improve population health. The document on prevention emphasises the human rights issues inextricably linked to mental disorders and how *'preventive measures are harmonious with principles of social equity, equal opportunity and care of the most vulnerable groups in society'* (WHO, 2004a). A separate publication on interventions for promoting mental health makes clear that prevention and promotion are distinct but have overlapping goals. Mental health promotion targets a wider audience, however, as it aims to improve mental health in the general population.

The public health definition of prevention of mental disorder used by the WHO (2004a) and defined by Mrazek & Haggerty (1994) aims at:

'reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their families and the society'.

Primary prevention can be universal (targeting a whole population group), selective (targeting individuals or subgroups at some risk of developing a mental illness) and indicated (targeting those at high risk). Secondary prevention aims to lower the number of established cases (prevalence) through early detection and treatment of those diagnosed with the disorder. Tertiary prevention encompasses interventions which seek to reduce disability, enhance rehabilitation and prevent recurrences or relapses of the disease.

The WHO defines mental well-being as:

'…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity…in which the individual realizes his or own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO, 2001, pg 1).

Both these definitions are used for the purposes of this report.

In a time of austerity and reduced public sector spending it is important not just to identify intervention programmes that work, but also to identify those that are also cost-effective. Zechmeister et al. (2008) and Knapp et al. (2011) do this in reviews of the evidence from economic evaluations of prevention and promotion programmes. They also reiterate the importance of investing in these given the potential benefits, but note the need for more robust evidence on cost-effective interventions.

As part of the drive to improve mental health, Governments have recognised the fundamental importance of mental well-being in the population and the need for preventing many of the harmful risks and stresses that lead to mental illness. Cross-national data on mental health and mental well-being has also been collected through two Eurobarometer surveys conducted on behalf of the European Commission between 2005-2006 and in 2010 (Special Eurobarometer 248, 2006; Special Eurobarometer 345, 2010); and through the European Health Information Survey (EHIS).

The focus on improving the mental well-being of an entire population has therefore represented an important shift towards acknowledging the potential benefits of promotion and prevention, together with improving the care and treatment of those with existing mental illness (Friedli, 2009). This, coupled with the growing evidence base on interventions for mental health promotion and the prevention of mental illness, has resulted in strong support for pushing mental health promotion and prevention higher up the policy agenda.

1.3 European mental health policy - an overview

Since 2005, considerable health policy attention has been directed towards mental health both globally and in Europe. In 2005, the WHO European Region, the European Commission (EC) and the Council of Europe approved a 'Mental Health Declaration and Action Plan for Europe' (WHO, 2005a; 2005b) to solve the major challenges facing mental health in Europe. European Ministers of Health put forward a twelve-point action plan, listing strategies for development and milestones to be implemented by 2010 (WHO, 2005b). These were to:

1. Promote mental well-being for all (e.g. mental health promotion across the lifespan and to adopt this as a long-term investment);
2. Demonstrate the centrality of mental health (to build a healthy, inclusive and productive society;
3. Tackle stigma and discrimination (e.g. protection of human rights and respect for people with mental illness);
4. Promote activities sensitive to vulnerable life stages (e.g. infants, children, young people and older people);
5. Prevent mental health problems and suicide (e.g. target groups at risk and establish self-help groups);
6. Ensure access to good primary care for mental health problems (e.g. detect and treat mental health problems);
7. Offer effective care in community-based services for people with severe mental health problems (e.g. empower service users and carers to access mental health and mainstream services);
8. Establish partnerships across sectors (e.g. create collaborative networks across services essential to users and carers' quality of life);
9. Create a sufficient and competent workforce (e.g. recognise the need for new staff roles and responsibilities across the health service and other relevant sectors);
10. Establish good mental health information (e.g. develop or strengthen national surveillance systems based on internationally standardized indicators);
11. Provide fair and adequate funding for mental health (e.g. assess whether the proportion of the health budget located to mental health fairly reflects people's needs); and
12. Evaluate effectiveness and generate new evidence (e.g. evaluate the impact of mental health systems over time and encourage the implementation of best practice).

Shortly afterwards, the European Commission published the Green Paper entitled 'Improving the Mental Health of the Population' which saw the mental health of the population of Europe as a resource for achieving some of the EU's strategic policy objectives, including *'to put Europe back on the path to long-term prosperity, to sustain Europe's commitment to solidarity and social justice, and to bring tangible practical benefits to the quality of life for European citizens'* (European Communities, 2005, pg 3).

Participants in a high level EU conference in 2008 recognized the importance and relevance of mental health and well-being for the European Union, its Member States, citizens and other stakeholders, and launched the European Pact for Mental Health and Well-being (2008). The Pact outlined five priority areas for the promotion of mental

health, prevention of mental disorders and promotion of social inclusion noting the target groups and settings of interest:

- Prevention of Depression and Suicide;
- Mental Health and Well-being of Children and Young People;
- Mental Health and Well-Being in Workplaces;
- Older People's Mental Health and Well-being; and
- Promoting Social Inclusion and Combating Stigma

Thematic conferences were convened for each priority area and the document 'European Pact for Mental Health and Well-being: Results and future action' welcomed the results of the five thematic conferences and invited Member States to make mental health and well-being a priority of their health policies and to develop strategies and/or action plans on mental health. These priority areas sit alongside European Directives such as those to improve the health and safety of employees and prevent the risks to health in the workplace, introduced in 1989 (Directive 89/391/EEC - OSH "Framework Directive").

Economic crisis

Since 2008, the economic crisis in Europe has prompted further concerns about the potential impact on mental health. This again highlights the social and economic determinants of health and the link between mental health problems and deprivation, poverty, and inequality for example. Increased levels of unemployment, numbers of people living in poverty and reductions in public spending all pose significant risks to the mental well-being of the population.

In response to the economic downturn, WHO Europe (2011) published a booklet to outline some of the benefits of implementing various actions that can mitigate the effects of the economic crisis. It argues that the successful recovery of European economies crucially depends on the mental health of the population. With this in mind, the recommended safeguards to lessen the impact include:

- the promotion of positive mental health and resilience which goes beyond the remit of the healthcare system and involves all government sectors;
- awareness of the most vulnerable groups most likely to be affected by the crisis, those on low incomes and people living on the poverty line;
- increase social protection responses, such as maintaining social and welfare spending to help buffer against the effects of, for example, unemployment, increased suicides and health inequality;

- activate labour market and family support programmes for those affected by the crisis;
- control alcohol prices and availability and introduce debt relief programmes; and
- improve primary care for people at high risk of mental health problems.

The consensus is, even within these difficult economic times, to continue investing in mental health and strengthening existing mental health policies. It has also been noted that the potential negative mental health effects of the recession can be reduced if governments make policy choices that help people retain jobs and re-gain employment, together with provision of family support measures and mental health related services (Stuckler et al., 2011).

At a broader policy level, the Europe 2020 Strategy (European Commission, 2010) has set out three mutually reinforcing goals to tackle the economic crisis to deliver high levels of employment, productivity and social cohesion – with fixed targets to be achieved by 2020.

The increasing life expectancy in Europeans is seen as another important challenge to address. It is predicted that by 2050 the number of those reaching the age of 65 years will double and those over 80 will triple. This aging population has implications for mental health, notably prevention and promotion in particular. An important response to this challenge is the European Innovation Partnership on Active and Healthy Ageing (European Commission, 2012) initiative. This seeks to increase the healthy lifespan of EU citizens by 2 years by 2020 through:

- enabling people to lead healthy, independent and active lives in older years;
- improve the efficiency and sustainability of social and health systems; and
- create new opportunities for businesses to generate innovative products and services in response to the challenges presented by an ageing population.

Further developments at policy level

In June 2011, the Council of the European Union adopted a series of conclusions that confirmed support for the European Pact (2008). The Council invited Member States and the Commission to set up a Joint Action on Mental Health and Well-being under the EU Public Health Programme 2008-2013. Using this as a platform to, among other things, tackle mental disorders through health and social systems, build innovative partnerships between health and other relevant sectors such as social, education, employment and manage the development of community based and socially inclusive mental health approaches

The WHO is due to publish a new European Mental Health Strategy which draws together promotion, prevention and the treatment of mental illness. The three cross-cutting objectives to the strategy are that:

- health systems provide good physical and mental health care for all;
- mental health services work in well-coordinated partnerships with other sectors; and
- mental health governance and delivery are driven by good information and knowledge.

A key element is that *mental health can no longer be seen as the sole responsibility of specialist mental health agencies* (Friedli, personal communication).

1.4 Objectives of the project

Within this context, our task was to produce up to date information of the 27 member states of Europe, candidate and EFTA/EEA countries; provide comparisons using appropriate cross-country indicators; and overall totals at EU level. Our main objectives were to:

- profile the mental health status of the population, focused on the prevalence of mental illness, key risks and protective factors;
- describe how mental health systems are currently organised and how they operate in relation to existing mental health promotion and prevention of mental illness programmes;
- set out expert proposals for initiatives to strengthen mental health systems in prevention and promotion at EU, country and regional level and by non-statutory agencies; and
- estimate the benefits to be derived from action and investments, performance in health, education, social development and economic growth.

Other relevant questions were also explored. These included:

- What promotion and prevention programmes have been implemented, where and with what effects?
- What legislative and policy changes have underpinned these programmes?
- What appears to be the impact of these developments on mental health indicators and what mediating factors (e.g. poverty) are implicated?
- What future impact is anticipated?
- What are the costs and the potential savings of effective measures to promote mental health?

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2. Methods

2.1 Literature review

Given the wide scope of the project's objectives, a detailed review of relevant research and grey literature published in the period 2000-2010 was carried out, although more recent relevant literature from 2010 was also included. This literature review incorporated a number of systematic reviewing techniques. Electronic bibliographic databases were accessed, together with manual searches to identify grey literature, any relevant books, book chapters and journal articles which were not available electronically or not identified by the database search. To ensure the most up-to-date literature was identified – including that *in press* – the project's coordinator (CS) approached relevant experts in Prevention of Mental Illness (MPI) and Mental Health Promotion (MHP) for information on recent studies and reports.

Inclusion criteria

The inclusion criteria for the literature review were kept deliberately broad to cover the full range of data and information needed. All study types, reviews, editorials, briefing papers, policy papers and reports were included if relevant. Publications were included if they were:

- European; referring to one or more Member States or Candidate or EFTA (European Free Trade Association) country;
- Comparative; comparing two or more European countries on any of the domains of interest (mental health legislation, prevalence of mental disorder, prevention and promotion activities etc.);
- Literature reviews of the relevant domains, particularly on the effectiveness and economic and social benefits of prevention and promotion programmes.

Non-English language papers were included where possible if they met the above criteria.

Exclusion criteria

This included any study or paper that did not meet the above inclusion criteria.

Search methods

The following eight bibliographic databases were searched:

MEDLINE/PUBMED	MEDLINE (Ovid)
EMBASE	ExcerptaMedica (Ovid)
PsycINFO	PsycINFO(Ovid)
AMED	Allied and Complementary Medicine (Ovid)
COCHRANE LIBRARY	Cochrane Database of Systematic Reviews (CDSR), Database of Abstract Reviews of Effects (DARE),
SSCI	Social Science Citation Index (ISI Web of Science)
ERIC	Education Resources Information Centre
CENTRAL	Cochrane Central Register of Controlled Trials (CENTRAL), Cochrane Database of Methodology Reviews (CDMR), Health Technology Assessment Database (HTA) and NHS Economic Evaluation Database (NHS EED)

Search terms

The search terms were defined by an Information Specialist. Two sets of search terms were developed to encompass all relevant subject areas from mental health systems to mental health status and prevention and promotion activities.

A selection of papers written by a key expert in the field was selected for use as a "litmus-test" to check the adequacy of the search strategy. Search terms were adjusted to match each of the databases and refined to ensure the key litmus-test papers were retrieved. The two lists of search terms can be found in Appendix 1.

Grey literature

The grey literature represents a major source of information in this area. Efforts were therefore focused on collecting all main relevant reports and policy papers written over the past six years since the EU Green paper (European Communities, 2005) and the EU Pact for Mental Health and Well-Being (Action Plan) (2008). The following sources were accessed to identify the grey literature:

- EU databases (see below for details);
- the project's Advisory Group;
- policy experts working at EU level;

- experts in mental health and those working in prevention of mental illness and promotion;
- cross-referencing of key papers and reports; and
- internet searches (using search engines such as Google).

Selection of studies

The initial retrieval from the search of bibliographic databases yielded 32,545 titles on the subject of prevention and promotion and 50,095 publications on the subject of policies, services and incidence. The articles were subjected to three tiers of screening in order to identify and retain the most relevant material.

A refinement of the inclusion criteria was considered for the second and third stages of screening. Four areas of investigation were drawn up relating to the research questions, as follows:

- profiling the mental health status of populations by focusing on prevalence rates of mental illness, key risk factors and protective factors;
- organisation of mental health systems and their operation in relation to existing prevention and promotion in mental illness programmes; investigation into policies that attempt to change mental illness systems; examining who is responsible for prevention and promotion programmes;
- expert proposals for initiatives to strengthen mental health systems from prevention and promotion activities from EU level through to regional level; and
- potential benefits to be derived from investment and activity in mental health prevention and promotion; economic and social development in health, in particular the effects of the economic downturn and its effect on mental health prevention and promotion activities.

Search results

The results from three levels of screening of the titles are as follows.

First screening

The initial screen was carried out using EndNote software and resulted in a total of 1,253 articles on the topic of prevention and promotion being retained. This figure comprised 670 articles plus a further 378 publications from non-European Union countries; 205

articles were coded as 'unsure' and retained for further consideration. Articles excluded and discarded numbered 31,292.

For the topic of policies, services and incidence, a total of 891 publications were retained. This comprised 701 articles, plus a further 16 publications from non-European Union countries; 174 articles were coded as 'unsure' and retained for further consideration. Articles excluded and discarded numbered 49,204.

Second screening

A second, more in-depth screening of the results of the first screen was performed via EndNote software by two members of the research team in parallel to ensure conformity, provide triangulation and avoid ambiguity. Criteria for the selection process as detailed above were used for this exercise. From 1,253 prevention and promotion articles reviewed, 165 publications were commonly selected. For the policies, services and incidence literature, of 891 articles originally selected in the first screening, 165 publications were retained.

Third screening

The final screening of the articles was carried out by a member of the research team, with these selections reviewed for inclusion by a second researcher. This procedure resulted in a final figure for retention of 40 prevention and promotion articles and 30 policies, services and incidence publications. This literature was analysed and summarised, and in the final review the focus was placed on the most recent of these articles.

Grey Literature

In addition to the retained articles for prevention and promotion and policies, 76 additional grey literature articles were identified and highlighted for possible review. Of that number, 46 were retained giving a total of 116 articles for inclusion in the literature review.

2.2 Selection of country collaborators

Attempts were made to recruit country collaborators from all 27 Member States. The methods used for identifying potential collaborators involved initial internet searches of senior mental health academics working at EU level, authors of key reports, those with experience of pan-European studies in mental health and related areas (such as public

health and drug and alcohol misuse), senior mental health professionals and civil servants working in the Departments/ Ministries of Health. We also obtained recommendations from academic and policy colleagues, the EAHC, and our own Steering and Advisory Group members (see Appendix 2 for a full list of our collaborators).

Collaborators were selected according to their expertise in mental health, familiarity with mental health systems in their country, and capacity to complete the required work within the set timeframes.

Collaborators were recruited for 23 of the 27 Member States and one candidate country (Croatia, which following the report's completion became a Member State 1 July 2013). Data for Denmark, Ireland, Luxembourg and the United Kingdom were collected by the authors.

Collaborators were paid a fixed fee for their data reports which were written and submitted in English.

2.3 Data collection from country collaborators

Data provided by country collaborators formed an important and significant part of the data needed for the project. For this reason, a template was written to cover all aspects of the data required to meet the project's objectives. The project was not resourced to conduct extensive primary research, so the data obtained by country collaborators is based on secondary sources of information (e.g. national data sources such as Government websites, published and grey literature). The template included detailed specifications to gather information comprehensively and in a standardised format, to facilitate comparisons between countries. Collaborators were required to list all sources of information cited. Collaborators' data were collected over a nine month period between March and November 2011.

Data template for collaborators

The data template listed eight tasks for collaborators to complete. Tasks were mapped according to the project's key domains. Table 3.1 below outlines the tasks specified.

Table 2.1: Collaborators' data collection tasks

Task 1	A brief description of the current Mental Health Legislation and any proposed *legislation and/or policy* that prioritise mental health promotion (MHP) and prevention of mental illness (PMI) activities or programmes.
Task 2	Describe the types and organisation of mental health services (both hospital and community- based) - noting any joint working in schools,

	the workplace and long-term care facilities for older people to promote mental health and/or prevent mental illness.
Task 3	Monitoring systems and feedback indicators and what additional comparable indicators (for comparison both between and within countries) are feasible and practical and based on reliable data.
Task 4	Mental Health status (facts and figures) using the *very latest figures/information* on mental illnesses as defined by ICD10 diagnostic codes (WHO, 1993). List key risk and protective factors for mental health.
Task 5	Prevention of mental illness programmes in schools, the workplace and long-term facilities for older people. Mental health promotion activities in the above settings.
Task 6	Financial investments allocated to mental health promotion and prevention initiatives in the settings of interest.
Task 7	Types of prevention programmes that reduce the risk factors (e.g. poverty and social exclusion) and programmes that enhance protective factors (e.g. good coping skills, supportive networks) in the settings of interest.
Task 8	Consult with up to *five* experts in prevention and promotion of mental health. These could include policy makers, academics and professionals (e.g. nurses, teachers, carers of older people) delivering such programmes.

To capture details on each country's mental health systems (Task 2), we adapted a matrix model designed by Thornicroft & Tansella (1999; 2008) with the express aim of identifying levels of implementation, strengths, weaknesses and the action needed to improve care. The model focuses on three main areas – input, process and outcomes. The specific information requested for each area included:

Input – the number, types of services and interventions used; the financial resources allocated to them; location of services and education and training required.

Process – access and usage of services to identify gaps and shortcomings in care, variations in delivery and unequal access to them.

Outcomes – the extent of implementation in relation to policies and operational plans/procedures; effectiveness of interventions implemented; activities on a day to day basis; and anticipated outcomes where evidence is lacking.

In describing and assessing current mental health services, we also focused our data collection efforts on mental health promotion and prevention of mental illness activities within mental health services and the health sector generally.

A separate section in the template was created to ensure collaborators reported as much relevant information on prevention and promotion programmes as they were able to identify. This included:

- aim(s) of the programme;
- stakeholders involved / target group;
- methods or approach used;
- main results of any evaluation; and
- duration and cost of programme or finances allocated.

The template was accompanied by a Collaborators' Brief to explain the level and amount of information required for each task. Definitions and terms were also included in the collaborators' brief. We applied those defined by Mrazek & Haggerty (1994) and used by the World Health Organization (see Appendix 3 for the Collaborators' Brief).

Definitions of mental health services

Mental health services, such as inpatient and community-based care, were broadly defined using definitions set by the WHO in their Mental Health Policies and Practices report published in 2008. Country collaborators, however, were also given scope to describe in their own terms the different types of inpatient and community-based mental health services. A glossary of definitions can be found in Appendix 5.

Collaborators' data sources

Collaborators drew on a broad range of national data sources to complete their data reports. Various government and non-statutory organisation websites were searched to collate up-to-date publications and information. These searches were restricted to those dealing with health, employment, social exclusion/inclusion, education and schools.

Search terms devised for the bibliographic literature review were shared with all collaborators to use for their publication searches. Results of the literature search yielded a number of reference titles that referred specifically to particular participating countries. These titles (papers) were put aside and sent to collaborators to include in their data report. Collaborators were also asked to provide the ten most important papers or reports on mental health systems in their country; and on those that concerned prevention and promotion of mental health.

Preparation and validation of country profiles

Completed data templates received from country collaborators were used to prepare a draft country profile by the research team. Any gaps in information were supplemented with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from each participating country in 2012. These experts provided additional up-to-date information and revisions where needed. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them.

2.4 Survey of key experts

A survey of key experts in the prevention of mental disorder and mental health promotion (up to five in each participating country) was conducted to obtain further information about the main challenges and potential solutions to implementing initiatives in these areas. The key experts included policy makers, academics and professionals (e.g. nurses, teachers or carers of older people) delivering these programmes. We also gauged the opinions of experts on ways to strengthen existing efforts and on the expected benefits if prevention and promotion activities were fully implemented.

The consultation was not intended to be a comprehensive or representative survey of experts, but a means for collecting important additional information to help inform our recommendations for improving and resolving existing challenges.

Questionnaire development

A questionnaire for the consultation was developed and included a series of open-ended questions with specific reference to the groups of interest (children and young people, adults in the workplace and older people in long term facilities). The topic areas covered the domains of interest; factors that hindered or facilitated the implementation of prevention and promotion activities; any outcomes achieved to date including those anticipated (e.g. economic and social gains); impact of the current economic difficulties on funding programmes; areas of weakness and strengths; the long-term expectations and the sustainability of programmes; and, future plans for policy and practice.

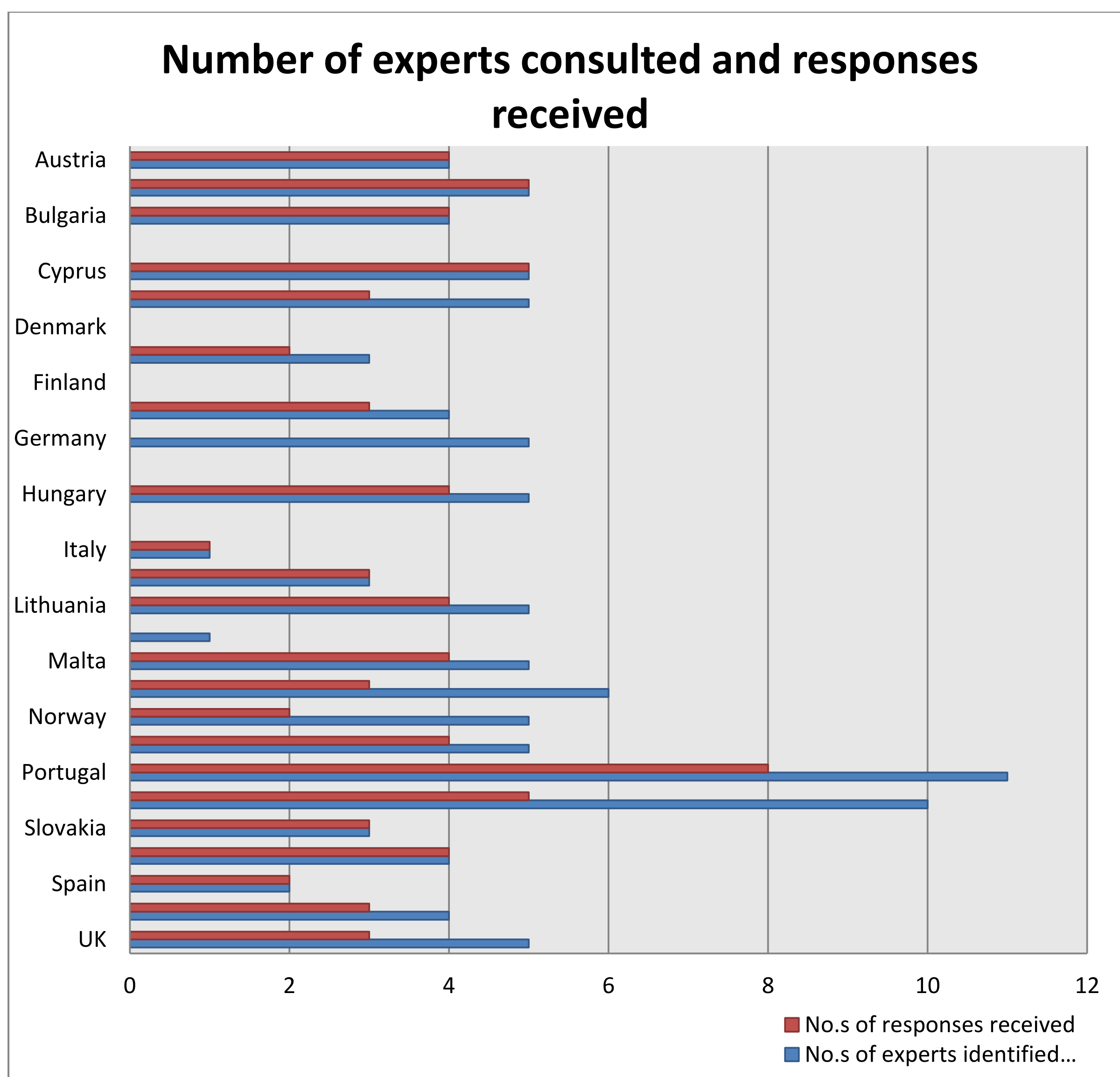
The questionnaire was written in English and piloted in three countries – Bulgaria, England and Norway. Amendments to the questionnaire were made accordingly which included rewording questions to elicit appropriate responses.

Identification of experts and questionnaire distribution

Experts were identified and invited to participate in the consultation via the country collaborators. Collaborators were asked to list and approach the names of five experts to consult. Experts were selected if they were involved in developing, commissioning, researching and/or delivering mental health prevention and promotion programmes in schools, the workplace and in older people's long-term care facilities. Experts agreeing to participate in the project were given the option to respond to the questionnaire by email/post or, if preferred, a face to face or telephone interview.

Figure 3.2 below details the number of experts identified and approached, together with the number of questionnaires completed. A total of 81 responses were received from 110 experts identified and approached by country collaborators; yielding a response rate of 73.6%.

Figure 2.1: Experts approached and questionnaires completed



Responders included experts holding senior positions in the Ministries of Health, Education and public health departments, universities, clinicians working in mental health services, coordinators or project managers of prevention or mental health promotion programmes, researchers, educators on programmes. Their years of experience working in their fields ranged from 3 to 15 years.

2.5 Databases and web sources

A range of European health-related databases and websites were searched to gather the full complement of available data and publications. Several main databases were examined to collect figures on the prevalence of mental illness; details of mental health systems and services; best practice examples; indicators and minimum datasets; and any information on prevention of mental illness and mental health promotion programmes

for participating countries such as investments and existing feedback indicators. The databases searched included:

- Information on individual European countries mental health systems, policies at: http://www.euro.who.int/mentalhealth/ctryinfo/20030829_1
- World Health Organization – Regional Office for Europe for evidence and data: http://www.euro.who.int/envhealth
- Europa and European Commission: for country profiles (general facts and figures) for the 27 member states on the EU, policy, indicators and best practice (Eurocompass): http://europa.eu/index_en.htm and http://ec.europa.eu/health/mental_health/policy/index_en.htm
- The European Project on Mental Health Promotion and Disorder Prevention: for country stories; details of action plans and European policies: http://www.gencat.cat/salut/imhpa/Du32/html/en/Du32/index.html
- Mental Health Europe: http://www.mhe-sme.org/en.html
- Mental Health Observatory: http://www.nepho.org.uk/mho/
- OECD Key data on OECD countries, including health and indicators: http://www.oecd.org/statsportal/0,3352,en_2825_293564_1_1_1_1_1,00.html
- Health Care Quality Indicators for Mental Disorders: http://www.oecd.org/document/25/0,3343,en_2649_33929_37091033_1_1_1_1,00.html
- EU Public Health: http://ec.europa.eu/health-eu/health_in_the_eu/statistics/index_en.htm
- European Social Survey
- Global Health Observatory (GHO): http://www.who.int/gho/en/

2.6 Analysis

Literature review

Because of the broad spectrum of the project and the high volume of reference titles generated by our extensive searches, we aimed to ensure that only highly relevant papers were included in the review.

In order to inform the report chapters, a process of analysis and summarising the final collection of articles was carried out. Each paper was précised and the central information of the article distilled into a short summary including the: purpose, target group, main findings, and conclusions.

For final inclusion in the literature review, the completed summaries were categorised under the project's main research questions and themes. The articles were finally abbreviated to the most cogent information and written into the review.

Matrix for collaborators’ data

Data reports received from country collaborators varied in size (from 7,000 to 8,500 words) and contained largely textual data. Data reports and additional information gathered from other sources (such as EU websites, databases, EU and WHO reports) where required, were used to compile individual country profiles.

An Excel spread sheet was created to summarise the data received from country collaborators. Additional Excel spread sheets were created for the five main domains and sub-themes to record the key information needed to create overall EU level comparisons. This database was used for its flexibility in accommodating both numbers and text.

Analysis of raw data, such as numbers of inpatient beds and lengths of stay, were plotted in an Excel scatter gram to help identify countries which clustered together to examine patterns in the data and test for any correlations.

Responses from the consultation exercise with experts

Open-ended responses from the semi-structured questionnaires sent to experts were entered into the qualitative analysis software package, NVIVO (version 9.1) to aid analysis. A thematic analysis was employed, beginning with the reading and re-reading of responses and subsequently coding the main themes, and developing categories which best described the patterns in the responses and emerging themes.

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3. Review of the literature

This chapter presents an overview of the available literature in relation to the:

- prevalence of mental illness throughout European Member states and other countries; whether these have increased over time; and the key contributory risks and protective factors;

- mental health systems in EU Member States; attempts to improve mental health services; and promotion of mental health and relapse prevention;

- prevention of mental illness and promotion of mental health in Europe based on EU funded initiatives and the current and emerging evidence base for schools, the workplace, older people and depression and suicide prevention; and

- current EU policy context and developing evidence-based policy and practice.

3.1 Mental Health status in the European Union

Despite the major difficulties associated with collecting epidemiological data, various attempts have been made at estimating the prevalence of mental illness in Europe. The European Policy Information Research for Mental Disorders (EPREMED) summarises these. The most recent estimate is that by Wittchen et al. (2011) who sought to establish the size and burden of mental disorders in Europe using results from various prevalence studies in European countries. The authors found that 38.2% of the total population (164.8 million people) in EU countries had experienced a mental disorder over the past 12 months. Their previous estimate published in 2005, revealed a prevalence of 27.4%, around 82 million people aged between 18-65 years (Wittchen & Jacobi, 2005). However, this does not represent an increase as such which is explained by the use of new inclusion criteria. The most common disorders were anxiety (14.0%), insomnia (7.0%), major depression (6.9%), and somatoform disorders (6.3%). Alcohol and drug dependence, Attention Deficit Hyperactivity Disorder (ADHD) and dementia were also prevalent. Mental disorders together with disorders of the brain accounted for 26.6% of the total ill health burden.

Having a mental disorder(s) was associated with a three-fold increase in the number of work days lost compared to not having a mental illness over the past 12 months. Only 26% of cases had consulted professional health care services for a mental health problem, which indicates a potentially large unmet need for treatment/services. This

unmet need was considered more pronounced for new EU Member States generally, and for older populations specifically (Wittchen & Jacobi, 2005).

Results of the European Study of the Epidemiology of Mental Disorders (ESEMeD) encompassing six EU Member States (Belgium, France, Germany, Italy, the Netherlands and Spain) showed that 25.9% of participants reported a lifetime mental disorder and 11.5% reported a mental disorder within the past year (Alonso & Lepine, 2007). The study also suggested that 14% of the sample had a lifetime history of mood disorder, 13.6% had a lifetime history of anxiety disorder and 5.2% had a lifetime history of alcohol disorder (Alonso et al., 2004a; 2004b). Major depression (12.8%) and specific phobias (7.7%) were the most widespread lifetime disorders. In terms of gender, women had double the risk of experiencing mood or anxiety disorders in each year compared to men, although men were more likely to have alcohol-related problems. The study also found that approximately 6% of participants needed mental healthcare, with 48% of that number receiving no formal healthcare (Alonso et al., 2007).

Mental health problems are estimated to account for 20% of the burden of ill health across Europe, with suicide being one of the ten most common causes of premature death and 90% of suicides being linked to mental illness (European Commission, 2010). Suicide rates were identified as being much higher in men and suicide was the principal cause of mortality among males aged 15-35 in the WHO European region. The rate of suicide has, however, fallen over the past 15 years, although there remains a marked disparity in levels between countries. The highest suicide rates were found in the new Member States of Estonia, Hungary, Latvia, Lithuania and Slovenia. Within the original EU-15 States, Finland, France and Austria were among the highest.

In terms of impact, the OECD (2012) found that just one in five people with mental illnesses are in work with many more wanting employment, and that productivity losses through mental ill-health are significant. Additionally, people with mental disorders often receive a range of working-age benefits including disability benefit, unemployment benefit and social assistance. The OECD report concluded that sufficient treatment can improve employment outcomes, and that policy has the ability to respond more effectively in increasing the inclusion of people with mental illnesses in the labour market.

Groups at risk and protective factors

In view of the high prevalence of mental illness in the EU population, it is important to identify the risks and protective factors, and the groups particularly at risk. These will have important policy and practical implications for mental health promotion and the

prevention of mental illness. The WHO recently published a background paper on the risks and protective factors for mental health in developing a comprehensive mental health plan (WHO, 2012). The paper lists a number of key points, one of which concerns the risks to mental health over the life course. Determinants of mental health and well-being are influenced not only by an individual's characteristics but also by the wider social circumstances and the environment in which they reside. All these determinants interact dynamically with each other.

Table 4.1 lists the main risk and protective factors by different age and social groups based on the literature:

Table 3.1 Risk and protective factors by groups and diagnosis

Groups at risk	Diagnosis	Risk factors	Protective factors
Infancy and early childhood	Anxiety/stress and insecurity	Attachment problems due to post-natal depression/maltreatment/neglect	Early attachment/nurturing relationships
Children	Poor cognitive and emotional skills/behavioural problems/trauma	Family violence or conflict/negative life events/parental mental illness	Supportive parenting and home life/adequate nutrition and stimulation/positive learning environments in schools
Adolescents and young people	Depression/anxiety/ behavioural problems/suicide	Tobacco/alcohol and drug use/isolation	Family/school support
Adults	Stress/Anxiety/depression /suicide/alcohol/drug disorders	Socio-economic disadvantage/unemployment Poverty/isolation/alcohol and drug use	Social and familial support Good 'work-life balance' Employment/economic empowerment

Groups at risk	Diagnosis	Risk factors	Protective factors
Older people	Cognitive decline/dementia/ depression	Social and family isolation/bereavement/physical illness/neglect/physical abuse	Social and familial support
People in low socio-economic groups/women/ ethnicity/socially excluded groups	Stress/Depression/anxiety	Societal and life stresses/discrimination/stigma/lack of income/family structures/low educational attainment/deprivation and poverty	Economic empowerment

Numerous studies have identified risks to mental health for each of the age groups listed above and for particular social groups. For example, several studies have identified young people as being at particular risk, indicating an early age of onset for mood, anxiety and alcohol disorders, often associated with poor social support and mental health problems in parents (Alonso & Lepine, 2007; Patel, 2005; Alonso et al., 2004a). Enhanced social and familial resources are protective.

Fryers et al. (2005) examined the associations between the prevalence of common mental disorders in working age adults and socio-economic disadvantage in six European countries using population surveys and other studies. Despite the difficulties with comparing countries due to differences in the methods, instruments and analyses used, Fryers et al. (2005) found high levels of common mental health disorders (largely non-psychotic depression and anxiety, either together or alone) in people of lower socio-economic status, however measured. These high levels were associated with poor education, material disadvantage and unemployment.

The unemployed, and the socio-economically disadvantaged in general, are prone to greater rates of mood disorders, alcohol disorders, social marginalisation and stigma (Alonso & Lepine, 2007; Patel, 2005; Alonso et al., 2004a; Thornicroft et al., 2009). Social and family support and Government initiatives to help employees retain their jobs are seen as key protective factors.

Stigma and discrimination

Stigma is arguably the main obstacle for the care of people with mental disorders according to Sartorius (2007). It can affect not only the ill, but several generations of

families, institutions and mental health workers. Stigma can be a precursor to discrimination and a negative influence on investment in mental health care. It can also create a vicious circle of discrimination, reinforcing negative attitudes, decreasing self-esteem and leading to a poor treatment effect or a high probability of relapse. Furthermore, Sartorius (2007) highlighted that many people contribute to stigma, including health care workers and mental health professionals through labelling people. It has been suggested that the most effective method of reducing prejudice at individual level is through direct social contact with people with mental illness (Thornicroft et al., 2008) by groups such as police officers, school students, journalists and the clergy. At a population level, social marketing is claimed as most effective. A main challenge lies again in determining which interventions are most cost-effective.

According to the Standing Committee of European Doctors (2011), community-based health services directed towards reducing stigma and social exclusion need to be gender-appropriate. Additionally, special attention should be offered to carers and other people close to patients. Patients' non-adherence to medication and development of stigma arising out of long-term illness are other significant factors.

Combating social exclusion, particularly in the elderly, and working against stigma were viewed as an utmost priority by the Impact Consortium (2011) when presenting the first outcomes of the implementation of the 'European Pact for Mental Health and Well-being'.

Consequences of mental illness

There is a growing body of literature highlighting the risks and disadvantages associated with having a mental illness. The economic and social consequences of developing a mental illness include loss of employment and with this greater debt and poverty, stigma and discrimination. Social exclusion, violent victimization and human rights abuse have been reported as more prevalent in people with mental health problems compared to those in the general population (WHO, 2012).

The presence of severe mental illness (e.g. schizophrenia, schizoaffective disorder, bipolar disorder) is linked to substantially reduced life expectancy compared to national figures, with between 8.0 to 14.6 life-years lost for men and 9.8 to 17.5 life-years lost for women according to one study (Chang et al., 2011). Psychological distress (measured using the General Health Questionnaire, GH1-12) has also been found to be associated with premature mortality (Russ et al., 2012). There is now evidence demonstrating that mental illness is an independent risk factor for cardiovascular disease, type II diabetes and injuries (Baxter et al., 2011).

3.2 Organisation of mental health care in the EU

The existing literature on the organisation of mental health systems in the EU reveals key issues in the process of de-institutionalisation and the associated shift towards community-based mental health care. Another development appears to be that responsibility for mental health promotion and prevention of mental disorders is gradually steering towards the domain of non-governmental organisations and away from direct governance by the state (Wills & Douglas, 2008).

De-institutionalisation and implementing community-based care

Becker & Kilian (2006) reported on the differences in the provision, cost and outcomes of mental health care in Europe. Having examined the findings of a number of studies on the development of mental health systems across countries, the authors report a common trend towards deinstitutionalisation, reduced inpatient treatment and improvement of community-based services (Becker & Kilian, 2006).

A key issue is defining where the balance in provision should lie between community, primary care, general hospitals, specialist mental health institutions and psychiatric hospitals (McDaid & Thornicroft, 2005; Gater et al., 2005). There is evidence that a balanced approach which includes community and inpatient services is required regardless of the amount of available resources (Thornicroft & Tansella, 2004). The World Health Organization (WHO) has called for a move away from traditional psychiatric hospitals and long-stay institutions in favour of community care as it can provide better outcomes (WHO, 2005a; 2005b). In a review of the care for people with long-term mental disorders, Caldas de Almeida & Killaspy (2011) concluded:

- access to mental health care for people with long-term mental health conditions is better with community-based services rather than traditional psychiatric hospitals;
- community-based services better protect the human rights of people with mental disorders and prevent stigmatisation of those people;
- studies comparing community-based services with other models of care consistently show significant better outcomes on adherence to treatment, clinical symptoms, quality of life, housing stability, and vocational rehabilitation;
- studies suggest that care in the community for acute psychoses is generally more cost effective than care in a hospital, although it is important to note that

these results cannot be generalised to all patients requiring admission to psychiatric beds;

- studies also show that hostel wards provide a cost-effective alternative for patients who require long-term stay in the hospital. When deinstitutionalisation is developed appropriately, the majority of patients who move to the community have less negative symptoms, a better social life and are more satisfied.

Semrau et al., (2011) overviewed other relevant research evaluating community-based mental health services across Europe. Despite the evidence being limited and mostly based on studies conducted in the UK that may not be generalisable to other countries, they concluded that community mental health care is on the whole effective.

Implementing community-based care

The DELOC study was conducted by Mansell et al. (2007) to determine the number of disabled people currently living in residential institutions and to identify successful strategies for replacing such institutions with community-based services in 28 European countries. They found that the process whereby institutions were superseded by community-based services generally led to favourable results, although success was not always guaranteed. In examining the transition from institutional to community-based care in three countries, the authors noted the importance of good coordination between the different agencies involved in this process. An institution cannot be left to dismantle itself. Other important factors include the role of regional and national governments in driving the process forward, both through their actions in developing the legal and policy context and in generating the incentives for encouraging this transition. Involving users is another important aspect of any service development, particularly when replacing institutional care with that which is community-based.

In terms of cost effectiveness, Mansell et al., (2007) explained that following a transfer to community-based care, policy makers can expect to achieve the same or lower costs depending on the severity of disability and the quality and level of care required. There are, however, four main considerations when planning to replace institutions with community care: a) the recognition that most support for disabled people comes from families, friends and neighbours which is often unpaid, and paid staff will be needed where this informal care is unavailable; b) the needs of disabled people usually span across many different agencies or sectors (e.g. health, social care, housing, education, employment); c) community-based services can be financed in a variety of ways, through taxes, social insurance, voluntary insurance and out-of-pocket expenses; a mix of these

can create difficulties, however, because of the incentives and disincentives that can emerge (Mansell et al., 2007).

There are a great many challenges facing some European Member States in replacing their institutions with community services. Reform is hampered by a lack of investment, comparable information and research, particularly in less developed countries (Muijen, 2008). Despite this, the recent WHO Mental Health Atlas (WHO, 2011b) on 184 countries (grouped into high, medium and low income countries including EU Member States), found the global median number of mental health services per 100,000 population of 0.61 for outpatient facilities; 0.05 for day treatment facilities, 0.01 for community residential facilities and 0.04 for mental hospitals. In terms of psychiatric beds, the global median is 1.4 per 100,000. These findings confirm the increasing trend towards community based mental health services.

Recent developments in mental health care

Several approaches have been developed and introduced in the EU which highlight the way mental health services can develop mental health promotion and relapse prevention initiatives.

Recovery and person-centred approaches

The use of Recovery-oriented and person-centred approaches for supporting people with mental health problems is becoming more widespread across Europe, as described in the introduction of this report. In the UK, for example, the Implementing Recovery through Organisational Change (IMROC) project aims to assist six demonstration sites, six pilot sites and 17 network members to improve the quality of these services by supporting those with mental health problems to lead meaningful and productive lives. The project also enables sites to demonstrate an innovative approach to quality improvement and cultural change across organisations (Mental Health Network, NHS Confederation, 2012). Recovery Colleges have also been introduced in England; four exist at present and several more are due to be opened. These colleges seek to deliver peer-led education and training programmes within mental health services, although they are not seen as a form of therapy. The idea is that service users become experts in their own self-care and develop the skills they need for living and working (Centre for Mental Health and Mental Health Network NHS Confederation, 2012). Some authors have also considered how public mental health and implementation of the well-being agenda can contribute to recovery and increase the opportunities for a life beyond illness (Boardman & Friedli, 2012). The authors suggest that this can be done by asking what sort of

communities support recovery, and by investing in the type of community based support that builds community capacity, reduces the need and demand for specialist mental health services and reduces the risk of crises (Boardman & Friedli, 2012).

In Aarhus, Denmark, Recovery approaches are influencing the way social care services organise their care. A personal coordinator carries out an initial assessment and provides the overall coordination of care between the different actors. Similarly, in Ireland the PROTECT partnership (Personalised Recovery-Oriented Treatment, Education and Cognitive Therapy) develops personal recovery plans for people with a diagnosis of psychosis, working with a range of service partners (e.g. early intervention service, voluntary sector/NGO organisations, employers services) to provide person-centred and recovery-oriented services in the community (examples cited in the European Social Network, 2011).

Early intervention for psychosis

Early intervention for psychosis is another important development in mental health care. The evidence base for its effectiveness indicates a reduction in the likelihood of relapse and admission to hospital compared to standard care following a series of eight randomised controlled trials with follow-up periods of up to 2-years (Bird et al., 2010). This specialist mental health service is mostly found in high-income countries (e.g. Italy and the UK), but some have argued that these services in low- to middle-income countries should be based on the public health models such as those used for infectious and non-communicable disorders, and integrated within existing healthcare programmes (Farooq, 2013).

Wider access to psychological therapies

The introduction of Improving Access to Talking Therapies (IAPT) in England since 2006 has been an important step in ensuring the availability of talking therapies in primary care for common mental health problems (e.g. depression and anxiety). Recent research suggested that psychotherapy provided by the National Health Service in England between 1991-2009 has been increased for those with the highest need, (i.e. from lower socio-economic groups) which is very encouraging (Jokela et al., 2013).

Financing mental health systems and promoting efficiency

Sustaining mental health care budgets in Europe to meet need in the wake of the economic crisis have provoked considerable concern among many stakeholders. As highlighted by the European Social Network (2012), essential services for young people

and adults with mental health needs are being cut. In Ireland, for example, there were plans to invest €35 million in mental health services to recruit approximately 400 staff and to open new units; €20 million were also to be invested in primary care. Instead funding for this original investment will be used to offset the deficit in the Health Service Executive. This and other funding cuts means that up to 600 public nursing home beds and a number of psychiatric inpatient beds are to be lost.

In mitigating the effects of the economic crises, the World Health Organization suggested introducing active labour market programmes, family support, primary care for people at high risk of mental health problems, control of alcohol prices and availability and debt relief (WHO, 2011).

Even prior to the current economic crisis, there were concerns about the growing treatment costs of mental health care which can negatively affect the ill and their families, health and social care systems and the national economy. Insufficient funding for mental health needs is a continual problem, and some authorities have emphasised the need to improve not only the effectiveness of health care but also its cost-effectiveness (Knapp & McDaid, 2007; Knapp et al., 2007).

Whilst having knowledge about the cost-effectiveness of interventions is helpful, it does not inform on how to best to address the issue of scarcity of funds. As an aside, the majority of new treatments (the newer classes of drugs, for example) also appear to cost more than the interventions they are designed to replace (Knapp & McDaid, 2007). Whilst there are many demands for economic evidence on the cost-effectiveness of interventions, there is additionally a need to understand how best use may be made of available resources overall through, for instance, reconfiguring systems to improve efficiency by the privatisation and sectorisation of care provision. Research into areas such as the relationship between mental health and employment may also be beneficial according to Knapp & McDaid, (2007). The Mental Health Economics European Network (MHEEN) has a wide aim to amass information and knowledge on the economics of mental health, to develop and strengthen contacts with policy makers, and to encourage economic evaluation in a wide range of aspects of policy and practice development in mental health. This could support decision making on funding and provision of services and improve efficiency in how inadequate resources for mental health are allocated.

More recently, McDaid et al. (2010) make an important case for prioritising mental health services at a time of austerity when the demand for services may well rise. They emphasise also the critical importance of investing in evidence-based prevention and promotion.

3.3 Mental health promotion and prevention of mental illness

Over the past decade there have been significant developments across Europe in relation to mental health promotion and prevention of mental illness. The EU policy initiatives, described in the introduction of this report, have provided an important impetus to raising the profile of mental health promotion (MHP) and the prevention of mental illness (PMI). The evidence base assessing the effectiveness of MHP and PMI has continued to grow both in Europe and internationally since these EU policies emerged in 2005 and 2008. The EU has been, and continues to be, an important source of funding for MHP and PMI initiatives and projects.

EU funded projects on mental health promotion and mental illness prevention

Since 2003, the European Commission together with other Member States have funded initiatives to guide and support the implementation of effective programmes and interventions in the field. The Implementing Mental Health Promotion Action (IMHPA) project aimed to develop and disseminate evidence-based mental health promotion and prevention of mental illness strategies across Europe, and to facilitate their integration into countries' policies, programmes and health care professionals' daily clinical work (IMHPA website: http://www.gencat.cat/salut/imhpa/Du32/html/en/Du32/index.html). The project's first phase, started in 2003, was financed by the European Commission, the Ministry of Health in the Netherlands and the Ministry of Social Welfare and Health in Finland, and included 20 European Member States. Its second (2-year) phase financed by the European Commission and the Department of Health in Catalonia, Spain, expanded to involve a network of 45 partners across 30 European countries and 7 other Europe-wide mental health networks. The project was completed in 2008 and comprised seven work packages. These included the development of an information system on infrastructures for MHP and PMI, country reports describing the situation of MHP and PMI, a mental health impact assessment, and an economic model. Their key publications include a Policy for Europe regarding MHP and PMI (Jané-Llopis & Anderson, 2005), "Country Stories" for 30 Member States of MHP and PMI (Jané-Llopis & Anderson, 2006), a training manual for prevention in primary care, and a training manual on advocacy skills in MHP and PMI (Anderson et al., 2008).

The 'Policy for Europe' report, following the Council Resolution of 18th November 1999 on the promotion of mental health and support for the outcome of the WHO Ministerial Conference on Mental Health (WHO, 2005), outlined the main priority for all European Member States. This called for comprehensive plans to be developed in MHP and PMI,

and for resources to be distributed to mental health in proportion to resources addressing the burden of mental health problems (Jané-Llopis & Anderson, 2005).

Other important information systems include the DataPrev project (2007-2009). This multi-country project was funded under the 6th European Framework programme and gathered together research and evidence across different settings for mental health promotion and prevention of mental illness for policy makers, policy implementers, researchers and European consumers (McDaid, 2008). The database appraised the evidence-based programmes currently implemented in countries across Europe (http://www.dataprevproject.net/). These included home-based and family-based programmes for infants and toddlers; school-based programmes for children and adolescents; work-based programmes for adults; and home and community-based programmes for elder populations.

European initiatives to produce guidelines for training care professionals in MHP include the PROMISE project (Greacen et al., 2012). Here a multidisciplinary scientific committee of academics, mental health service providers and public health organisations from eight European sites developed ten quality guidelines for training care professionals in MHP. These criteria included: embracing the principle of positive mental health; empowering community stakeholders; adopting an interdisciplinary and inter-sectoral approach; including people with mental health problems; advocating; consulting the knowledge base; adapting interventions to local contexts; identifying and evaluating risks; using the media; and evaluating training, implementation processes and outcomes.

The European Network for Mental Health Promotion (ENMHP) provides information, tools and training to support the implementation of MHP (http://www.mentalhealthpromotion.net/?i=portal.en.about). The EU Compass for Action on mental health and well-being also aims to facilitate the uptake and exchange of good practice and policies across Member States (European Commission, 2010b). This database houses a collection of standardised good practice examples, relevant reports/studies and policy documents.

MHP and PMI – current and emerging evidence-base

As described in the introduction of this report prevention of mental illness refers to interventions that stop mental illness happening, including reducing risk factors and enhancing mental illness protective factors. Prevention programmes aiming to reduce the incidence, prevalence and recurrence of mental illness, time spent having symptoms, preventing or delaying relapse and decreasing the impact for the person and their families – essentially primary, secondary and tertiary prevention (Mrazek & Haggerty, 1994). Mental health promotion refers to initiatives that promote positive mental health

by increasing social and psychological well-being, competence, resilience, and creating supportive living conditions and environments (WHO, 2004).

The current and emerging evidence on MHP and PMI generated in European countries and internationally has been summarised in a series of reports and reviews. The Foresight Mental Capital and Wellbeing Project (2008), for example, made a significant contribution to the field by highlighting the key factors that will drive change: the increase in life expectancy and the challenge of maintaining optimum mental capital in older people; changes in the global economy and the world of work and the importance of developing mental capital; the changing nature of society (e.g. mix of cultures in the UK, family structures); changing attitudes and new values; and new technology and science to identify new ways of addressing mental illness and learning difficulties.

Campion et al. (2012) reviewed a large part of the evidence-base on public mental health interventions and their potential economic savings. In drawing up the European Psychiatric Association (EPA) guidance on prevention of mental illness, Campion et al. (2012) make several recommendations to promote the implementation of early treatment of mental illness and prevention of relapse, interventions which address inequality and promote mental health and recovery, and a cross-government approach in partnership with non-governmental organisations (NGOs) and communities to deliver and sustain these interventions. We provide below an overview of the main findings for MHP and PMI for interventions in schools, the workplace and for older people.

School-based interventions

School-based interventions provide an important opportunity for dealing with the high prevalence of children who experience mental health problems - up to 25% for those in developed countries (Ravens-Sieberer et al., 2008, 2008b; Harden et al., 2001). As a consequence, a very considerable number of school-based interventions have been carried over the last twenty years across the world. Early-age interventions also present cost-savings opportunities as untreated problems in childhood can result in profound long-lasting social and economic consequences into adulthood. These include anti-social behaviour, increased rates of health service use, greater involvement with the criminal justice system, receding levels of employment, and problems with personal relationships (McDaid et al., 2010; Browne et al., 2004).

Weare and Nind (2011), as part of the DataPrev project, identified 52 reviews (from 1990) in their systematic review of school based MHP and PMI interventions for those aged between 4-19 years. Around twenty of their selected reviews took place in European countries (Belgium, the Netherlands, Norway and the UK); the remainder were conducted

in the United States, Australia, New Zealand and Canada. Interventions on positive mental health, well-being and social and emotional learning had small to moderate effect sizes. Those seeking to prevent violence, bullying, conflict and anger had a small effect when aimed at universal populations, but a stronger effect when targeted on high-risk children. Generally, the intervention effects were variable, but their effectiveness depended on the clarity, intensity and fidelity with which they were implemented. The more effective interventions were those that included teaching skills, a focus on positive mental health, a balance between universal and targeted approaches, starting with younger children and continuing with older ones, taking place over a long period of time, using a multi-modal/whole school approach that is integrated within the curriculum, teacher education, parent liaison, community involvement and work with external agencies.

A review by Stallard (2010) examined the different programmes and outcomes of school-based interventions to prevent anxiety. SEAL (Social and Emotional Aspects of Learning) aims to promote the emotional health skills that are thought to underpin effective learning and positive behaviour. This approach appears to produce a small positive impact on emotional well-being, but not in terms of reducing anxiety. Cognitive behaviour therapy (CBT) programmes, however, have been shown to be effective at reducing anxiety when used in school-based prevention and early intervention programmes; particularly the FRIENDS for Life programme, a 10-session programme teaching anxious children problem-solving skills (Neil & Christensen, 2009).

In a recently published randomised controlled trial in the UK, a classroom-based CBT intervention failed to reduce the symptoms of depression (Stallard et al., 2012). The intervention was the Resourceful Adolescent programme which had been found to be effective in Australia and New Zealand and was established as being feasible and viable for use in the UK. The study assigned adolescents (aged between 12-16 years) from eight schools to either CBT, attention control or the usual school provision. Outcomes (symptoms of depression, negative thinking, self-worth etc) were measured using self-completed questionnaires administered at baseline, 6- and 12-months. The authors found no evidence that the intervention reduced depressive symptoms in adolescents at high-risk of depression, despite the high fidelity to the programme. A key finding was that the intervention had a potentially harmful effect compared with the usual school provision; higher rates of depressive symptoms were found in the intervention group at 12 months, where two thirds of participants at high risk continued to be at risk of depression. The investigators suggested adopting a cautious approach to implementing depression programmes in secondary schools despite this setting being a convenient focus for mental health interventions.

In summarising the effectiveness of depression prevention programmes for children and young people, Stice et al (2009) identified 47 trials evaluating 32 programmes and found small but significant reductions in symptoms of depression and in risk for developing future depressive disorder. The authors also examined what predicted the size of the intervention effects. They found that the content of the interventions (e.g. increasing problem-solving skills) and the design features (e.g. random assignment and use of structured interviews) were not associated with effect sizes. Instead, larger effect sizes were found for interventions that were targeted at high-risk participants, that included homework, that were delivered by professional interventionists and that were of a shorter duration (< a median of 12 hours). However, caution needs to be used when interpreting these results as the authors did not take into account the heterogeneity between studies and their quality. Han & Weiss (2005) identified the factors that can support teacher implemented school-based mental health programmes (acceptability to teachers and motivation, feasibility, adaptability and flexibility) that can be enhanced through teacher training and feedback from a classroom consultant.

Mindfulness meditation is another approach being used within the classroom, with some emerging evidence suggesting a positive effect on well-being in adolescent students. An RCT by Huppert & Johnson (2010) examined mindfulness training (based on a programme developed by Kabat-Zinn and associates from the US) comprising 40 minute classes, once a week designed to introduce the principles of mindfulness meditation to 173 students (aged 14-15 years) in two schools in the UK. Although no significant differences were found between the intervention and control groups overall in mindfulness, resilience or psychological well-being scores, there was a notable improvement on measures of mindfulness and psychological well-being for students who practiced outside the classroom.

Workplace interventions

As with schools, the workplace represents an important setting for MHP and PMI initiatives, particularly in view of the high prevalence of mental health problems among employees. On average and at any one time almost 1 in 6 employees in the UK experience a mental health problem such as depression and anxiety or both (Sainsbury Centre for Mental Health, 2007); and 1 in 5 for the workforce in Europe (OECD, 2012). Mental health problems are one of the leading causes of absenteeism and early retirement across the entire European Region (Baumann et al., 2010).

The human and economic consequences of mental health problems in the workplace are considerable in terms of loss of productivity, absenteeism, high staff turnover, early retirement and exclusion from the workforce. Employers are often unaware of how costly

mental illness and stress at work is. According to one recent estimate the total cost of work related depression across the EU27 Member States amounts to nearly €620 billion per annum; €270 of which is borne by employers as a result of absenteeism and presenteeism[3], and €240 billion by the economy due to lost output (Matrix Insight, 2012).

Figures for 10 countries (including Austria, Belgium, Norway, Switzerland, Sweden and the UK) show that people with mental health problems are at a considerable employment disadvantage; those with moderate mental health problems lag behind by around 15 percentage points (30 percentage points for those with severe mental illness) compared to those without mental health problems (OECD, 2012). This represents an important challenge for the labour market and so underpins the need for workplace MHP and PMI initiatives. There is also an important evidence base on effective interventions to support those with mental health problems to retain or find employment (Seymour, 2010; Sainsbury Centre for Mental Health, 2009; Burns et al., 2007), although in this section we focus on workplace MHP and PMI interventions.

Czabała et al. (2011; 2010, part of the DataPrev project) selected 79 studies from Europe and internationally (from 1988-2009) on psychosocial interventions to promote mental health in the workplace. These studies focused on stress reduction and better coping, increasing job satisfaction and effectiveness, enhancing mental health and reducing absenteeism due to mental health problems. The types of interventions included skills training (to manage stress, problem-solving etc.), interventions to improve occupational qualifications, interventions to improve working conditions (flexible work times, improve employer relationships), relaxation techniques, physical exercise, and multi-component interventions (e.g. combining physical exercise, stress, coping techniques etc).

The most effective interventions, classified under five categories, included:

Stress reduction/better coping (37% of studies) – a study by Nielsen et al. (2006) aimed to change attitudes of canteen staff in care homes and hospitals to boost their confidence in carrying out health-promoting initiatives and taking responsibility for shared competencies. One of the two interventions assessed showed positive outcomes for stress symptoms, job satisfaction, and opportunities for personal development and vitality, but not for social support. The organisational structure and major conflicts among employees were said to hinder any further changes, however. The most promising intervention appeared to be Stress Inoculation Training which reduced stress in teachers and enhanced their coping skills (Cecil & Forman, 1990).

[3] Presenteeism is the term used to refer to reduced productivity when employees come to work, but are either not fully engaged or perform at lower levels as a result of ill health.

Improving mental health (16% of studies) – a multi-modal intervention, the Worksite Health Promotion Programme, providing stress management training (relaxation and meditation), educational workshops and counselling, and self-directed behaviour change was evaluated by Peters & Carlson (1999). Improved outcomes were found for reducing health risks, health self-efficacy, curiosity, depression, social support, access to health care and health behaviour. The programme was well-received by the participating employees.

Increased job satisfaction (18% of studies) – Dupuis & Struthers (2007) assessed Social Motivational Training (SMT) which comprised of two components based on cognitive theoretical frameworks to increase participants' awareness of people's tendency to make spontaneous attributions. The invention showed positive improvements for expectations, responsibility, intentionality, anger, sympathy, readiness to cooperate and social motivation.

Job effectiveness (23% of studies) – The ACTion Team programme is a problem-solving intervention designed to improve employees' health and well-being and job effectiveness. Tailor-made action plans were created for each assessed worksite aimed at resolving any problems identified. The ACTion team reviewed plans and monitored progress to improve co-worker support and recognition. Positive outcomes were found for organisational climate, co-worker and organisational support, communication, well-being, job stress and health status.

Reducing absenteeism/sick leave and high turnover (6% of studies) – Czabała et al. (2011) included three studies within this category – a relaxation programme, a multi-component intervention and a physical exercise programme – which largely appeared to reduce absenteeism.

Despite the relatively high number of studies identified and selected by Czabała et al's (2011) review, a large proportion were fairly dated. As these authors conclude, there remains no conclusive evidence of the effectiveness of mental health promotion programmes in the workplace and newer interventions are needed, assessed with more robust research methods.

Another review of the effectiveness of universal/preventive and targeted outcomes programmes in the workplace found that of the 27 studies examined there was no consistent evidence to back any one particular approach or programme given the range of programmes (e.g. Cognitive Behavioural Therapy and other psychotherapeutic approaches, stress management, problem solving, employment training and exercise) and methods used (Matrix Insight, 2012). However, 19 of these studies had significant

positive impacts, for example, on reducing depression, anxiety or stress and a faster return to work, but not in terms of reducing sickness absence.

Good practice examples and effective approaches

There are several projects, such as the MentHealthWork (run by the European Network for Workplace Health Promotion, ENWHP) and Promoting and Protecting Mental Health (ProMenPol), that highlight the importance of MHP at work, plus others that report good practices such as the EU-OSHA project (Hassard et al., 2011). Some examples include employers who use **a holistic approach** to mental health at work (targeting the individual and organisational level) to improve communication and feedback, social support and problem-solving (Creativ Company, Denmark; ATM, Italy), an approach found to reduce sickness absence and improve health (Michie & William, 2003).

Other important approaches include **systematic planning and monitoring** of an action where the intervention aims to address a combination of protective and risk factors for mental health in employees which has been used by "R", a company from Spain, and shown to be effective (Leka et al., 2008); **active involvement of workers** to gain their support and commitment to an MHP intervention is essential (e.g. the 'Work-life balance and employees' participation' programme of Oriflame, Poland); cultivating a sense of 'ownership' is a key success factor for work-related stress programmes (Leka et al., 2008b). **Commitment and involvement of management** is another key ingredient for MHP programmes to be effective in terms of implementation of initiatives and encouraging employee support (North-Rhine Westphalia, Germany and Procter & Gamble, Belgium). So too is **assigning responsibility of the programme** to an individual or group who can emphasise its importance, communicating the aims and importance of the programme to employees (ATM, Italy and Procter & Gamble, Belgium), integrating health promotion into policies and daily life and **monitoring/ evaluating action and progress** (Hassard et al., 2011).

In the UK, the London Underground (Hay, 2010) and British Telecom (Neumann, 2011) are also good examples of attention given to workplace mental health. Size of a company, however, is an important consideration as the BT model may not be applicable to small and medium sized enterprises. What is achievable for larger companies may not be applicable to small or medium sized enterprises (SMEs) with limited staff numbers and resources. Martin et al. (2009) viewed this as a neglected sector in work health research.

Barkway (2006) identified numerous activities such as anti-bullying and stress management in the workplace, but added that there remains scope for fully utilising the workplace setting for mental health promotion. Hillier at al. (2005) noted in their review

of wellness at work that the recruitment of managers with good technical skills in preference to those with effective managerial skills appeared to contribute to stress issues in employees, together with associated poor employee retention, absences and reduced profitability. It has been reported that workplace mental health is not generally taken seriously by employers and that more training of line managers in well-being is required (Cooper & Dewe, 2008). Cooper & Drewe add that provision of information and opportunities to participate in prevention activities need to be increased, and that encouraging managers to adopt a more responsible attitude towards well-being can lead to good practice.

Interventions for older people

Depressive disorders are the most prevalent mental health problem among older people and estimated to affect circa 12% of adults in Europe aged 65 or above (WHO, 2008; Copeland et al. 2004). The evidence on psychosocial interventions for mental health promotion and prevention of depression in older people aged 65 and above was comprehensively reviewed by Forsman et al. (2011) through a systematic review and meta-analysis assessing the effectiveness of interventions. The authors used a definition that encompassed both positive mental health promotion and illness prevention. A total of 69 studies with a controlled design were selected for review and 44 studies were included in the meta-analysis. The interventions examined were categorised into physical exercise, skill training, group support, reminiscence, social activities and multi-component activities. Forsman et al. (2011) found that psychosocial interventions overall had small but statistically significant positive effects on quality of life and mental health; and pooled interventions had significant effects on reducing depressive symptoms. Meaningful social activities also improved mental health, life satisfaction, and quality of life and reduced symptoms of depression. Interventions with a duration of more than 3 months had more positive effects compared to shorter ones. The authors noted, however, that despite some promising findings the evidence in this area is relatively limited and further research/evaluation is needed urgently given the magnitude of the problem and potential benefits to be achieved in older people.

The Impact Consortium (2011) also recognises the need to prioritise issues concerning older people which are underpinned by important humanitarian, social and economic arguments. There is a growing aging population in Europe due to reducing birth rates and increasing longevity of life, resulting in a larger number of older workers, pensioners and very old people. There is a strong economic case for maximising the contributions that older people can make to the economy and society, and also for minimising the cost of care for older people with poor mental health through interventions that can prevent and promote mental health.

Depression and suicide prevention

Against a backdrop of a WHO forecast that approximately 1.5 million people will complete suicides in 2020 with ten times that amount attempting to end their lives, Hoven et al. (2010) stated that serious gaps in knowledge in the area remain and suggested that the diagnosis of depression needs to improve and that more treatment be given. Yet there is evidence for psychological interventions to prevent the onset of depressive disorders (Cuijpers, et al., 2008).

The economic impact of suicide arises from costs as attributable to police, funeral services, healthcare use, and lost productivity as well as less tangible costs as those arising from pain and grief (McDaid et al., 2010b). These authors found that, on average, each completed suicide accrues a lifetime cost of approximately £2m. McDaid et al. (2010b) claimed that suicide prevention interventions are highly cost-effective, even for a modest 1% reduction in suicide rate. Multi-sectoral suicide prevention programmes which target restriction in access to means of suicide, prevention of depression, good recognition and treatment of mental disorders, and support for those at risk may offer best results according to Wahlbeck & Makinen (2008).

Hegerl & Wittenberg (2009) focused on mental health care reforms in Europe against a background of prevention of suicidal behaviour and The European Alliance Against Depression (EAAD). The authors concluded that the Alliance offers an evidence-based concept for care of depressed people and preventing suicide in its multi-level intervention. They also claimed the model could be easily adapted across different countries and cultures. The scheme being expanded into wider regions since its inception and offers an example of how EC-based models directed at improved care for depressed persons and those at risk of suicide can be implemented (Hegerl et al., 2008).

An on-going EU funded project in this area includes the Supreme project; a suicide prevention initiative in seven Member States (Estonia, Hungary, Italy, Lithuania, Spain, Sweden and the UK) targeting adolescents and young adults between the ages of 14 and 24 years. It aims to develop an internet model for MHP that uses existing resources to promote MHP and prevent suicide, to develop guidelines and partnerships for action, and to produce strategies to reach target groups via peer groups and mental health professionals (http://www.supreme-project.org/).

Recent developments and the current EU policy context

MacKean et al. (2011), in a review of recent developments in national level MHP policies in several individual countries internationally and across EU Member States, found evidence of major shifts since 2007. The authors noted an increasing emphasis, even if

not made explicit in such policies, on adopting a population health approach; better recognition of the role of the social environment for people with mental health problems; and increased cross-sector collaboration to tackle the social determinants of health. Mental health promotion has become a major focus in public health policies and action plans, particularly in England and Scotland. Embedding MHP in a broader mental health policy is now a common theme internationally (e.g. New Zealand, Australia and Canada), as well as in Europe.

The IMPACT Consortium assessed the initial outcomes from the European Pact for Mental Health and Well-Being (2008) following the five thematic conferences held between 2009 and 2011 (Impact Consortium, 2011). The Consortium concluded that priorities for future action include a greater need for promotion and prevention of mental disorders and action in the following areas:

- Children and young people - in early years, educational settings, health services, community environment, and new media technologies and the internet;

- Prevention of suicide and depression – developing strategies and policy frameworks, programmes to address risk factors, mainstream mental health into other health disciplines, build partnerships, improve healthcare access, e-health and building a robust evidence base;

- Older people – MHP through increasing social participation, improving life-styles, living environments and retirement policies, PMI, protecting vulnerable older people, and MHP in informal and family carers;

- Promoting social inclusion and combating stigma – strengthen social protection and inclusion, breaking the cycle of discrimination, promote recovery through employment and meaningful activities, safeguarding rights and offer comprehensive health and social support for people with mental health problems;

- Promoting mental health and well-being in the workplace – creating mentally healthy work places, provide interventions for at risk employees, monitor and assess for risk, and support those with mental health problems.

In the context of current EU policies, the EU 2020 strategic objectives are focused on promoting growth over a ten year period (European Commission, 2010c). The five targets set – in employment, education, research and innovation, social inclusion and poverty reduction, and climate/energy – and the seven 'flagship initiatives' for growth overlap significantly with the need/calls to promote mental health and prevent mental illness; although only few explicit references are made to mental health. Council

conclusions on the Pact for Mental Health and Well-being confirm this in backing the recommendations made by the Pact in relation to the EU 2020 objectives and flagship initiatives (Council of the European Union, 2011). The Council has invited Member States and the European Commission to continue its cooperation initiated under the Pact to pursue MHP and PMI.

Implementing evidence- and practice-based MHP and PMI initiatives are a crucial next step for policy makers and other stakeholders in Member States. A new 3-year Joint Action on Mental Health and Well-Being (launched in February 2013) is a further attempt to strengthen and ensure the adoption of MHP and PMI priorities within policies and to promote the evolution towards community based approaches to treatment and care. Following the 2011 Council conclusions, this Joint Action will bring together 45 collaborating partners representing 30 Member States and other countries in a concerted effort to build on the Pact's work by formulating policy recommendations establishing a sustainable commitment to implementation and developing an agreed common framework for action. The Joint Action will aim to address four main areas:

- The promotion of mental health at the workplace and in schools;
- Promoting action against depression and suicide;
- Developing community mental health care; and
- Promoting the integration of mental health in all policies.

Implications of the evidence base for policy and practice

Decisions on whether to adopt evidence-based initiatives are not solely based on their health outcomes but depend also on a broad range of factors such as political, ethical and equity issues, social justice, public attitudes, and the availability of resources (Jané-Llopis et al., 2011). Using evidence based on high quality research methods (e.g. controlled designs) will help identify the interventions that work, the health and other outcomes they can achieve, their cost, and what they can potentially save in terms of economic and social costs. Where evidence is available, it needs to be accessible to key audiences such as policy makers, practitioners and the general public, and results from studies presented in a way that can be easily understood (Clement & Buckley, 2011; Moher et al., 2010). Engaging key stakeholders through developing a shared vision with clear goals and objectives is also key to implementing a given MHP intervention (Barry & Jenkins, 2007).

Aarons et al. (2011) developed a conceptual model of evidence-based practice implementation in public service sectors, including public mental health. The model comprises of a multi-level, four phase implementation process – exploration, adoption/preparation, implementation and sustainment. Each phase is dependent, however, on what the authors define as 'inner' (e.g. organisational characteristics and networks, leadership) and 'outer' contexts (e.g. socio-political/funding, client advocacy) which present challenges and opportunities which are considered by their conceptual framework. A good understanding of these challenges and of the opportunities for implementing the evidence-based practice will help the various relevant stakeholders to navigate the complex process more effectively (Aarons et al., 2011).

Sufficient high quality evidence needs to be available to answer questions about what works and what is cost-effective. It can take many years for sufficient evidence to be generated and its transferability to the real world or between different countries or cultures cannot be assumed. Such evidence can also be contradictory, making it difficult to draw firm conclusions. Furthermore, evidence is never 'value free' and will always be informed by different values and perspectives (Jané-Llopis et al., 2011).

Gaps in the evidence base for MHP and PMI interventions in the workplace and for older people are apparent (as noted above), and further investment into generating sufficient evidence in these areas will be important. EU investment in MHP and PMI has been used to generate important information databases, training and practice guidelines, and intervention studies to support the implementation of MHP and PMI in Member States. It will be important therefore to make full use of the existing evidence-base despite the gaps (McDaid & Park, 2011).

Practice-based MHP and PMI initiatives are often implemented and sustained in the real world; they are not always evaluated, however, which needs to be encouraged (Jané-Llopis & Anderson, 2006). Developing partnerships between practitioners and researchers to evaluate and implement MHP and PMI initiatives could also potentially improve the quality of interventions and generate real world evidence to support the decision-making process (Pope & Mays, 2006). The CLARHC (Collaboration for Leadership in Applied Health Research and Care) is a good example of how this can be achieved. This type of collaboration between a university and healthcare organisations aims to improve patient outcomes by conducting high quality applied research, implementing the findings in clinical practice and increasing the capacity of healthcare professionals to engage with and apply research (http://www.clahrc-ndl.nihr.ac.uk/clahrc-ndl-nihr/index.aspx). Dissemination of the research findings to lay audiences is achieved in part through producing highly accessible 'need to know' information using 'CLAHRC BITEs' (Brokering Innovation Through Evidence), newsletters and stories of the trials in the programme.

The returns on investments in mental health promotion and prevention are considerable. McDaid and Park (2011), in their systematic review of the extent to which high income countries have put forward an economic case for investing in mental health and well-being, found a case for investing in parenting and health visitor-related programmes, especially where the impact beyond the health care sector is taken into account. In the workplace, comprehensive health promotion programmes and stress management projects (mostly from the US) were identified; and for older people, group-based exercise and psychosocial interventions were found potentially beneficial. (A description of the economic and social gains from MHP and PMI is found in Chapter 7 of this report).

The Foresight Mental Capital and Wellbeing project (2008) as described above also provides an overview of, and recommendations for, interventions that promote mental health and address mental ill health in children and adolescents, adults of working age and older people. The rationale for pursuing these goals for policy makers and other relevant stakeholders (e.g. employers) is also about ensuring equal access to MHP and PMI programmes as part of tackling social and economic inequalities; and the need for greater efficiency in the use of available resources.

In an assessment of the return on investment for MHP and PMI, Roberts and Grimes (2011) noted that returns usually show up in a different sector to which the investments are made. The authors suggest a 'mental health in all policies' approach with strong leadership across relevant sectors to promote MHP and PMI.

There are now guidelines developed in the UK that help policy makers and those that commission services decide how best to implement public mental health initiatives. An example is a recently published report by the Joint Commissioning Panel on Mental Health (JCPMH, 2012). It outlined the importance of implementing good quality public health interventions, estimating the local impact and the economic savings that can be made, and awareness of how and why good public mental health can contribute to the aims of mental health, public health, health and social services and improve their quality and productivity (JCPMH, 2012).

Similarly, in an effort to increase the number of public policies that are informed by the existing evidence, a recent initiative - 'What Works Centres' - has been launched in the UK to guide decision-making in public services. Four Centres are to be created – Local Economic Growth, Better Ageing, Early Intervention Foundation, and Crime Reduction – and funded from a variety of sources, including the government and the National Lottery (Cabinet Office, 2013). The Centres will produce high quality syntheses of the research evidence for each field, which will aim to inform social policy decision making. A National Advisor will lead the What Works network and will have a liaison and advisory role to promote the evidence.

The Way Forward?

This investigation was carried out at a beleaguered time for EU and world economies, and clearly this has had a deleterious effect on mental health prevention and promotion in the past few years. Various justifications, not least financial ones, can be put forward for the implementation of policy for further developments in the area, but there is still an impression of a fear of, or inability to, invest an initial outlay to gain returns. This is in spite of a large body of evidence pointing to the success and cost-effectiveness of a wide range of mental health prevention and promotion initiatives in disparate environments and with different age groups.

Developments in the domain of mental health prevention and promotion, as in many other areas, appear to have deteriorated during a coincidental period with the economic downturn. While this may be obvious to state, it is nevertheless indicative of a general lack of funds and confidence in spending what funds remain available.

Perhaps a related inhibiting factor is that these gains may be envisaged as being over the medium- to longer-term only, rather than immediate. It is a consideration that general financial uncertainty and vulnerability – and also the perception of them – need to change before significant further progress can be made in mental health prevention and promotion. Greater and more widespread evaluation may, as suggested, be useful although the evidence and justification for them already exists. Continued raising of awareness and stimulating commitment towards mental health promotion and prevention is therefore fundamental.

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4. Country Profiles

4.1 Austria

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Summary

- Mental health legislation and policy is integrated into general health policy, policies on prevention and promotion of mental health are usually part of general health promotion and illness prevention policies.
- The responsibility for the provision of mental health services rests mainly with the nine regions. Related policies and plans differ in the individual regions.
- A range of community mental health services are available, although psychiatric services are fragmented into several sub-disciplines such as psychosomatics or child and adolescent psychiatry. This fragmentation and the lack of coordination hinder the development of integrated mental health care services.
- No own mental health budget exists. Mental health financing is highly complex with state, insurance and co-payments being linked in a complicated way. On a regional level, mental health services are usually funded by both the health department and the department for social services. Several mental hospitals have been closed or their size reduced.
- The interest in and the activities related to health promotion and illness prevention has increased in Austria over the past 5 to 10 years.

Data for this country profile were gathered in the first instance by the project's country collaborator for Austria. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Austria. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	8,404,252
Population density Inhabitants per km² (2009)	101.5
Women per 100 men (2011)	105.2
GDP PPP 2010 EU27 = 1	1.1
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	36.5
Standardised Suicide rate by 100,000 inhabitants (2011)	15.3
Gallup Wellbeing index (2010)*	
Thriving	57%
Struggling	40%

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

General health legislation, such as the Federal Constitutional Act (*Bundesverfassungsgesetz*, BVG) and the Federal Hospital Act (*Kranken- und Kuranstaltengesetz*, KAKuG) covers mental health and deals with the structure, provision and responsibilities of the different health care system stakeholders (e.g. Federal Government, regions etc.). Patients' legal rights when admitted to hospital on a compulsory basis are regulated in the Law for compulsory admission to mental hospitals (*Unterbringungsgesetz* UbG, 1990), which was modified in July 2011 to avoid successive compulsory admissions (without an increase of the cumulative length of stay). Other related laws deal with competency/guardianship issues for people with mental illness (*Sachwalterrecht* 1984; *Sachwalterrechts-Änderungsgesetz* SWRÄG 2006), the restrictions of liberty in residential facilities (*Heimaufenthaltsgesetz* HeimAufG 2004; HeimAufG-Novelle 2006), and Penal Law – relevant for mentally ill offenders (*Strafgesetzbuch* StGB §11, §21).

The Austrian Health Promotion Act (BGBl. No. 51/1998) is a Federal law that enacted measures and initiatives to promote health and provide health education and information (*Gesundheitsförderungsgesetz*, GfG). The Austrian Health Promotion Foundation (Fonds Gesundes *Österreich*, FGÖ) was charged with the implementation of this law. The work of the Austrian Health Promotion Foundation consists in funding practical and scientific projects, the creation of structures for health promotion, the provision and support of initial and continuing training and education offerings, networking, information and public education. The Finance Equalization Act

(*Finanzausgleichsgesetz*, FAG) (section 8) regulates the allocation of an annual sum of €7.25 million for health promotion, education and information. This is the budget of the FGÖ. Other legal frameworks for health promotion and prevention are also defined in the General law on social insurance (*Allgemeines Sozialversicherungsgesetz*, ASVG) and other social insurance legislation (e.g. for civil servants, self-employed, farmers, etc.). Prevention in problem areas specific to young people is regulated by the Law providing support for young people (*Jugendförderungs-gesetz*, JuFöG). Prevention and health promotion for workers is regulated by the Labour Protection Act (*ArbeitnehmerInnenschutzgesetz*, AschG). Professional legislation (e.g. for physicians, psychologists, health care workers and nurses, etc.) may include issues related to health promotion and/or illness prevention. An additional legal framework for health promotion (and therefore also for Mental Health Promotion (MHP) is found in the statutory agreement on the organisation and financing of the health care system (Art.15a B-VG [Federal Constitutional Law]) which is agreed on by the Federal Government and the regions at regular intervals and currently valid from 2008 to 2013.

None of the above mentioned laws refer explicitly to mental health promotion or prevention of mental illness.

Mental health policy and inclusion of prevention and promotion

The Mental Health Plan (updated in 2004), several regional psychiatric plans, the Health Care Structure Plan and regional health plans form the basis of mental health policies and plans in Austria. No mental health policy for children and adolescents exists in Austria, although in April 2010 a children's health dialogue was initiated by the Minister of Health and eventually a children's health strategy was defined in June 2011. The strategy is composed of 20 targets which are grouped into five thematic areas. Several targets deal with prevention and health promotion matters. A Mental Health Strategy for Social Insurance is also in the making which will be based on an assessment of the status of mental health services in Austria by the Main Association of Austrian Social Security Institutions and the regional health insurance fund of Salzburg between 2010 and 2011.

Interest in and the activity related to health promotion and illness prevention has grown since the enactment of the Austrian Health Promotion Act in 1998 and the establishment of the FGÖ to implement the Act. The Federal Ministry of Health (*Bundesministerium für Gesundheit*, BMG) states that health promotion and prevention featured as one of its areas of key interest for financial support in 2011 and among the topics (e.g. child and adolescent health, women's health and ageing, infectious diseases). Mental health promotion and illness prevention are also featured.

An Advisory board for mental health has been introduced at the Ministry of Health. A national strategy on the basis of the Helsinki Declaration and the Mental Health

Declaration for Europe has been developed. Current projects by the board include: data collection on the prevalence of mental illnesses; replication of a Stigma Survey conducted in 1998; and an assessment of treatment pathways for people with a mental illness, noting costs incurred through service utilisation in an effort to improve health service planning. A suicide prevention programme is on the way.

Mental health services

Organisation and functioning of mental health systems

Following the reform of psychiatric services beginning in the mid-1970s, 60% of psychiatric hospital beds were closed, the size of psychiatric hospitals were reduced or closed and psychiatric departments opened as part of district general hospitals. The number of adult psychiatric inpatient beds per 100,000 population for 2009 was 36.5 (excluding day care, rehabilitation, substance use and child and adolescent beds) (GÖG/ÖBIG, 2011). Prior to this there were 15 beds per 100,000 located in psychiatric units based in general hospitals (World Health Organization, 2008).

Various community mental health services now include day hospitals, crisis intervention, hostels for those with mental illness and multidisciplinary teamwork, social and vocational rehabilitation, housing units, daily structure and employment. Psychiatric services, however, are fragmented into several sub-disciplines such as psychosomatics or child and adolescent psychiatry. This fragmentation and the lack of coordination of these services hinder the development of integrated mental health care services.

Access and usage

General practitioners are the main contact point for people with mental illnesses, constituting 94.2% of all physician visits in 2009. In the same year approximately 120,000 patients visited a specialist in psychiatry (Main Association of Austrian Social Security, 2011).

In 2007 the total number of inpatient admissions with an ICD 10 diagnosis (F code) was 112,907. This equated to 45% men and 55% women. Admissions were attributed to about 73,000 patients. On average patients with an F diagnosis remained in hospital for 24.9 days, the longest average stay being 50.9 days (Schizophrenia), 39.3 days (Schizoaffective psychosis) and 36.9 days (Eating disorders). The majority of patients were admitted to psychiatric departments in general hospitals (62%), whereas about 19% were admitted to departments of internal medicine and 6% to children's neuropsychiatry (GÖG/ÖBIG, 2010).

Variation and gaps

Given Austria is based on a federal system, the development of community mental health services across the country has occurred at different speeds. Some provinces therefore have advanced forms of services and others lag behind.

Financing

The total expenditure on health (% of Gross Domestic Product) in 2009 was 11%. How much of the healthcare expenditure is spent on mental health services is unknown, and no separate mental health budget exists. Mental health financing is highly complex with state, insurance and co-payments being linked in a complicated way. On the regional level, mental health services are usually funded by both the health department and the department for social services.

Mental health workforce

In 2009, there were 1891 medical specialists working in Neurology and/or Psychiatry. These practiced Child- and Youth Psychiatry (9 specialists), Neurology (352 specialists), Neurology and Psychiatry (438 specialists), Psychiatry (421 specialists), Psychiatry and Neurology (645 specialists) or Psychiatry and psychotherapeutic medicine (26 specialists) and about 100 specialists on child and youth psychiatry. Approximately 73% of these specialists are employed part- or full-time (either in hospitals or other institutions). The majority of these, about 80% work in hospitals. About 53% of all specialists work in private practices either part- or full-time. About a quarter of all specialists work in a hospital and in private practice. Two hundred and sixty one specialist doctors had contracts with at least one social health insurance institution. Social health insurance expenditure for neurologists/psychiatrists came to €53,959,918 in 2009.

There exists a system of further education on three levels in the field of mental health for all medical disciplines, which is especially useful for general practitioners, organised by the medical association (Österreichische Ärztekammer). At the end of 2011, 2.2 doctors graduated with a diploma in “Psychosocial Medicine”, 1.7 in “Psychosomatic Medicine” and 1.2 in “Psychotherapeutic Medicine”.

At the end of 2009, there were 6,908 registered psychotherapists (8.27 per 10,000 inhabitants). Regional variation in the number of psychotherapists was between 3.6 and 17.0 per 100,000 population, with 55.4% of the registered therapists working on a freelance basis. The individual working hours of the registered therapists (full- or part-time) are unknown. In 2009 social health insurance funds spent €62,654,096 on psychotherapy and psychotherapeutic medicine, and around 65,500 patients received services related to psychotherapeutic medicine.

At the end of 2010, there were 7,830 psychologists (clinical and health psychologists).

Responsibility and delivery of mental health promotion and prevention of mental illness

At policy level, several Austrian ministries are involved in health promotion and illness prevention. These are the: Federal Ministry of Health; Federal Ministry of Labour, Social Affairs and Consumer Protection; Federal Ministry for Education, Arts and Culture; Federal Ministry of Economy, Family and Youth; and the Federal Ministry of Justice. Several social health insurance institutions also play a major role in health promotion and primary prevention, despite these areas not being their key responsibility. Social insurance funds mostly concentrate on settings such as the workplace and schools. Other related activities include community health promotion and individual illness prevention (e.g. smoking, nutrition, stress, dental health, physical activity). A variety of health promotion networks also exist in cities and communities, hospitals, schools and workplaces, and integrated within these networks are mental health promotion and prevention activities.

The development of health promotion and illness prevention in Austria is strongly influenced by the regional structure and fragmentation of responsibilities for health between national and regional stakeholders. No systematic national approach in health promotion and illness prevention exists, although the health care reform of 2005 intended to address the divisions between the different health system sectors by increasing cooperation and coordination.

Health promotion activities show a strong focus on hospitals and communities (WHO networks) and on the workplace (e.g. activities of social health insurance funds). In the past years several health promotion initiatives for pregnant women, mothers and their children (early interventions) have been undertaken. The topic of mental health is also discussed in connection with social inequality and in the context of workplace health promotion. In 1997, health promotion in schools was made compulsory (*Grunderlass zur Gesundheitserziehung)*.

Mental health status

Prevalence of mental health in the population

National epidemiological data on the prevalence of mental illness is not as yet available in Austria. The Austrian advisory committee on mental health has suggested funding an epidemiological study, which has however so far not been undertaken yet. Currently information/reports on prevalence and/or incidence of mental illness in Austria is/are usually based on estimates from other countries or derived from service utilization data.

In 2009, around 900,000 people received social health insurance benefits due to mental illness/suffering (estimate based on: drug prescriptions of the group of psychotropic

drugs, hospital stays, individual taking sick leave due to a psychiatric diagnosis and extrapolation of contacts with doctors and therapists). Based on data for inpatient stay, sick leave and prescriptions for long-term medication, between 200 and 250 Austrians (about 3% of the population) have more severe or long-term conditions. In the same year, around 840 Austrians received antidepressants, antipsychotics or tranquilizer. About 78,000 Austrians were on sick leave due to mental health problems, of which approximately 70,000 were admitted to hospital. The majority of these took medication.

Incidence

Not reported.

Protective and risk factors

None reported; reference should be made to the international body of literature as no Austria-specific data exists.

Prevention and promotion programmes /activities

A considerable number of health promotion and prevention initiatives in the area of schools and the workplace exist in Austria. Initiatives targeting the elderly do exist but tend to be small and localized, or at a pilot stage. In some cases there are programmes or long-term activities for mental health promotion (MHP) and mental disorder prevention (MDP), which form part of general health promotion or illness prevention activities. MHP and MDP activities are often not coordinated. At the national level very few initiatives exist which involve different policy areas (e.g. health, education, social affairs). So far few evaluations have been conducted and little evidence of their impact exists. However, projects funded by the FGÖ are always evaluated. Relevant mental health promotion and prevention initiatives include:

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
Schools			
Give - an initiative of the Federal Ministry of Education, Arts and Culture, Federal Ministry of Health and the Austrian Youth Red Cross	Aim: to promote health through a nationwide service centre providing information (on projects and activities) for teachers and employees of educational facilities on health promotion. Topics covered include violence, alcohol, addiction, eating disorders and sexuality.	Teachers/ Pupils	

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
BMUKK - a School-Psychology Educational counselling (*Schulpsychologie-Bildungsberatung*)	Aim: to prevent violence, addiction and provide sex education. This national school psychology service aims to increase knowledge on protective- and risk factors for mental health, improve social competencies, school and class-atmosphere.	Pupils	
'We feel well' – mental wellbeing in healthy communities	Aim: to inform interested citizens about different ways to stay mentally healthy (stress-prevention, burn-out prevention, time-management, etc.) through lectures, workshops and courses.	Citizens and pupils (Implemented in 25 healthy villages and 6 schools)	1 year duration. Funded by the Carinthian Government and the Association Healthy Carinthia (*Verein Gesundheitsland Kärnten*), cooperating with institutions, citizens and pupils
"Gesunde Schule"	Aim: to promote sustainable and quality assured health promotion in Austrian schools. Includes a project website www.gesundeschule.at, information on the activities of the project partners in the area of healthy schools are presented.	Children of school age; Main Association of Austrian Social Security Institutions; Federal Ministry of Education, Arts and Culture; Federal Ministry of Health	Started spring 2007
Eigenständig werden (becoming independent) project	Aim: to combine personality development, health promotion, promotion of the life skills, prevention of addiction and violence in primary schools (children between 6-10 years). Evaluation results of the programme exist (surveys from October 2005 and June 2006).	Primary school children	Co-funded by the Austrian Health Promotion Foundation (FGÖ), Mentor Österreich and Rotary Österreich – Distrikt 1910, BMUKK and various regional offices for addiction prevention.

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
Weisse Feder (White Feather)	Aim: to provide pupils, parents and teachers with practical and effective tools for prevention and intervention. At the federal level, BMUKK runs this violence prevention programme. The "White Feather – Joining Forces for Fairness and against Violence" drive is based on an overall strategy for violence prevention and serves as the umbrella for 12 sub-projects that leverage violence prevention in diverse fields	School aged children.	Funded by the WHO and launched in 2007 by the Minister of Education.
Association of Austrian psychotherapists (Vereinigung Österreichischer Psychotherapeutinnen und Psychotherapeuten, VÖPP) and Viena Association for psychotherapy (Wiener Landesverband für Psychotherapie) in cooperation with the Austrian Association for child- and adolescent psychotherapy (Östereichische Vereinigung für Kinder und Jugendlichenpsychotherapie, ÖVK) and ökids	Aim: to broaden the social competencies of teachers and pupils and strive to achieve changes of related systemic concepts in the school-system. Joint organisation of events on the topic of "schools" to present school models promoting personal development in the international setting.	Teachers and pupils	

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
Network health promoting schools	Aim: to provide teachers and school managers on how to become a health promoting school. Information is provided online with a brochure: http://www.bmukk.gv.at/medienpool/14249/schrittfuerschritt.pdf (2001). Basic ordinance on health education published by the then Ministry of Education and cultural matters (Bundesministerium für Unterricht und kulturelle Angelegenheiten, BMUK) (1997)	Teachers and school managers	Since 1993.
"Social work at school" pilot project	Aim: to reduce school absenteeism and truancy. Initiatives in place in nearly all Austrian regions. Evaluation of the project is undertaken by the Ludwig Boltzmann Institute Health Promotion Research 2011-2012, which was commissioned by the BMUKK. More information on a research and benchmarking on early school leaving/drop out can be found at http://www.bmukk.gv.at/schulen/unterricht/ba/schulabbruch.xml (accessed 21.10.11)	School children	Funded by the European Social Fund. Started in 2009/2010.
Service Stelle Schule	Aim: to provide support via School service centres, available at eight regional areas providing counselling, guidance and support for planning and implementing school health promotion projects, information (brochures, health data, expert contacts, information on services and activities provided in each region and by all partners).	School children	
Project "Healthy School" (Wir bauen ein Seelenhaus)	Aim: to strengthen mental health in children in elementary school and improving their social competencies. Organised by AVOS and the Kuratorium für Psychische Gesundheit.	Primary school children	
Project "Vom starken Ich zum neuen Wir" (from the strong I to the new we):	Aim: to promote the integration of pupils within the class, strengthening social competencies, thereby improving the sense of community. Applied: play- and theatre paedagogics, 3-6 times for 2 hours.	Pupils aged 6-18 years.	

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
Project "FeelOK"	Aim: an internet-based programme for health promotion and prevention providing counselling and options for communication/ex-change for young people and teachers, covering topics such as smoking, love and sexuality, self-esteem, cannabis, stress, and internet for beginners. Implemented throughout Austria.	Young people (aged between 12-18 years); teachers	
KiVi (Kids Vital) in Vorarlberg	Aim: to provide a structured health promotion programme for schools with a high degree of participation in developing the programme. Includes physical exercise, nutrition, social wellbeing, relaxation, etc. through films, education, manuals, information, parents-meetings, personal letters for parents (different languages), training and posters.	School management, teachers, pupils, parents, families with a migration background / with a lower educational status,	Programme started in September 2000. Duration: 5 years,
Workplace			
FGÖ - workplace health promotion projects	Aim: to include mental health promotion, prevention of burn-out, mobbing prevention, social capital in the workplace. FGÖ supported the awareness campaign "Work in tune with life. Move Europe", organised by the European Network for Workplace Health Promotion. 40 Austrian projects nominated as models of best practice.	Employees	FGÖ funded
'Austrian Network for Workplace Health Promotion'	Aim: to provide counselling by work psychologists, information on burnout (how to prevent and deal with burnout), and information/services related to coping with stress and addiction. Brochures on psychosocial matters. Services provided by the Chamber of Labour.	Employees, Chamber of Labour	
Pro mente	Aim: to provide work assistance to support people in danger of losing their job due to mental or psychosocial problems, and for those looking for work who require psychosocial support (clarification of job-perspectives, conflict-management, problem solving at the workplace, etc.).	People at risk of losing their jobs because of mental health issues	

Programme name	**Aim/approach**	**Stakeholders/ target group**	**Duration, Cost of programme**
Fit2Work Initiative	Aim: to prevent early retirement due to mental illness. Project by the Federal Ministry of Labour, Social Affairs and Consumer Protection (BMASK).	Employees and employers	
Campaign '*I schau auf mi und di – for mental health*', organised by the Kuratorium für Psychische Gesundheit, the Chamber of Labour and the regional sickness fund.	Aim: to provide health promotion information. Services include: Presentations for companies, information material and a cabarett-DVD	Directors, managers, employees	
Prevention services provided by workplace physicians: 120 companies are offered services (in Vorarlberg)	Aim: to provide prevention and mental health promotion in employees. Presentations on coping with stress, work-life-balance, healthy management courses / seminars for managers psychological evaluation of mental burdens at work cooperation with Prevention Management Vorarlberg, especially in the areas of re-integration following work-leave after a mental illness	Employees and managers	
Chamber of Labour	Aim: to provide prevention and mental health promotion in employees. Services provided include: counselling by work psychologists, information on burnout (how to prevent and deal with burnout), and information/services related to coping with stress and addiction. Brochures on psychosocial matters include: Assessment of psychosocial burdens (2010), stress at the workplace (2010) or harassment and violence at the workplace (2011)	Employees	

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
"Healthy Management" programme in Carinthia	Aim: to deliver a workplace health promotion programme developed by the University of Klagenfurt (Institut Sozialwirtschaftliche Intervention). Target group: older collaborators within the management – aiming at developing a healthy and fair attitude among employees in time of increased job cutting. Partners: Carinthian Government, Alpe Adria University Klagenfurt, University of Applied Sciences Feldkirchen. Includes physical training, career training, relaxation programmes, communication training, meetings and supervision. Evaluation in process.	Employees	Duration: 2 years
Older people in long-term care facilities			
The Main Association of Austrian Social Security Organisations (http://www.hauptverband.at)	Aim: to increase autonomy for the residents and combines a number of approaches including also relatives and friends of the residents. Runs a project in three nursing homes in cooperation with Wiener Gesundheitsförderung and LBI Health promotion research.	Older people in nursing homes	
NGOs Diakonie and Caritas health promotion and prevention services	Aim: to care for older people and also provide health promotion and prevention services. This includes information campaigns on certain topics, raising awareness, providing services for people without social health insurance, for homeless etc.	Older people	
Pro mente services for people with dementia	Aim: to offers exchange meetings for persons with Dementia and their families "aktivtreff" and "Tandem", home visits (twice a week) for these persons offering them support and assistance in their own surroundings.	People with dementia and their families	
Hospiz Österreich	Aims: to runs a pilot in eight nursing homes introducing principles of palliative care and raising competence in care and attendance in terminal state of residents. A by-product of this project resulted in quality criteria on these issues which are enforced by the Austrian Ministry of social affairs.	Employees	

Other programmes			
FGÖ conducts public relation activities to raise public awareness concerning mental health	Aim: to raise awareness of mental health issues. An Austrian-wide awareness campaign 2004 "Schau auf dich" (Take care at yourself"). Developed and distributed a free brochure on "mental health" including information, advice and addresses.		Since 2003 -
BMWFJ: Project Elternbildung Education for parents	Aim: to prevent and promote mental health in children by educating parents A website providing information for parents (studies, brochures, events, courses, etc.) on educational matters (for ages ranging from babies to adolescents). Prevention topics include: conflict management, violence prevention, etc. It is implemented in all Austrian regions.		The programme has existed for about 10 years and is funded by the Family Equalisation Fund (Familienlastenausgl eichsfonds).
Events in Salzburg organised by the Kuratorium für Psychische Ge-sundheit together with cooperating partners	Aim: to improve mental health and burn-out prevention for teachers through presentations and seminars.	Teachers	
Sigmund Freud Private University (Vienna, Paris)	Aim: general prevention generally and to prevent relapse in those with mental illness. Psychotherapy, education and counselling services for all age groups and other specific groups.	All age groups; people in the workplace; those with drug use problems; migrants.	
A range of projects in Salzburg	Aim: to promote mental health of pregnant women -"Wie ich mich fühle" (How I feel). Prevention activities and psychological counselling for children of parents with a mental illness (JOJO project). The "Willkommen im Leben" project to help babies and their mentally ill mothers. Kinderseelenhilfe – services for children and adolescents with mental illness to improve their quality of life.	Pregnant women; mothers with mental illness and their babies; children and adolescents with mental illness.	

KIPKE project (Lower Austria)	Aim: to provide support for children of parents with a mental illness; to strengthen protective factors and enhance a child's resilience. Children are informed about the illness of their parents in a child-appropriate way and are informed about how to cope with acute episodes.	Children of parents with a mental illness (3-18 years). Children of clients visiting psychosocial services. Partners: Psychosocial Service of Caritas St. Pölten, Psychosoziale Zentren GmbH. Supported by NÖGUS.	Started July 2010
SAFE programme me	Aim: to promote a safe relationship between child and parents. Aimed at helping parents to be empathetic with their offspring, to provide support in difficult situations, to help parents understand their own attachment experience and how it can influence their behaviour towards their own children. Methods: 10 days of training before and after birth (parent groups) as well as a hotline for questions. Evaluation report: expected by end of 2011.	Supported by NÖGUS, organised by the Austrian Liga for child- and adolescent health.	January 2009-May 2011

Financial responsibility for prevention and promotion activities

The FGÖ funds and coordinates general health promotion and prevention activities at different levels and in a range of settings (national level). Various initiatives are undertaken by ministries or social insurance institutions (national and regional level). At regional level, the health departments and/or the departments for social affairs coordinate and fund a range of projects, including long- and short-term activities. Furthermore the communities and other organisations, such as non-governmental organisations (NGOs), organise and support projects.

Investments into mental health – health, education, social development and economic growth

It is not possible to identify the amount of money invested in mental health promotion and prevention. Even identifying the overall money spent on health promotion and prevention is a challenge.

Most of the funds spent on health promotion and health care prevention services mentioned above were spent on medical rehabilitation, preventive (periodic) health check-ups, measures improving the dental health status of the population, services related to the mother–child pass examination programme and vaccinations.

Based on the health expenditure data from Statistik Austria (based on the OECD System of Health Accounts), health expenditure on prevention and public health services amounted to €439 million in 2009 (about 1.9% of total public health expenditure).

The FGÖ, the national competence centre for health promotion, is allocated an annual budget of €7.25 million for funding projects related to health promotion and primary prevention, as well as for providing further education on these topics. The budget-share spent on mental health is not known.

Initiatives to strengthen mental health systems in relation to mental health promotion and prevention of mental illness

These are described above and largely concern the enactment of the Health Promotion Act, introduction of a number of key policies, investments and the establishment of the FGÖ to implement and finance general health promotion and prevention initiatives.

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4.2 Belgium

Authors

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Summary

- Mental health services in Belgium largely rely on psychiatric hospitals with alternative facilities and long term care centres for specific groups.
- A diverse range of community mental health services is available including centres for mental healthcare operated by a multidisciplinary team with an emphasis on treatment for anxiety, mood disorders and addictions. Other facilities include psychiatric nursing homes for the elderly and sheltered and family accommodation.
- Although there are alternatives to psychiatric hospitals, these have long waiting lists. This is in spite of maximum legal standards not yet being reached.
- Mental health prevention and promotion is not specifically provided for in Government legislation. However, it is delivered at community level, typically in mental healthcare centres. A range of activities target schools/young people, the workplace and older people.

Data for this country profile were gathered in the first instance by the project's country collaborator for Belgium. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Belgium. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them.

Completed and Validated 2012

Background information

Population (1 January 2011)	10,951,665
(July 2012 population estimate)	(10,438,353)
Population density Inhabitants per km² (2009)	356
Women per 100 men (2010)	104.1
GDP PPP (2010)	1.1
Psychiatric care beds in hospitals per 100,000 inhabitants (2012)	179.2
Standardised Suicide rate by 100,000 inhabitants	17.6
Gallup Wellbeing index (2010)*	
Thriving	56
Struggling	41
Suffering	3

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

New mental health legislation was enacted in 2000. This updated the previous 1976 law which had set a maximum number of psychiatric beds in mental health services. In 2007 new legislation was adopted which concerned the detention of people with a mental disorder. Specific legislative guidelines for child and adolescent disorders were introduced in 2002. Legislation also includes a General Hospital Act with provision for mental health.

There is no specific reference to prevention and promotion in mental health, and it appears that this is included within the existing mental health legislation.

Mental health policy and inclusion of prevention and promotion

Belgium has a national mental health policy, introduced in 1988 and a community mental health policy. A national mental health programme was developed in 1990. This reformed the provision of psychiatric care so that the most appropriate treatment was available for psychiatric patients. The reform aimed to reduce the number of psychiatric hospital beds and encourage the social integration of patients into mainstream care. As a result of the reform, a greater proportion of care was delivered outside psychiatric hospitals. In addition alternative facilities for mental health care, such as psychiatric nursing homes, sheltered accommodation and home care were developed. In 1999 further policy reform targeted improvements to intensive and specialist care in

psychiatric hospitals, cooperation between intra- and extra-mural / community services and continued the shift from hospital and care beds for older people to psychiatric nursing homes and places in sheltered accommodation.

In 2002 ministers responsible for Public Health, Health Policy and Social Affairs signed a Joint Declaration on the future policy for mental health. According to this Declaration (and the 2004 amendment) future acute and chronic mental health care were to be organised through "*care circuits*" and "*care networks*", bringing mental health care as close as possible to the needs and demands of people with mental health problems. This approach intended to avoid as far as possible admissions to residential (or inpatient) units. However, when hospitalization is unavoidable, efforts are to be made to keep inpatient stay as short as possible.

A care circuit covers the full range of mental health provision tailored to the specific needs of a target age group. It provides all possible care modules for people with mental health problems belonging to a specific age group: children and adolescents, (young) adults or the elderly.

Each care circuit is organised through collaboration between care providers. Such cooperation is consolidated in a care network: a network of care providers which brings together one or more care circuits. The concepts of 'care system' and 'care networks' are included in Article 11 of the Law on Hospitals and other Healthcare Facilities.

In 2009, the Conference of ministers, responsible for Public Health, began trialling care circuits for adults and adolescents. A call for projects was launched in 2010 following an information campaign. Ten projects were approved to start in 2011, with 9 other project to start in 2012. Care circuits and care networks are to be developed in 19 regions which represent about 2/3 of Belgian territory.

The most prominent reference to prevention and promotion of mental health in Belgian health policies is found in the Flemish action plan for suicide prevention (2002 and 2012-2020 plan). The goals of this policy/plan aims are to:

- promote the mental health of the population;
- maximise the care offered to people at risk of suicidal behaviour;
- develop networks to enable follow-up with patients at risk;
- offer support to and share relevant knowledge and information with other carers;
- advocate for suicide prevention within local networks.

A number of policies also refer to schools, the workplace and nursing homes. There are several duties concerning mental health promotion and prevention. Since 2007, schools must include mental health in their general health policies. In the workplace there is a policy concerning the promotion of wellbeing and prevention of the psychosocial

distress caused by aggression, harassment and sexual intimidation. For nursing homes a policy introduced in May 1999 states that the Centres for mental health care should draw particular attention to older people (aged 60+).

Other policy initiatives in the Flemish action plan include building resilience for people in poverty (2010-2014) and assisting people with mental health problems find work through, for example, career guidance, and employment in a social economy or sheltered work.

Mental health services

Organisation and functioning of mental health systems

Belgium is developing more community-based mental health care and moving from a supply-driven, mostly residential mental health services towards a more differentiated demand-driven mental health care. This new mental health care provision is based on the needs of people with mental health problems, taking into account their existing circumstances and environment as starting point.

The types of mental health services available in Belgium are: psychiatric hospitals; psychiatric departments in general hospitals; Centres for mental health care (providing ambulatory care, consultation or a home visit); psychiatric nursing homes; and facilities for sheltered accommodation. There are also rehabilitation centres (for addiction problems, day centres, crisis intervention and therapeutic communities), psychiatric home care and private practices.

- Inpatient care: The total number of psychiatric inpatient beds for January 2012 was 18,705 (179.2 per 100,000 population); 15,364 of these psychiatric beds were located in 67 Psychiatric Hospitals, with the remaining 3,341 psychiatric beds in 66 General Hospitals with psychiatric departments.

  In 2008, there were 68 psychiatric hospitals (38 in the Flemish region, 10 in the Brussels- Capital region and 20 in the Walloon region), with a total of 221.0 beds per 100,000 population. Psychiatric departments in acute hospitals reserve 10% of their beds for part-time admission and short term treatment. Alternative facilities to hospitals include day and night hospitals, long-term care centres for specific groups, such as the elderly and people with mental illness.

- Community mental health care: The number of Centres for mental health care is 20 in the Flemish community and 63 in the Walloon Region providing outpatient services (2012). A multidisciplinary team provides both treatment (mostly for anxiety, mood

disorders and addictions) but also prevention of problems through early detection and early intervention support. Many Centres also provide programmes for children and adolescents. There are also centres for mental health rehabilitation.

- Psychiatric nursing homes: These facilities are for people with a stable but long-term mental health problem not requiring hospital treatment. There are 42 psychiatric nursing homes: 5 facilities (252 beds) in Brussels, 24 facilities (2,230 beds) in the Flemish community and 13 facilities (801 beds) in the Walloon Region.

- Sheltered housing and family accommodation: There are 45 facilities in the Flemish community (2,605 beds), together 27 facilities (764 beds) in the Walloon Region and 16 facilities (471 beds) in Brussels (2009). Accommodation is also provided for people with mental health problems within a host family. This traditional form of care includes 770 family accommodation places in the Flemish region and 120 in the Walloon region in 2003.

Access and usage

Access to mental health services are ideally through a GP. Since 2000 admissions to psychiatric hospitals have gone from 0.85 per 100,000 population in 2000 to 0.91 in 2006. Centres for mental health care are designed to see patients with serious mental illness or at risk of developing one.

Variation and gaps

There are long waiting lists for the residential alternatives to psychiatric hospital, namely psychiatric nursing homes and sheltered living, even though the legal maximum standards not yet have been reached.

Financing

Mental health expenditure is 6% of total health budget. In 2009, health expenditure as a proportion of GDP was 11.8%. Mental health services are mainly financed through social insurance, private insurance, out of pocket expenditure by the patient or family, and tax-based funding.

Mental Health Workforce

The number of psychiatrists per 100,000 population is approximately 18 (World Health Organization, 2005); more recent figures are not available. According to the World Health Organization Mental Health Atlas (2011) for the Wallonia region (per 100,000 population) there were:

0.04	Mental health nurses
1.34	Psychologists
0.89	Social workers
0.03	Occupational therapists
1.46	Other health workers

Responsibility and delivery of mental health promotion and prevention of mental illness

Prevention and promotion of mental health appear to be integrated within community mental health services such as centres for mental health care. A number of related health policies require schools, workplaces and nursing homes for older people to incorporate within their practices.

Mental health status

Prevalence of mental health in the population

Data for 2008 show that just over a quarter (26.0%) of people aged 15 and above, have some form of psychological distress (as measured by the GHQ), with 14.2% potentially having a serious mental health problem, and a 9.5% prevalence of depression. Mental health for this group appears to have worsened when compared with figures from a similar survey conducted in 2004 (HiT, 2010). Indicators for mental health, for selected years between 1997 and 2008 are as follows:

	1997	2001	2004	2008
Mean GHQ-12 score of psychological distress	1.6	1.3	1.3	1.4
Psychological distress (GHQ score 2+) (% of the population)	31.1	24.8	24.5	26.0
Probable mental disorder (GHQ score 4+) (% of the population)	17.2	13.2	12.7	14.2
Prevalence of depressive disorder (% of the population)	–	8.6	8.0	9.5
Reported depression in the last 12 months (% of the population)	6.5	6.3	5.9	6.1
Lifetime suicidal ideation (% of population)	–	–	12.2	11.7
Lifetime suicide attempt(s) (% of the population)	–	–	3.7	4.9

Source: IPH 2010a. *Note:* GHQ: General Health Questionnaire.

Additional prevalence data is available from the minimum psychiatric data (Minimale Psychiatrische Gegevens/Résumé Psychiatrique Minimum, 2006) of people registered in residential care. 33,353 people suffered from substance abuse (or 35% of the total number of admissions into hospital).

- Dementia - In 2010, there were 101,000 people with dementia in Flanders (Van Deurzen, 2010) and estimated to be 9.3% (or 161,000 people in 2001) for those aged 65 years and above.
- Substance misuse - Data from ambulatory care of the centres for mental health care (2009) reveal that 10% or 5,000 people were treated for substance misuse.
- Psychosis – 15,247 people suffered from psychosis (or 16% of the total number of admissions into hospital). Data from ambulatory care of the centres for mental health care (2009) reveal that 110,000 people (22% of their service users) were treated for psychosis.
- Schizophrenia, schizotypal and delusional disorders - Data from ambulatory care of the centres for mental health care (2009) reveal that 1,500 people (3% of their service users) were treated for psychosis.
- Mood disorders – 20,012 people suffered from mood disorders (or 21% of the total number of admissions into hospital). According to the National Health Interview Survey (2008), 8.2% of the Flemish people and 11% of the Walloon population reported depressive symptoms in the 12 months previous to the interview. Depressive disorders were less common, with 6% of the Belgian population reporting a depressive disorder in the last year (Flanders= 5.1%; Wallonia=7.3%).
- Neurotic, stress-related and somatoform disorders - Data from ambulatory care of the centres for mental health care (2009) show that 10% of service users (5,000 people) were treated for psychosis.
- Conduct disorders - Estimates of the prevalence of ADHD among children between 6 and 12 years old range between 4.2% and 26%. Most estimates fall within the range between 5 and 10%. ADHD among the adult population occurs in 4.1% of the cases (De Ridder, Bruffaerts, Danckaerts, Bonnewyn, De Myttenaere, 2008).

Incidence

Not reported.

Protective factors

Social support, higher education.

Risk factors

Divorce, unemployment, sexual identity (being gay or lesbian), ethnicity (being an immigrant), urban living and loss of a friend, close relative or traumatic event.

Prevention and Promotion programmes /activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Prevention coaches in schools	Aim: to deliver mental health policies in secondary schools. Approach: One prevention coach for every province who support the delivery of mental health policies in secondary schools.	Students in secondary schools; Centre for guidance of students (CLB) and local health networks (LOGO's)	3 years
An integrated health policy paying attention to mental health, substance abuse, harassment and violence.	Aim: to detect mental health problems early and recognize the signs. Approach: Teachers take part in 3 day-training. They screen students and refer to professionals if problems are identified. Also, to raise awareness of services providing mental health care and improve communication between schools, higher education, psychiatric and social services.	Children and young people	
Various school programme activities	Aim: to contribute to the promotion of mental health through a positive school atmosphere – increase social integration. Approach: By creating peer support systems, reduction of academic stress and development of personal characteristics.	Children and young people	
Workplace			
Prevention advisors for psychosocial wellbeing in the workplace	Aim: to increase psychosocial wellbeing in employees. Approach: External companies provide prevention advisors who work with a company of medical		

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	officers to deliver wellbeing, deal with formal complaints, attempt reconciliation and resolve issues in the workplace.		
Work based risk analysis – an annual action plan	Aim: to counter stress, interpersonal and group conflicts, violence (verbal and physical aggression, harassment and sexual harassment at work. Approach: Using risk analysis looking specifically at: job content, conditions of employment, circumstances of the employment and employment relations.	Employers and employees	5-year action plan
Various work-based policies	Aim: to improve work/life balance. Approach: Includes parental and care leave arrangements, affordable crèches, flexible working hours, anti-smoking campaigns, mindfulness at work that increase concentration and lead to less work related stress, exercise activities etc.	Employees	Continuous
Older people in long-term care facilities			
'Coming home' project	Aim: to prevent depression and dementia in older people. A project of the elderly team of the centre for mental health care Brussels among (new) residents of nursing homes. Approach: By means of the game 'Ganzebord', residents make a life review and talk about former experiences in different life stages. This takes place in 10 sessions. It helps new residents with the	Older people in care homes	

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	transition to their stay in the nursing home.		
General projects for adolescents			
Anti-bullying campaign week across Flanders	Aim: to prevent bullying in schools. Approach: Various national campaigns in schools, training for children and young people, and competitions.	Children and young people	Launched February 2012
'Fit in je hoofd' (a healthy mind)	Aim: to prevent mental illness in adolescents. Approach: A website with a test comprising of 10 evidence-based steps to guide the person towards a better mental health. The test includes themes such as mental resilience, depressive symptoms, symptoms of generalized anxiety, stress and other mental health problems.	Adolescents	Launched May 2006 and February 2009
NGO activities and initiatives	Aim: to reduce stigma of discrimination for people with mental illness. Approach: Ranges from telephone helplines for children and adolescents. Websites for happiness - "Pluk je geluk" (pick your luck), campaigns for destigmatising mental illness and support for relatives of people who have committed suicide.	General population to specific groups such as young people and adolescents	

Financial responsibility for prevention and promotion

(see below)

Investments into mental health – health, education, social development and economic growth

Both Flemish and French communities have defined prevention and promotion policies over the past 5 to 10 years. These policies have included targets to prevent depression and suicide (Flemish community), and to promote mental health and well-being (French community) in parallel with other public health objectives. In the Flemish community meeting these objectives has been through collaboration with a range of organisations – e.g. supporting working group, partner organisations, centres of expertise in healthcare prevention, healthcare workers, other governments and local health networks (LOGOs). Delivery of health promotion work at the district level is by LOGOs who include health and welfare workers. However, in 2010 the number of LOGOs was reduced from 26 to 15.

In the French community health promotion at the local level is organised and coordinated by the Local Centres for Health Promotion (CLPS); and in the German community health promotion objectives (including promotion of mental health and well-being) is supported by the Council for Health Promotion and the Service for Child and Family at local level, who also co-finance non-profit making organisations.

Benefits to be expected

Prevention of mental illness and promotion of mental health are expected to help dispel the 'taboo' and stigma surrounding mental health problems and increase educational attainment in children with learning disabilities. In the workplace it hoped that programmes would lead to reduced absenteeism and help people get back to work after a period of absence due to mental illness. There is a growing awareness of mental health issues, alongside physical health problems, for people who are entering and resident within nursing homes and the need for provision of appropriate counselling when needed.

Initiatives to strengthen mental health systems in relation to MHP and PMI

Due to Belgium's ageing population, the policy recommendations are to invest in continued care for older people, as often they are overlooked by organised care. Problems such as loneliness or social isolation are more prevalent in this group and the Federal Government wishes to create more capacity and multidisciplinary teams (geriatricians, neurologists, mental health specialists and the staff of the nursing homes) for the elderly. Moreover, the aim is to improve coordination of the services of different care providers and in collaboration with primary care to improve support for older people who continue to live at home.

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4.3 Bulgaria

Authors and validation

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Summary

- Mental health inpatient services are generally split between psychiatric dispensaries, psychiatric hospitals and departments within general hospitals.
- Mental health care is provided through a number of centres for mental healthcare, sheltered homes, day centres, social care homes and transitional residences exist.
- Outward migration of mental health specialists (both psychiatrists and psychiatric nurses) and the lack of adequate training for mental health nursing have led to a significant shortage of mental health professionals.
- There is a considerable lack of community-based mental health services, particularly for those with more severe problems and many institutions operate in isolation with little coordination with others.
- Very little attention has been given on prevention of mental illness and promotion of mental health both at policy level and in terms of activities on the ground, although a small number of programmes were reported in schools and the workplace.

Data for this country profile were gathered in the first instance by the project's country collaborator for Bulgaria. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from Bulgaria. This expert provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by the Governmental expert and a final version validated by them.

Completed and Validated 2012

Background information

Population (1 January 2011)	7,504,868
Population density Inhabitants per km^2 (2009)	68.3
Women per 100 men (2011)	106.8
GDP PPP (2010)	0.9
Psychiatric care beds in hospitals per 100,000 inhabitants (2011)	63
Standardised Suicide rate by 100,000 inhabitants	9.4
Gallup Wellbeing index (2010)*	
Thriving	6
Struggling	58

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

No specific mental health legislation exists in Bulgaria. The Public Health Act (passed in 1973) sets out the rules for involuntary admission. A subsequent Health Act in 2004 includes a separate chapter on mental health which provides details on compulsory treatment, obtaining informed consent, definition of mental health services and institutions responsible for patients' rights.

Inclusion of mental health promotion and mental illness prevention are in part covered by Regulation 24 of 07 July 2004 which assigns these activities to different health specialists. Psychiatric specialists, doctors and other supporting staff from centres for mental health should be involved in providing health education for the general public and existing patients covering topics relating to risk factors, healthy lifestyle and behaviour, recovery of mental health and mental illness prevention.

A national suicide prevention Programme has been set out, although at present this has not reached an active phase.

The main responsibility for mental health and mental health services rests with the Ministry of Health and other related Governmental Institutes within the Ministry of Health, in particular the National Centre for Public Health Protection, other agencies that are involved include the:

- Ministry of Health for inpatient psychiatric care;
- Ministry of Labour and Social Policy for day care centres, supporting housing and social and nursing homes;

- Ministry of Education and Science for the specialized schools;
- Municipalities for outpatient care in the dispensaries; and
- Private sector for most psychiatric outpatient care

Collaboration between Ministries has proved difficult. To improve this situation the Ministers of Health and Labour and Social Policy signed a Framework agreement (on 13th of January 2006) establishing the rules for collaboration and the obligations between the ministries for the deinstitutionalisation of services for people with mental disability/severe mental disorders. Key to this endeavour has been a strengthening the policy ties between different ministries, Ministries of Health and Labour and Social Policy, Education and Science and Finance. Without this essential cross-government collaboration the successful transfer from institutional care to community-based mental health services is virtually impossible.

The Ministry of Health has not defined a specific department for mental health but is supported by the National Council for Mental Health Care, which started its work at the beginning of 2006, and the National Consultant for Psychiatry. The National Centre for Public Health and Analysis has a functioning role for mental health, including the planning and implementing of preventive measures and promotion of mental health, but it does not have decision making powers. There is also a lack of financial support for the proposed programmes for prevention and promotion.

The role of regional governance is limited. The main agencies are the Regional Health Centres, which are part of the Ministry of Health, and have two main tasks: to collect information from health facilities in their region and to oversee these services and health professionals.

Mental health policy and inclusion of prevention and promotion

The Mental Health Policy of Republic of Bulgaria was approved in 2004 together with an Action plan for 2005 to 2012. It prioritised equal and adequate access to mental health care for people with psychological problems; the establishment of a comprehensive system of community-based mental health services; the integration of mental health services within the general health system; and other changes. The National Health Strategy 2008-2013, adopted by the Ministry of Health in 2008, makes health promotion and disease prevention a priority objective, but does not include reference to mental health.

There is also a “National Strategy against Drugs 2009-2013“, which is being implemented via the National Addictions Centre.

Mental health services

Organisation and functioning of mental health systems

Mental health care includes both inpatient and community services. The system is predominantly institutionally based despite policy seeking to establish more community-based care. Municipalities are responsible for organising community based services. Outpatient visits usually take place in psychiatric dispensaries and less often in day care centres and supporting housing. Collaboration between health and social care sectors at municipal level is relatively weak and often problematic. However, there are some proposals to enhance the role and responsibilities of municipalities in organising mental health services in view of the general process of decentralization currently underway.

Mental health inpatient services include:

- 12 - Psychiatric dispensaries, with total capacity of 1,500 beds, also provide a national network of outpatient office-based services.
- 12 - Psychiatric hospitals, with total capacity of 2,685 beds. Nine are situated in Northern Bulgaria and three in the South and financed directly through the Ministry of Health Budget. The amount of resources provided for these is usually determined by the historical budget taken together with the index of the officially recorded inflation. These hospitals fall outside the overall scheme of health protection, (i.e. they do not have contractual relationship with the National Health Insurance Fund (NHIF), and have no care pathways. These hospitals have a special regime and the regular governance mechanisms do not apply to them. This in turn leads to the persistent delay in reform and innovations in the psychiatric field.
- 21 - Psychiatric departments (Multi-profile hospitals for active treatment (MPHAT)). These departments receive their finances based on the number of patients. However, due to the low incomes coming from the NHIF and the protracted stay of their patients, these departments are not that appealing to the hospitals, as they bring much lower incomes, compared to the other specializations.
- There are number of University psychiatry clinics with complex financing systems and usually at a disadvantage compared to the other university clinics who receive financial contributions via the care pathways.

All mental health institutions function in an environment of high deficit. Mental health has been prioritised in policy programme and the law; however there has been no financing for the development of activities such as rehabilitation of people suffering from mental illness; mental health centres for children and adolescents; inter-regional specialized expert medical commissions; forensic psychiatry etc. Instead these services

are regarded as a financial burden by the structures responsible for them and the resources delegated to mental hospitals, dispensaries and MHATs reflects the numbers of patients rather than the amount and quality of the services performed.

Out-of-hospital mental health services are performed by specialists who work with the NHIF. The centres for mental health which are a specific part of the health system with a number of special tasks comprise of:

- 12 - Centres for mental health care with 1,450 beds in 2010; and 1,328 in 2011 (National Statistical Institute, 2012).
- 11 - Functioning sheltered home programmes for people with SMI with a total capacity of 102 people
- Less than 20 - day care centres, each one with an average capacity of 25 persons. (Missing link, 2010)
- 100 - Social care homes for adults with dementia, elderly people and people with physical and sensor disabilities, with a total capacity of 6,072 people
- 2 - Transitional residences for adults with mental disorders with capacity for 9 people in all. Ideally, this kind of service should be in the community but both are based in the grounds of psychiatric institutions.

Primary health care plays a limited role in the treatment of mental health problems, including common mental disorders such as depression and anxiety. There is a lack of supportive liaison (except among some single Balint groups – groups for professional support and internal supervision) between primary and secondary care, with no opportunities to discuss criteria for referral, communication, shared care, guidelines or difficult cases.

Access and usage

Access to specialist services is by referral through General Practitioners in primary health care. GP referrals to specialist services operate through a system which limits the number of referrals that can be made each month, and the amount of information regarding possible diagnosis or therapeutic advice that can be shared when communicating with secondary care professionals.

Access to mental health services for people with severe mental illness can be difficult for various reasons, including a lack of available services, such as social care services; lack of help from other specialists; stigma; bureaucratic procedures; lack of information; and issues related to the condition.

A National representative study of common mental disorders (EPIBUL), with a sample of 5,318 respondents aged over 18 years, interviewed between 2003-2007, found that the most common medical treatment (in the 12 months prior to interview) was for people with panic disorder (59% of cases). The treatment gap for people requiring specialist care is also notably high. For example, data from the EPIBUL study shows a high prevalence of PTSD (post-traumatic stress disorder) but the annual turnover of people with PTSD to a general practitioner is 31.7%, and to a psychiatrist only 3.7%. The contributing factors accounting for this large treatment gap include low education, low income, stigma and the lack of social inclusion. Women were twice as likely to receive less adequate care compared to men; although men were less inclined to admit to a mental health problem and to seek help.

Variation and gaps in services

The lack of community-based mental health services, particularly for severe mental health problems is considerable and many continue to be treated in hospital and institutions. Many institutions operate in isolation with little coordination for the provision of care or planning services. There is also an uneven distribution of all psychiatric services nationally, including inpatient and outpatient services. The distribution of psychiatric services is characterised by the presence of large hospitals located in some areas while other parts of the country have limited numbers of inpatient and outpatient services. Psychiatrists are mostly concentrated in larger cities. There are no defined catchment areas for services and as a result patients are able to use any hospital or psychiatric dispensary they prefer.

Financing

The proportion of GDP spent on healthcare: planned budget expenditures for 2012 - 4.0 % (3,261 billion Leva). The proportion of healthcare expenditure/spending on mental health care: about and less than 2% from the expenditures on healthcare.

National Health Insurance Fund is the main source of funding for health services generally. Expenditure for mental health services is complex and mixed. All psychiatric inpatient services (in mental hospitals, psychiatric dispensaries and psychiatric wards in general hospitals) are financed by the Ministry of Health. The financing of psychiatric inpatient care differs from the financing of somatic inpatient care which is financed by the National Health Insurance Fund (NHIF). Financing of psychiatric inpatient care is based on the number of admissions, which encourages ‘revolving door’ admissions.

The 12 dispensaries are funded through the local municipalities with ear-marked money from the State. There has been a trend towards privatized care for psychiatric services where private offices or Centres are now replacing the former policlinics. Private psychiatrists usually enter into contracts with the health insurance fund, although part of

their work is based on out-of-pocket payments by the users of these services. A major part of psychiatric outpatient visits therefore is funded by the National Health Insurance Fund, although this fund does not cover long-term therapies.

Around 20% of the population (approximately 1 million inhabitants, often those that are poor with a high prevalence of mental illness) are not insured and only entitled to free emergency health care or pay out of pocket expenses for non-emergency treatment.

Day care centres, clubhouses and supported housing which form an essential part of community-based mental health services are delegated to the sector of social welfare and the main funding should be from the municipalities and Ministry of Labour and Social Policy.

There is no funding for psychiatric rehabilitation. The Bulgarian Psychiatrist Association's (BPA) has proposed a scheme on 'Modifying the Financing Scheme in the Field of Mental Health Care'. The Proposal aims at improving the quality of psycho-medical services and overcoming the present problems in this field.

Mental health workforce

Figures for 2009/2010 include a total of: 519 – psychiatrists; and 1095 – of all psychologists. According to the World Health Organization Mental Health Atlas (2011) there were (per 100,000 population):

6.75	psychiatrists
431.01	nurses
0.91	psychologists
0.36	social workers

There has been significant migration of mental health specialists from Bulgaria to other EU countries in Central and Northern Europe. In 2004, there were a total of 610 psychiatrists, already well below the European average, and by 2009/2010 reduced to 519 psychiatrists (a decrease of 14.9%). This shortage of psychiatrists is particularly notable in community-based mental health services.

There is lack of trained psychiatric nurses, due to a lack of adequate mental health training or accredited specialisation, which is also impacting negatively on mental health care in general and in the development of community based care. Nurses presently working in psychiatric settings have low status.

Social workers work both in the mental health care under the Ministry of Health as well as in the day care centres and supported housing under the Ministry of Labour and Social Policy. The social workers are the main professional mostly involved in psychosocial rehabilitation, but they too are lacking in number. There is an urgent need for launching curricula for psychosocial rehabilitation at all levels.

Responsibility and delivery of mental health promotion and prevention of mental illness

Existing mental health services are focused almost exclusively on diagnosing, treating and managing mental illness and it is likely that few prevention and promotion activities are performed by mental health and social care professionals. However NGOs are also involved in mental health and their work does include promotion of mental health, prevention of illness, along with advocacy, training of psychiatric nurses, treatment and rehabilitation.

There are some mental health promotion and prevention activities, but there is no systematic or planned approach. Some NGO's, such as the Global Initiative of Psychiatry (Helsinki Committee), are active in the areas of advocacy and anti-stigma and discrimination. One potential approach for developing mental illness prevention and mental health promotion activities and support the process of deinstitutionalisation, would be to include a specialist at regional and national level with administrative responsibilities to develop, coordinate and support promotion and prevention initiatives; using 'ready-made' models; that are disseminated through existing relevant networks.

Mental health status

Prevalence of mental health in the population

There is a high level of hidden mental disorder in the population. According to findings from the EPIBUL study the mean statistical risk for developing a mental illness in the population is 19.5%. One in five residents has experienced some form of common mental health problem during their lifetime; the prevalence for which is shown to increase with age, except for people above the age of 65 years where it decreased.

The lifetime prevalence for anxiety disorders is 11.4% and the 12-month prevalence rate is 7.6%. The relevant data for the affective disorders are 6.2% for lifetime prevalence and 2.8% for 12 month prevalence. The lifetime prevalence of PTSD is 1.9% and the twelve-month rate is 1.2%. In impulse-control disorders the lifetime occurrence is 1.1% and the twelve-month is 0.8%, respectively. In substance use disorders the values are: 3.3% - lifetime prevalence, and 1.2% for all types of substances. The risk of developing two

common mental disorders is 5.4%; and 1.9% for three disorders. However, the risk was lower in older people over the age of 65 years.

Data from 2008 on the percentage of people in the general population who have used medicines prescribed by a doctor by diagnosis is:

- 3.2 % - for depression
- 8.2 % - for anxiety disorders
- 1 % - for chronic depression

Historically, the prevalence of mental illness rose from 2,656.7 per 10,000 cases in 1990 to 2,892.1 per 10,000 in 2004, and subsequently to 2,287.7 per 10,000 in 2006. For people with schizophrenia and schizotypal personality disorders the number was 388.2 per 100,000 cases; and 234.8 per 100,000 cases for those with affective disorders.

According to the National Centre of Public Health and Analysis the number of suicides in Bulgaria for 2011 is 796 with 3,153 registered suicide attempts. The ratio is approximately 4:1, which does not correspond with the data from the literature, giving a ratio of 6 to 25:1. Most attempts are by people aged between 15 to 45 years. The ratio for suicides in men/women with is 3.3:1, and the ratio is 1.36:1 for women.

Incidence

No data reported

Protective and risk factors

Risks include drug use, although data are very limited in this area.

Prevention and promotion programmes /activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Schools without violence	Aim: to prevent violence. A pilot initiative in 6 schools in the city of Sofia.	Children	Funded by UNICEF at a cost of 42 000 BGN
Department for Information and In-Service Training of Teachers (DIUU)	Aim: to offer mental health promotion information for educational policies through distributing examples of good pedagogic practices to	Children, adolescents, parents and families	

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	develop personal potential and performance of adolescents; life skills; and positive interaction between school and parents/family.		
Workplace			
ViK-Iovkovtsi, Veliko Tarnovo Two-phase programme for key competencies training and enhancing knowledge skills	Aim: to enhance competencies and skills. Key competences training: teamwork skills and conflict management in teams; communication skills and customer services, leadership skills.	Employees, ministry of Labour and Social Policy, National Employment Agency	2009-10 – funded by the ESF and supported by the Ministry
'Move Europe – Healthy Lifestyles in the Working Environment'	Aim: to promote healthy lifestyles. Mental health promotion in the workplace and exchange of good practice.	Employees, managers, companies	Running since 1998. ESF funded
Older people in long-term care facilities			
No relevant programme found			
Related programmes			
National Employment and Training Programme for Persons with Permanent Disabilities	Aim: to increase the employability and ensure employment for all those registered with the 'Labour Office' Directorate (e.g. those with permanent disabilities, or people successfully completing addiction treatment.	People with disabilities, drug addiction	
Programme established under the National Strategy against Drugs 2009-2013	Aim: to set up information programmes; telephone hotline for advice; consultations for families; centres for prevention; special education for experts on the treatment of the addictions; rehabilitation; analysis of data and studies.	People with addiction problems; professionals working in substance misuse	

Financial responsibility for prevention and promotion

There is no specific budget for mental health promotion and mental illness prevention.

Investments into mental health – health, education, social development and economic growth

None identified.

Initiatives to strengthen mental health systems in relation to MHP and PMI

The Ministry of Education, Youth and Science (MEYS) is preparing a new Law on preschool and school education. At present, work is being done to separate the function of the pedagogical advisor and that of the school psychologist. The goal is to 'optimise the work on mental health in schools and to implement a bio-social approach when working on school cases.' There are two current proposals for children that aim to incorporate screening/early detection of difficulties in children in all kindergartens ("Programme for Screening of Children Aged 0-3") and to provide appropriate input to children with existing behavioural, emotional and social problems or at risk of developing these (the Standard for Integrating Education).

Another proposal is "The National Programme of Republic of Bulgaria on Suicide Prevention and Prophylactics of Republic of Bulgaria 2010–2016". This was prepared by experts from the National Centre for the Protection of Public Health in 2010 with the aim of limiting attempted suicides and to reduce the suicide rate. However, the Programme has not yet been adopted by the Ministry of Health. Some practical aspects of the Programme are being implemented on a voluntary basis by mental health experts of the department of the National Centre for the Protection of Public Health.

The main difficulty, however, is that no budget has been allocated for the above mentioned projects.

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4.4 Croatia

Authors and validation

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Summary

- Mental health legislation, national strategies and policies are well-developed, but the implementation is impeded in areas where it relies on financial resources.
- Psychiatric hospitals and departments and university hospitals are distributed across the country. Some facilities have bad building conditions and over-occupancy of rooms. Inpatient facilities represent a large part of mental health services, as the development of a broader range of local community services has just begun.
- Institutionalized mental health care largely provides similar and standardized diagnostic and treatment options across the country and for all patients. Modern pharmacotherapy is available everywhere, but psychotherapy is limited by a lack of therapists in some regions.
- There is a significant gap in supply of both hospital and community child and adolescent psychiatric services.
- Community mental health services are at an early stage of development. A network of centres for mental health is available in every county, but ensuring sufficient staff and funding resources is often difficult. The centres stress prevention, counselling, early recognition, treatment, public education and joint programmes in schools and local communities; particularly in the field of drug and alcohol abuse.
- Basic health insurance is obligatory for all and covers the costs of care for all mental illnesses and the cost of psychotropic medication.
- A range of prevention and promotion programmes were reported with particular emphasis on children and young people; however these lack proper monitoring and evaluation. Funding for NGO mental health promotion and prevention programmes is from governmental and local community funds.
- There is a lack of community-based psychiatric services, such as day care centres, home visits, other psychosocial interventions and half-way, sheltered and assisted houses, especially for people with long-term mental illness.
- Although prevention activities for older people tend to focus on somatic illnesses, individual activities in long term care facilities exist including initiatives for art and music therapy and socio-therapeutic groups. Mental health promotion in workplace largely depends on company initiatives.
- The cooperation among sectors (health, social care, education, work and employment and other relevant sectors) is often formal and there is a need for true synergy in planning, implementation and follow-up of activities.

Data for this country profile were gathered in the first instance by the project's country collaborator for Croatia. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Croatia. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated 2012.

Background information

Population (1 January 2011)	4,290,612
Population density Inhabitants per km^2 (2010)	78.1
Women per 100 men (2011)	107.2
GDP per capita (2010)	5.1 (10.394€)
Psychiatric care beds in hospitals per 100 000 inhabitants (2010)	96.6
Standardised Suicide rate by 100 000 inhabitants (2010)	14.7
Gallup Wellbeing index (2010)	
Not available	

Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Some elements of mental health promotion and prevention of mental disorders are integrated into national legislation and various policies. The new Health Care Act was enacted in 2008 and last revised in 2012. Mental health care is provided as part of primary, secondary and tertiary health care by the Croatian Institute of Public Health and health care institutions.

The rights of people with mental disorders are also protected by the Law on the Protection of Persons with Mental Disorders, enacted in 1997 and last revised in 2002. The Law requires the use of least restrictive procedures; as such involuntary admission to hospital for people with mental illness is only allowed in cases that require immediate intervention to prevent death or serious harm to the patient or others or to prevent serious deterioration of the patient's clinical state; or upon court order. Involuntary admission is time limited and must be ceased once the risk of danger has passed.

Involuntary hospitalisation must be reported via the court who: 1) must visit an involuntarily admitted person within 72 hours, 2) name an independent expert psychiatrist who is required to give an expert opinion regarding the necessity for involuntary hospitalisation; and 3) must make a decision regarding involuntary hospitalisation within eight days.

The new Law on Social Care was enacted in 2012. The Law covers a range of services that are important for mental health prevention such as psychosocial counselling, early childhood intervention and social inclusion. Community services and civil society participation are also promoted by the Law.

Mental health policy and inclusion of prevention and promotion

The most recent mental health policy is the National Mental Health Strategy 2011-2016. The strategy objectives are: the promotion of mental health for all; addressing mental health disorders through preventive activities; promotion of early intervention and treatment of mental disorders; improving the quality of life of persons with mental health disorders or disability through social inclusion, protection of their rights and dignity; development of the information system, research and knowledge in the field of mental health. There are six priority areas: 1. Promotion of mental health of the general population; 2. Promotion of mental health in specific ages groups and vulnerable populations; 3. Promotion of mental health at workplace; 4. Addressing mental ill health through prevention, treatment and rehabilitation; 5. Community mental health care; 6. Cross-sectoral collaboration, information and knowledge exchange, research.

The Strategic Plan for the Development of Public Health for 2011-2015 includes goals concerning mental health promotion, prevention of mental illness, improving the quality of life of people with mental illness or disability through social inclusion and protecting their rights. However, action plans, funding and outcome indicators have not been set and the new Strategic plan 2012-2015 is still being developed.

Many other policies have also been developed which include elements of mental health promotion and prevention of mental illness: The Strategy of Development of Croatia in 21st century"; National Sustainable Development Strategy accepted in 2009; National Population Policy; National Family Policy; National Gender Equality Policy 2011-2015; National Strategy on Equal Opportunities for Persons with Disabilities 2007-2015; Joint Memorandum on Social Inclusion; National Strategy on Combating Narcotic Drugs Abuse 2006-2012; National Strategy on Prevention of Alcohol and Drug Abuse and Related Disturbances, 2011-2016; National Strategy on Protection against Family Violence 2011-2016; National Strategy on Prevention of Behavioural Disturbances in Children and Adolescents 2009-2012; the National Programme for Youth 2009-2013; National Action Plan for Children's Rights and Interests 2006-2012; National Action Plan on Children and Youth Suicide Prevention 2011-2013; and the National Programme of Helping the Victims of the War.

The implementation of policy measures, though, is impeded in areas that are heavily dependent on financial resources. In the field of education, the new National Educational Curriculum, accepted in 2010, provides the basis for the introduction of important mental health promotion and prevention themes at preschool, primary and secondary school levels. However, implementation mechanisms have not yet been adequately and systematically developed.

Mental health services

Organisation and functioning of mental health systems

Mental health care is provided at primary (GPs, school medical specialists, psychiatrists and other mental health professionals in mental health centres and public health institutes), secondary (mental health professionals, mainly psychiatrists) and tertiary levels (mental health professionals, mainly psychiatrists).

Psychiatric hospitals and departments represent a large part of the mental health services. Some facilities suffer from bad building conditions and over-occupancy of rooms. There are 7 special psychiatric hospitals (with 3,414 beds), psychiatric departments in general (432 beds) and university hospitals (442 beds) and 18 day hospitals. Hospital facilities are well distributed throughout the country, apart from child and adolescent mental health services. Specialist psychiatric services (out-patient) for people with long-term mental illness are also available.

Outpatient mental health services are available in psychiatric and general hospitals. The city of Zagreb has one community mental health service integrated in primary health centre. Prior to 1991, psychiatric and other mental health outpatient services were available in every primary health centre, but this is not currently the case.

Twenty Centres for mental health and drug abuse prevention are situated in county public health institutes and form a national network of these services. Some additional counselling services are available in rural areas and islands as part of county public health services. Services include prevention, counselling, early recognition and early treatment, public education, joint programmes in local schools and communities, promotion activities in local communities. A significant amount of drug abuse prevention work is carried out and recently has this scope been broadened to include general mental health with dedicated services for this purpose. Funding is from the Ministry of Health and local counties and it is due to be increased.

A network of seventeen Family centres carries out primary prevention activities as part of the social care system (e.g. counselling for family members, parenting skills development, marital problems, and abuse prevention). Family centres formed a separate network for family counselling and were involved in many projects concerning families and victims of war. Following the new Social Care Act (2012) family centres were integrated within the social care system. The focus of activities is on families, parenting, and partner relationships, with special care to avoid overlapping of services with social care centres and other institutions in social welfare system.

The Croatian Institute for Occupational Health Protection and Safety at Work has some mental health promotion and prevention programme, but most of the activities are

carried out by mental health professionals (mainly psychologists) employed in larger companies.

Twenty one county Gerontology centres provide some prevention activities for older people in the community across the country. These services include psychosocial interventions, clubs, prevention of somatic and mental health problems, help in everyday living and are funded by counties, Zagreb municipality and the Ministry of Health.

Access and usage

Patients can freely choose mental health services and professionals, with access to both local (county) and national services as preferred. GPs usually refer people with mental health problems to psychiatrists in health centres, psychiatric hospitals or general hospitals' psychiatric departments. The recent introduction of centres for mental health in county institutes of public health, arising from centres for drug abuse, is progressing although is still not fully operational in terms of mental health prevention.

Variation and gaps

Institutionalized mental health care largely provides similar and standardized diagnostic and treatment options across the country for all patients. Modern pharmacotherapy is available everywhere, but not psychotherapy which is limited by the lack of available therapists in some regions. Community based mental health services such as mobile teams for home visits, half-way houses, sheltered or assisted housing, or day care centres for chronic patients are scarce. Sufficient provision of child and adolescent psychiatric services and professionals represents a significant gap in existing mental health services, which is currently being addressed. Cooperation among sectors (health, social care, education, work and employment, and other relevant sectors) is often formal and there is a need for true synergy in planning, implementation and follow-up of activities.

Financing

National insurance-based health system offers universal coverage to all citizens. There is no separate budget allocation for mental health, apart from drug addictions. Basic healthcare is available for all and is provided by the Croatian Health Insurance Institute. This covers the treatment of all mental illnesses and the cost of psychotropic medication. Supplementary and private insurance is possible but uncommon.

Mental health workforce

According to the Croatian Health Service Year Book (2010) the mental health workforce comprises of:

Number of psychiatrists per 100 000	11.8
Nurses in mental health services	1568
Psychologists in mental health services	128

Social workers in mental health services	45
Occupational therapists	25
Other professionals	138
Psychiatrists	524

Responsibility and delivery of mental health promotion and prevention of mental illness

The responsibility for prevention and promotion of mental health lies with the Ministry of Health and the Croatian Institute for Public Health, although other institutions and authorities also play a part in these activities. This primarily refers to the Ministry of Social Policy and Youth, local and regional authorities. Services are delivered by professionals working mainly in health and social care institutions. Academic institutions and professional associations are active in promoting evidence-based mental health protection programmes. The Croatian Police have a visible role in promotion and prevention, especially in the field of alcohol and drug abuse. Croatian Education and Teacher Training Agency supports continuous education of preschool and school professionals in specific mental health areas. National and local authorities are increasingly supporting NGOs in delivering mental health promotion and prevention services.

Mental health status

Prevalence of mental health in the population

According to the Croatian Health Service Yearbook, in 2010 mental health morbidity at the primary care level accounted for 5.2% of all general morbidity causes – a rate of 1337.8 per 10,000 population. Fifty percent of all mental health diagnoses in primary health care are for common mental health problems - neuroses, mood disorders, stress induced disorders and somatoform disorders. Mental health disorders accounted for 7.2% of all hospitalizations in 2010, mental disorders due to use of alcohol being a leading group of diagnoses, followed by schizophrenia, depressive disorders and reactions to severe stress (PTSP included). The prevalence for drug misuse in 2010 was 253.0 per 100,000 (206.7/100,000 for opiates). Data from the Disabilities Registry show that 26% of all disability causes or co-morbid diagnoses are due to mental disorders and mental retardation (codes F00-F79).

The suicide rate in 2010 was 17.5 per 100,000 according to the Croatian Committed Suicides Registry. The prevalence for drug misuse was 258.9 per 100,000 (209.2/100,000 for opiates).

Incidence

Hospital incidence of schizophrenia and schizoaffective disorder is 0.27/1,000 for persons older than 15, and the estimated prevalence for this age group is 5.3/1,000. Other incidence data are not available.

Protective and risk factors

No data based on country statistics and follow-up are available.

Prevention and promotion programmes/activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Prevention of drug abuse in schools	Aim: to educate, raise awareness, identify problems, find professional help, and educate educators Approach: via interactive lectures by health and law professionals from institutions, sometimes also by former addicts and relevant NGOs.	School children and adolescents, parents, teachers and educators	Since 2000 in every county, carried by the regional Centres for Protection of Mental Health and Prevention of Drug Abuse. Cost of programme meme: not known, depends on regional allocations and needs.
Prevention of depression and suicide in the city of Zagreb	Aim: to prevent the development of mental illness and allow early recognition of disturbance. Approach: educating teachers and educators in primary schools on risk factors, symptoms, and procedures in multi-disciplinary approach to children at risk.	Children, teachers and educators in primary schools in the city of Zagreb	Since 2008; carried by Centre for Crisis Situations (NGO); Cost: approx. €10.000 annually; sponsor City of Zagreb
National Programme of depression, suicide and conduct disorders prevention in children and adolescents	Aim: to reduce the risk of depression, suicide or conduct disorder development and improve multi-sectorial cooperation for children and adolescent mental health protection. Approach: education of school and social care professionals (three-level programme me); development of regional	School psychologists and educators, social workers and educators, other mental health professionals; children, adolescents, and their families	Since 2009. Carried by Centre for Crisis Situations (NGO); Costs: approx. €40.000 annually; sponsors Ministry of Health, Ministry of Social Policy and Youth

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	school, social and health care cooperation networks (team development); direct work with children and families.		
UNICEF Prevention Programme “Stop violence amongst children” in elementary schools	Aim: to prevent violence. Approach: workshops, media promotion, 7-step Programme in schools. Evaluation: 50% violence reduction amongst children in the schools with programme.	School children	Duration: 5 years. Costs: unknown, various sponsorships.
Helping hand	Aim: to prevent peer violence in schools. Approach: telephone help lines, e-counselling, counselling in person and workshops	School children	Since 2008, carried by Tesa (NGO), Costs: unknown; sponsor: Ministry of Science, Education and Sports
Family, peer violence and conduct disorders prevention	Aim: to prevent family and peer violence and conduct disorders development; Approach: individual, family and group counselling; psychosocial treatment of perpetrators; education of other mental health professionals.	School children and youth, family members, mental health professionals	Since 2003, carried by Society for Psychosocial assistance and Modus (NGO); Costs: unknown
Project “Peace ambassadors”	Aim: To reduce violence in the Osijek county. Approach: training Programme for peer helpers.	School children in Osijek county	Since 2009. carried by Promo Vita (NGO) Costs: unknown
Brave Phone	Aim: to prevent violence in children and young people; Approach: Telephone help-line, workshops, education of other professionals.	Children and youth, parents, professionals	Since 1997; costs unknown
Blue phone	Aim: to prevent violence in children and young people. Approach: Telephone help line, e-counselling, in person counselling, workshops.	Children and youth	Since 1991; costs unknown

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Dokkica	Aim: to promote mental health and prevent antisocial behaviour in the Osijek county; Approach: Creative workshops.	Primary school children	Since 2009, carried by Breza (NGO); costs unknown
Promotion campaign "I'm beautiful" against eating disorders	Aim: to prevent eating disorders. Approach: Video spot, brochures and posters.	General public, students, adolescents	Duration: 2 years. Carried by PET+ (NGO) Costs: unknown. Funds from various resources, governmental and private
"Stranger in the mirror", prevention of eating disorders in the county of Osijek	Aim: to prevent eating disorders. Approach: Workshops delivered by mental health professionals.	High school students in Osijek	Duration: unknown. Carried by Promo Vita (NGO) Costs: unknown, funded by local county
"I want to be your friend" IPA Programme	Aim: to promote inclusion of children with disabilities: Approach: Workshops.	Children, professionals, general population	Since 2011; Carried by Sto koluri (NGO), costs unknown
Protection of mental health of children and family members of people with mental health disturbances	Aim: to protect mental health of family members of people with mental health disturbances. Approach: Individual and group support, psycho-education, early interaction counselling.	Children and other family members of people with mental health disorders in the city of Zagreb	Since 2008;, on-going carried by the Community Mental Health Centre Zagreb West and Psychiatric hospital Sv. Ivan Costs €10.000 annually
Project "Healthy eco life" in Zagreb	Aim: to promote healthy living, social skills, and ecology. Approach: Workshops and education.	School children in selected schools in Zagreb	Duration: 2 years. Carried by PET+ (NGO) Costs: €207.062,00, funded by various governmental and other resources.
Training of life coping skills	Aim: to improve resilience and life coping skills. Various approaches used.	School children	Duration: on-going. Carried out by county public health institutes Costs: unknown
Project "Healthy School"	Aim: to promote healthy living. Various approaches used.	Children in elementary schools	Since 1993; costs unknown; carried by Croatian Institute for Public Health and the School for Public Health A. Štampar (part of European collaboration project)
Project "School hour	Aim: to raise knowledge	School children in	Duration: unknown.

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
for emotions'	on emotions. Approach: workshops by professionals.	Osijek county	Carried by Promo Vita (NGO) Costs: unknown. Funded by the county.
Project (PATHS-RASTEM)".	Aim: to implement evidence-based prevention Programme of socio-emotional learning. Approach: Educating the educators, education of children, research, workshops.	Kindergarten and school children in selected schools in Zagreb and some other cities.	Duration: 3 years. Performed by the Education-Rehabilitation School Zagreb with international partners. Costs: unknown.
Peer helpers training	Aim: to promote mental health. Approach: Peer helpers training on communication skills, expressing emotions, sexuality, non-violent behaviour.	Adolescents in Rijeka county	Duration; 9 years; carried by Potential (NGO); costs unknown
General note: Various regional programmes and services run by NGOs for families, children and young people, including psychological counselling for high risk groups (e.g. orphans, abused children) and drug abuse prevention programmes also exist; this list is restricted to organisations that responded to the questionnaire and complied with the inclusion criteria			
Workplace			
Prevention of alcohol and drug abuse in workplace	Aim: to prevent alcohol and drug abuse. Approach: Various. Included in the national strategy for drug abuse.	Employees	Duration: 10 years. Cost: unknown, funded partially by Ministry of Health, counties, local communities, other sponsorships depending on local resources.
Prevention Programme "European workplace and alcohol", includes 15 European countries	Aim: to develop effective methods of engaging with workplaces, and their workforces, raise awareness and bring about organisational and individual change that lead to safer alcohol consumption, and a reduction in alcohol-related absenteeism, presenteeism and injuries.	Employees, Zagreb county	Duration: 30 months, 2010-2012, on-going. Costs: €986.000 (total project, not known for Croatia).
Project "Let 's work healthy" conducted by the Institute for Public Health Andrija Štampar	Aim: to promote mental and physical health in the workplace. Approach: 6 topics in educational workshops on bullying /	Employees, Zagreb county	Duration: 2 years. Costs: unknown

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	mobbing in workplace, mental health and satisfaction in work, prevention of burn-out, adaptation to workplace, exercise in workplace, relaxation in workplace. Also educational brochures.		
General note: Some NGOs offer counselling on mobbing / bullying and stress in workplace, but no Programme or project is officially endorsed nationally. Some activities are offered by mental health professionals (mainly psychologists) in private companies but there are no available data on endorsed activities and impact. Smoking in working place and public facilities is forbidden by law.			
Older people in long-term care facilities			
General note: Prevention activities for older people in long-term facilities are mostly based on the prevention of somatic illnesses (diabetes mellitus, hypertension, cancer, cerebral-vascular disease, obesity). There are programmes in long-term facilities that include art and music therapy, occupational therapy, socio-therapeutic groups, support groups, counselling and clubs for the elderly. It highly depends on the local staff in the institution and local resources. Most have consultation psychiatrist on call.			

Investments into mental health – health, education, social development and economic growth

The Ministry of Health, the Ministry of Social Policy and Youth, and some regional and local authorities are the main funders of activities in mental health promotion and prevention. Other sources of funding come from NGOs and private sector. The recent economic crisis, however, seriously limits investments in the field of mental health which, in turn, seriously limits the potential for social and economic growth and well-being.

Initiatives to strengthen mental health systems in relation to MHP & PMI

Policy initiatives to strengthen mental health promotion and prevention are evident, although not yet adequately financially supported. Community services are being increasingly developing (in process of development), and addressing mental health issues through many sectors.

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4.5 Cyprus

Authors

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Summary

- Inpatient and outpatient care for people with mental illness is provided in five hospitals in specialised psychiatric units that provide a wide range of services including for mental disability, drug and alcohol addiction and psychotherapy.
- The transfer of services from institutionally based care to the community care has been part of a trend for decentralisation over the past few years. This process is, so far, successful and on-going.
- There is a reported lack of social workers operating within mental health services in Cyprus.
- In recent years the emphasis has been placed on mental health problems in childhood with resultant developments in prevention of mental illness and also well-being of the population. An assortment of prevention and promotion programmes is reported for schools and young children but nothing in the domain of the workplace or for the elderly.

Data for this country profile were gathered in the first instance by the project's country collaborator for Cyprus. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from Cyprus and validated by them.

Completed and validated 2012.

Background information

Population (1 January 2011)	804435
Population density Inhabitants per km^2 (2009)	86.5
Women per 100 men (2011)	100.7
GDP PPP (2010)	0.9
Psychiatric care beds in hospitals per 100,000 inhabitants (2008)	26.1
Standardised Suicide rate by 100,000 inhabitants	3.6
Gallup Wellbeing index (2010)*	
Thriving	45
Struggling	50

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

The current mental health legislation in Cyprus is based on the 1997 Mental Health Law "On Psychiatric Nursing Care", which has been amended a number of times. This legislation created momentum in the move away from institutional care to the establishment of community psychiatry. It also set out the rights of patients during involuntary detention and the minimum standard during their hospital stay. The Department of Mental Health Services is processing new legislation on out-of-hospital settings e.g. legislation on Community Mental Health Care.

Mental health policy and inclusion of prevention and promotion

Mental health policy over the past few years has focused attention on the transfer of services into the community and away from institutional based care. This has been achieved to a great extent and is still continuing. A framework of cooperation between the State Service, local community authorities and NGO or volunteer organisations aims to provide effective and good quality services which are accessible to all.

Alternative structures that are necessary for a successful and modern mental health service are continuously been developed and expanded. In recent years emphasis has been on mental health problems in childhood, with the development of Child and Adolescents Mental Health Services. This has been in parallel with developments in drug addiction; attention is now being paid to preventing mental illness and promoting mental health and well-being of the population.

Treatment, rehabilitation and prevention of mental illness lie at the heart of mental health policy. The main aim and targets are to:

- modernise services and therapeutic approaches in line with EU and WHO recommendations
- further decentralise community and socially oriented services, through the sectorisation of Cyprus
- promote closer cooperation with other public services involved, especially with primary health care services and social welfare departments.
- encourage the involvement of voluntary sector and the community in general in psychosocial Rehabilitation and Prevention (especially in relation to drug addiction and domestic violence), quality of life and mental health promotion.

Mental health services

Organisation and functioning of mental health systems

Mental health services range from inpatient to out of hospital care for people with mental illness. There are 5 hospital units specialising in mental illness. The main psychiatric units include:

- Athalassa Hospital – comprising of 7 wards (2 admission wards with a total of 37 beds), 3 rehabilitation wards (with 64 beds), 1 high secure ward (20 beds) and 1 mental disability ward (23 beds). The final number of patients at the end of 2010, after admissions, readmissions, releases and deaths was 105.
- Psychiatric Wing of the Nicosia General Hospital - A voluntary admission unit with 22 beds providing short-term treatment for acute conditions. The unit also acts as a screening clinic for those who require admission to the Athalassa Hospital. During 2010, 437 patients were admitted with a 10 day average duration of stay.
- Psychiatric Wing of the Limassol General Hospital - is similar in function to the Psychiatric Hospital in Nicosia with a 24 bed capacity. In 2010 there were 252 admissions of a 12-day average stay.
- Therapeutic Unit for Addicted Persons (THEMEA) – a unit specialising in the physical and mental rehabilitation of people with alcohol misuse. The Unit operates both on an in-patients and out-patient basis and in 2010 was transferred to renovated premises in the Athalassa Hospital. In 2010, 81 individual cases were treated, 39 of which were new incidences, 42 older cases and 9 who continued treatment from 2009. Also, THEMEA’s staff replied to 460 phone calls for support, 307 phone calls asking for information and 178 applications for admission through the 24hour Open Telephone Line of Direct Response.

- ANOSIS: The Unit specialises in the physical and mental rehabilitation of adult drug addicts applying programmes of motivation development and preparation of individuals to be admitted into therapeutic programmes both within the Unit and other relevant rehabilitation services. In 2010 there were 130 admissions (involving 62 individuals, 14 of whom were new cases) with a success rate of 79%.
- Outpatient departments: a total of 18 primary care outpatient clinics (14 in Nicosia, 1 in Limassol, 1 in Paphos, 1 in Larnaca and one in the free Famagusta area. Counselling centres are also available for young people aged between 14-22 with drug addictions and their families. The PERSEA's unit operates in cooperation with schools, the Cyprus Anti-Narcotic Council and the Army. In 2009, 183 interventions were delivered to 65 young addicts and their parents.
- The TOXOTIS Counselling Centre is a collaboration between the Mental Health Services and the Cyprus Anti-Drug Association. Its main objective is the evaluation and preparation of individuals for admission to in-patient clinics or counselling support on an out-patient basis if this is not possible. Other drug counselling, day and rehabilitation centres are also available.
- Out-Patient Clinics: A network of out-patient clinics form the basis of community mental health services. Multi-disciplinary staff include psychiatrists, psychologists, nurses and occupational-therapists who offer psycho-social education, counselling, psychotherapy and intervention in crises and relapses. The majority of the patients go to these centres for psychiatric treatment. The centres also offer community nursing. In 2010 there were a total of 57,001 visits to these clinics.
- Psychosocial rehabilitation units for people with mental problems: These out-patient settings promote the social re-inclusion of people with long term mental illness. They provide opportunities for professional training and employment, or, wherever possible, they promote the development of self-care skills, work and social skills. There are 4 Day Centres for this purpose: 1 in Nicosia, 1 in Limassol, 1 in Larnaka and 1 in Paphos.
- Work Rehabilitation Units: Two of these units are in operation (1 in Limassol, the other in Nicosia) and work within mental health services in conjunction with the NGO organisation, 'Association for the Protection of Mental Health' and the Ministry of Labour and Social Insurance. The programmes and services of these units are backed by actions under the Programme "Employment, Human Capital and Social Cohesion" of the National Strategic Report Framework (ESPA) for the Cohesion Policy 2007-2013. The main objective is to support individuals with mental health problems achieve successful labour market re-inclusion through assistance in finding employment and supporting people already in work.
- Psychotherapy Department - The Department of Individual and Family Psychotherapy is situated within the Nicosia General Hospital. It provides specialised psychotherapy

on an individual, family and group level using modern psychotherapeutic approaches for mental health issues; raising awareness and the further training of the professionals in the Service. In 2010, 108 applications were treated for psychotherapy, of which 31 were new cases. The total number of interviews was 339 (210 individual, 95 family and 34 couples). There were also 120 supervision interviews and 66 counselling interviews for mental health personnel.

- Occupational Therapy Service – Occupational therapists are employed by the Mental Health Services. Their clinical work spans across in-patient and outpatient departments for children/adolescents, adults and older people in both mental health and addiction services. Their main fields of work include the prevention of mental illness and the promotion of mental health, organisation and implementation of individual and group therapy programmes and interventions, training and clinical supervision. In 2010, occupational therapists served 1,771 adults and 133 children/adolescents.
- Department of Clinical Psychology – Work in this department is mostly on prevention, administering psychometric tests, therapy and the reduction of the patients' mental health issues and the promotion of their mental well-being. This involves counselling, psychotherapy support of the individual and family, group support and rehabilitation. In 2010 there were 21,036 consultations (a rise of 20.71% compared to 2009), with 2 527 new cases (a rise of 31.82% compared to 2009).
- Child and Adolescents Mental Health Services – Includes 4 Centres (2 in Nicosia and 3 covering other districts) in 2011, for children and adolescents up to the age of 17. The service operates as an open treatment system and works with other services or bodies. Their role includes: prevention, diagnosis, intervention, training and research.

Access and usage

Information on usage included above.

Variation and gaps

The main gap in services concerns the lack of social workers in mental health services.

Financing

Total spent on mental health services was €27,126,413 in 2010, up from €26,630,930 in 2009. Mental health expenditures by the government health department/ministry are 4.82% of the total health budget (World Health Organization, 2011). Main sources of funding for services are through tax revenues, out of pocket expenditure, social insurance and grants.

Mental Health workforce

The current workforce employed in mental health services per 100,000 inhabitants includes:

5	Psychiatrists
1.3	Neurosurgeons
45	Psychiatric nurses (in the mental health services)
2.6	Neurologists
6.2	Psychologists (in the mental health services)

The total number of other staff includes:

2	Social workers (in the mental health services)
38	Occupational therapists (in the mental health services)

Responsibility and delivery of mental health promotion and prevention of mental illness

The Mental Health Services work on all three levels of prevention where financial resources and expertise allow. The educational psychology services, under the General Director of the Ministry of Education and Culture includes in its mission the protection and promotion of mental health and the general development of each individual in the education system. The service is also responsible for the development of social skills, prevention programmes aimed at promoting mental health, improving communication and crisis management of traumatic experiences. Programmes are also developed in cooperation with Municipalities and local communities. These programmes are based on the involvement of school, teacher, family and youth.

Mental health status

Prevalence of mental health in the population

There are no epidemiological data on the prevalence of mental illness in the general population or available statistical data on individuals attending Mental Health Services by diagnosis. A computer register has been initiated using ICD10, but not as yet complete.

Incidence

No available data

Protective and risk factors

Not reported

Prevention and promotion programmes /activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Daphne II "Needs assessment and awareness raising programme for bullying at school"; and Daphne III "Development and Implementation of a school based training programme for teachers"	Aim: to raise awareness, detect bullying early on and enhance coping skills. Approach: Psycho-educational intervention was implemented for students, teachers and parents. The programme was interstate and in Cyprus was represented by the Child Psychiatric Services Department.	Teachers, children and parents	2005 to 2010. Funded by the EC and the Ministries of Education and the Health of each state.
Promotional material preventing depression	Aim: to prevent depression in children and young people. Initiative of the Minister of Health publishing educational material aimed at the. It is planned that the Mental Health Services will have a wider role in this area.	Children and young people, Ministry of Health	
Functional literacy programme in secondary schools	Aim: to prevent school and potential social exclusion of students by reducing marginalization, delinquency, self-destructive behaviour, use and abuse of substances, mental and physical health problems. Approach: Targeted at functionally illiterate students. Currently in 64 schools with 1 975 students to teach functional literacy. Delivered by the department of Educational Psychology.	Students in secondary schools	On-going
Zones of Educational Priority (ZEP): Programme against the early school leaving, school failure and	Aim: to reinforce social cohesion, reducing the risk of social marginalisation and social exclusion. Approach: Provides	Students	On-going

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
delinquency.	additional teaching staff, and teaching hours with specialised curriculum, development of teaching material according to the school's needs and additional psychosocial support for students and parents through the settings of Information and Psychological Support Centres.		
Workplace			
None reported			
Older people in long-term care facilities			
ALCOVE: Alzheimer Cooperation in Europe	Aim: to improve the quality of care and services for people with Alzheimer's disease and give recommendations regarding health policy issues. Approach: An exchange of knowledge and experience programme. Cyprus is an associate partner though the Mental Health Services.	People working with those with Alzheimer's disease	On-going
Alzheimer Campaign – Multidisciplinary Committee on Alzheimer's Disease	Aim: to raise awareness on alzheimer's disease. The Director of the Mental Health Services is President of the Multidisciplinary Committee on Alzheimer's disease. Through the Committee's activities 2 Dementia Centres operate in Nicosia in the last 5 years. Since 2002 one of the medications is offered for free. Volunteers with dementia participate in the Committee to help raise awareness. There are also programmes for patients and carers.		On-going

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Training on dementia	Aim: to train professionals to work with people with dementia. Approach: Within the framework of organized care for older people, community nurses, psychologists and occupational therapists are sent abroad to train on programmes for persons with dementia. They also administer awareness raising programmes to educate and train carers of people with dementia in long term care facilities in urban and rural settings.	Older people; health professionals working in the community and in long term care facilities	On-going
National Strategic Plan on Dementia	The same Committee is also involved in drafting the National Strategic Plan on Dementia		
Other relevant programmes			
Campaigns	Aim: to raise awareness within the framework of Promotion of Mental Health and of combating the stigma of mental disorders several events are organized (e.g. World Mental Health Day) in all cities. Approach: Events include art, lectures, Mass Media interviews and press releases, as well as press conferences by the Minister of Health and the Director of Mental Health Services.	General public	Annually
Promotion of Public Health	Aim: to promote mental health, raise awareness and combat stigma. Approach: A collaboration between the Community Mental Health Committee	General public	On-going

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	(including mental health personnel), representatives of the Municipalities, service users with mental health problems, the Association Elpidoforos (Hope Carrier) of the Mentally Ill, voluntary organisations (KAPSY and of the Association for the Protection of Mental Health) lectures and partnership actions were organised.		

Investments into mental health – health, education, social development and economic growth

The level of financial investments into prevention and mental health promotion activities are not known, but resources allocated to mental health services contribute indirectly towards these.

Initiatives to strengthen MH systems in relation to MHP and PMI

Mental health and related policies state a strong commitment towards prevention and promotion initiatives in mental health. However, it is not clear the extent to which financial resources have been dedicated to initiatives in these areas.

Data sources

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4.6 Czech Republic

Authors

Tomas Petr (Chairman of Psychiatric Section of Czech National Nurses Association); and validation by Ondrej Pec (Chairman of Section for Social Psychiatry of the Czech Psychiatric Association)

Summary

- Inpatient care is divided into acute and after-care services. Theoretically, acute care should be provided in psychiatric wards in general hospitals and after-care in psychiatric institutions. However, in practice, 80% of psychiatric beds remain in institutions where care is still provided.
- Regarding community mental health services, day clinics, 50% of which are in larger inpatient facilities, provide treatment for mental illness. These facilities are generally situated in larger cities. Other available services include psychiatric rehabilitation services provided by NGOs. Crisis centres are insufficiently developed.
- There is an imbalance in provision of facilities with a bias towards larger cities.
- There is a general lack of psychiatric wards for acute care. During the past decade, 510 beds are reported as being closed with no substitute provision of psychiatric wards or community services.
- The Czech Republic employs a system whereby schools have an obligation to create dedicated programmes for primary health prevention, either themselves or through external contractors, which is built into the school curricula. These have a wide focus including drug and alcohol use, eating disorders and bullying. Apart from a wide range of prevention and promotion activities in schools, there are a myriad of activities directed towards older people and the general public.

Data for this country profile were gathered in the first instance by the project's country collaborator for the Czech Republic. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from the Czech Republic and validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	10532770
Population density Inhabitants per km^2 (2009)	135.8
Women per 100 men (2011)	103.8
GDP PPP (2010)	18.5
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	103.3
Standardised Suicide rate by 100,000 inhabitants	12.4
Gallup Wellbeing index (2010)*	
Thriving	39
Struggling	51

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Mental health care is incorporated within general health care legislation rather than through a separate Mental Health Act. Care for people with mental illness ill is regulated by several legal norms. On a constitutional level, the Charter of Fundamental Rights and Freedoms guides the fundamental rights and freedoms of psychiatric patients, with the Convention of Human Rights and Biomedicine having precedence over national law.

On a statutory level, the provision of health care is set out in general health care legislation, namely Act 372/2011 Col. on medical services, which came into force on April 1, 2012 replacing Act 20/1966 Col. on care of people's health. Guidance concerning involuntary admission is provided in Act No. 99/1963 Coll., Civil Procedure Code, which details the procedural rules for the "involuntary admission". This Act also determines the time limits for decisions by the courts. Other laws regulating psychiatric care are the Criminal Code, which deals with the issues relating to compulsory treatment, and the Preventive Detention Act.

There is no legislation, which prioritises mental health promotion and prevention of mental illness.

Mental health policy and inclusion of prevention and promotion

A National Programme of Care for Mental Health has been in preparation since 1992. The Conceptual Plan for psychiatric care, drawn up by the psychiatric medical association, was adopted by the Ministry of Health in 2002. The major goals of the plan are deinstitutionalization by reducing the number of beds in institutions, an increase in

the number of acute psychiatric wards and the creation of a community based network of mental health services. Implementation of the plan for psychiatric care, however, has failed, partly because of the rigid restriction on health care funding (and the lack of political will). The Conceptual Plan for psychiatric care was revised by the Czech Psychiatric Society in 2008, but not approved by the Ministry of Health.

The Ministry of Health has introduced a complex healthcare reform, but it is difficult to anticipate the impact of this on mental health care.

Mental health services

Organisation and functioning of mental health systems

Psychiatric care is provided through a network of facilities whose basic elements are psychiatric inpatient facilities, outpatient clinics and community care facilities, combining both psychiatric and social services.

Inpatient care: There are two types of inpatient psychiatric care – acute and after-care services. According to the general strategy acute care should be provided in psychiatric wards and after-care at psychiatric institutions. However, 80% of all psychiatric beds are still located within psychiatric institutions, so most acute care is delivered within these facilities though their main task is to provide long-term treatment and rehabilitation for people with a psychiatric illness of all ages. In 2009, 17 psychiatric institutions had a total number of 9,207 beds for adult patients and 3 institutions for children with 260 beds. The average length of stay in psychiatric institutions in 2009 was 80.7 days (ÚZIS, 2010).

There were 31 psychiatric wards with 1,383 beds in 2009. Psychiatric wards are usually part of hospitals, but some exist as self-contained facilities or are attached to a university hospital for teaching and educational purposes. The average length of hospital stay in these wards was 20.4 days in 2009 (ÚZIS, 2010).

Outpatient care: Psychiatric outpatient clinics are another core element of the system of mental health care. In the majority of cases, these are where patients’ first encounter with psychiatric care takes place. Very often this contact is of long-term, continuous nature and the psychiatrist providing outpatient services becomes a coordinator of a patient's care – providing guidance within the system of psychiatric services, and follow-up medical and social services. In 2009, there were 971 psychiatric outpatient departments (ÚZIS, 2010). Specialized outpatient clinics are also available for children, geronto-psychiatry, addiction treatment, psychotherapy and other specialized treatments (Wenigová et al., 2009).

Community services: Twenty-one day clinics provide treatment for people with mental illness. Roughly half exist as part of a larger inpatient facility and half as independent facilities. Day clinics are more often found in larger cities. New facilities were being established during the 1990s, but after 2000 almost no new facility was opened. There are only three crisis centres with 24-hour availability of a psychiatrist, two in Prague and one in Brno.

Case management services and the rehabilitation of people through home visits provided by psychiatric nurses were introduced in 2006. However, only 3 facilities provide this service - 2 in Prague, 1 in Ostrava.

Psychiatric rehabilitation services (defined as social services) are carried out solely by 29 NGOs, which in 2007 employed 470 social workers who provided direct care for some 4,600 clients (Asociace komunitní péče - Community Care Association, 2007). Most of these services are situated in larger cities, with some regions (e.g. Zlín) having few or none of these facilities.

Access and usage

Services for the mentally ill are relatively easy to access. However, catchment areas of 17 psychiatric institutions, that provide the majority of inpatient care, permit a distance between home and hospital of more than 100 km. Such distances make regular contacts between patients and their families (within their home environment) or with community services difficult.

The total number of people released from in-patient psychiatric facilities with a mental illness (ICD10: F00-99) in 2009 was 57,591 (30,552 males and 27,039 females). The number of outpatient examinations per 100,000 population was 24,876.6; for first examinations it was 4,603.4 per 100,000 inhabitants (ÚZIS, 2010).

Variation and gaps

Variations in mental health services tend to be those concerning out of hospital and community services which, where available are mainly found in larger cities. There is a general lack of psychiatric wards for acute care and major gaps in community based mental health services (e.g. home visits, specialist community services, sheltered housing). Over the past 10 years only 510 asylum beds have been closed, with the number of psychiatric wards and community services remaining unchanged.

Financing

Health care expenditure has been around 7% of GDP in recent years and some 3.5% of total health care funds are allocated to mental health (Scheffler and Potůček, 2008). Mental health expenditure is 2.91% of the total health budget (World Health Organization, 2011).

Several stable sources of funding finance mental health services in the Czech Republic - The Health Insurance Fund (covering inpatient and outpatient psychiatric facilities, daily clinics and with some exceptions other services); Subsidies from the Ministry of Labour and Social Affairs and the Ministry of Health to non-governmental non-profit organisations; subsidies from the Ministry of Health to health care facilities; out of pocket payments by recipients of services/patients; Direct payments by service users for private facilities.

Workforce

In 2009, the number of specialists working in outpatient facilities totalled 1,270. These included 730 outpatient physicians, 415 nurses and 84 psychologists. For psychiatric institutions the number of specialist staff amounted to 5,838 workers, including 550 physicians, dentists and pharmacists; 2,976 nurses; 99 social workers, 120 psychologists (ÚZIS, 2010).

The number of mental health professionals (per 100,000 population) according to the WHO (2011) Mental Health Atlas included:

Psychiatrists	11.85
Nurses	28.24
Psychologists	2.03
Social workers	0.9
Occupational therapists	0.34
Other workers	17.21

Responsibility and delivery of mental health promotion and prevention of mental illness

Not reported with regards to mental health services. However, schools are obliged to create their own programmes of primary prevention, which are built into the school curricula. Schools can implement their own programmes or contract external organisations to deliver these and can apply to Ministry of Education for funding. Programmes are focused primarily on prevention of: drug and alcohol use, smoking, eating disorders, child abuse and neglect, violence, bullying, truancy and theft.

Mental health status

Prevalence of mental health in the population

Figures for the prevalence and incidence of mental illness according to ICD10 diagnostic codes in Czech Republic in 2010 – (in psychiatric care):

ICD10 diagnostic code	prevalence*	incidence*
F00-09 - Organic, including symptomatic, mental disorders	51.4	14.7
F10 - Mental and behavioural disorders due to psychoactive substance use	25.9	6.3
F11-19 - Mental and behavioural disorders due to psychoactive substance use	16.7	3.0
F20-29 - Schizophrenia, schizotypal and delusional disorders	39.5	4.5
F30-39 - Mood (affective) disorders	89.6	16.5
F40-48, F50-59 - Neurotic, stress-related and somatoform disorders; Behavioural syndromes associated with physiological disturbances and physical factors	183.2	48.5
F60-63, F68-69 - Disorders of adult personality and behaviour	23.4	5.5
F64-66 - Disorders of adult personality and behaviour	2.7	0.5
F70-79 - Mental retardation	17.2	2.5
F80-98 - Disorders of psychological development; Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	21.8	6.7
F99 - Unspecified mental disorder	2.0	0.7

** per 100,000 inhabitants. Source: (ÚZIS ČR 2011). The figures show prevalence and incidence of treated cases in psychiatric services, they do not include untreated cases.*

Incidence

See above.

Risk factors

The main risk factors for mental illness are drugs and alcohol; socio – economic factors (economic hardship, unemployment etc.); other well-known general factors (genetic, stress etc.), being a migrant and from a minority ethnic group.

Prevention and promotion programmes /activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
State aid programme for NGOs working with children and young people	Aim: to create a range of leisure activities; education on healthy lifestyle. Approach: Support is focused on regular and long term activities for the widest range of children and youth.	Children and young people. Stakeholder: NGOs	For 2011 - 107 910 000 CZK
Minimize bullying	Aim: to find effective methods and to reduce the incidence of bullying at schools; to exchange educational tools and procedures for handling bullying. Approach: training seminars for school directors and teachers.	Children and young people. Stakeholder: O_2 Foundation	From 2005 to the present. Finances: not available
Safety Line in Your Classroom	Aim: to introduce possible ways of solving problems and difficult life situations, using their own competences, social environment and professional services. Approach: use of interactive and experiential techniques in groups up to 20 children.	Children. Stakeholder: Safety Line Association	Financial support from the Ministry of Education Finances: not available
Prevention of social pathological behaviour	Aim: to prevent pathological social behaviour with focus on drug use. Approach: using a set of interactive workshops and discussions on various topics for students, families and teachers.	Students, families and teachers. The project was introduced and is supported by Ministry of Education.	Not known
Schools without bullying	Aim: to teach school staff to work with socially pathological behaviour in children and students relating to bullying. Approach: to support teaching staff and provide	Children, students and teachers. The project is supported by Ministry of Education and open to all schools across the Czech republic.	Duration: 2010 to 2012. Finances: not known

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	education in preventing bullying and socially pathological phenomena at elementary school / high school.		
Are you crazy? And what?	To: focus on prevention of mental illness and promotion of mental health in schools. Approach: delivered by moderators and people with experience of mental illness. Uses interactive and creative techniques for understanding mental health issues.	People aged between 15-25 years of age. Stakeholders: European structural funds and is run by the NGO, FOKUS Praha	2006 to the present
VIDA – Programme for schools	Aim: to educate students to become tolerant and respectful of people with mental illness. Approach: discussions and lectures in schools in Czech Republic about living with mental illness. People with mental health problems are involved in the project and visit schools to share their experiences with students.	Students. Ministry of Health, project is run by VIDA (NGO)	
Workplace programmes			
International campaign 'Work in tune with life. Move Europe'	Aim: to collect and present examples of good practice of mental health and wellbeing in the workplace. Approach: self-evaluation of the level and quality of activities in mental health in the workplace; specific recommendations for improvement. Second round: Excellent Practice Models organisations with the best results in self-evaluation share their experience and knowledge.	Employees and employers. European Network for Workplace Health Promotion; run by The National Institute of Public Health in CR	2009-2010 Finances: not available
Prevention of violence in the	Aim: to improve the safety culture in the workplace	Targeted for Trade unions and social partners. Run by	Funded by European social

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
workplace, especially in health care and social service facilities	through an accredited course. Support the development of social dialogue, particularly between employees and employers. Approach: diagnostic investigations, the creation of educational programmes focusing on knowledge and skills necessary for the prevention of workplace violence, recognizing violence and stress at work, practical skills for managing crisis communications and workplace violence, focusing both on management and health care professionals.	Czech-Moravian Confederation of Trade Unions under the supervision of Ministry of Labour and Social Affairs	fund
Older people			
Promotion of healthy lifestyles for older people	Aim: promotion of healthy lifestyles. Approach: lectures, presentations and discussions on various topics, (e.g. the importance of diet, physical activity, mental health and social contacts, stress and relaxation techniques, good coping skills. Lectures are held in long-term care facilities and community centres	National Health Promotion Network NGO	Finances: not available
Age in motion	Aim: to motivate seniors to exercise and do so regularly. Approach: uses a range of leisure activities, organisation of new courses, focusing on physical and mental fitness.	ELPIDA Plus, NGO, Endowment fund GSK	Finances: 170,000 Kč
Moving to a better life	Aim: to create for older people and those with disabilities an outdoor environment for them to exercise. Approach: each client is recommended for	Older people and people with disabilities. Caritas, Endowment fund GSK	Cost : 73,000 Kč

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	appropriate physical activity, with a pre-prepared individual exercise plan.		
Volunteering connects seniors	Aim: to support seniors who live in residential homes or at home. Approach: provides regular care by volunteers to improve their quality of life.	ADRA, NGO, Endowment fund GSK	Cost: 170,000 Kč
Goat's garden for seniors	Aim: to rebuild lost confidence and responsibility in older people living in shelter housing. Approach: to create a suburban garden for keeping small domestic animals and to grow fruit and vegetables. The garden will also serve the town of Sokolov, especially for mothers with children, nursery and primary schools.	Older people, mothers with young children, children of nursery and primary school age. Pomoc v nouzi, NGO, Endowment fund GSK	Cost: 232,000 Kč
Other programmes			
Programme for good health (PPDZ)	Aim: to improve the physical health of psychiatric patients through educational programmes for improving diet and exercise. Aims to prevent weight gain and promote weight reduction. Approach: a 16-week structured Programme delivered by trained psychiatric nurses in 23 centres.	1242 patients with the diagnosis of schizophrenia-spectrum disorder participated.	2004 to June 2009, financially supported by Eli Lilly ČR s.r.
ITAREPS - rapid and targeted recognition of early warning signs of psychotic disorder relapse.	Aim: to detect early signs of relapse in psychosis and enable early intervention and prevent unnecessary hospitalizations. Approach: using modern communication and information technology	People with psychosis. Stakeholders: Academia Medica Pragensis Ltd. for Eli Lilly and Comp.	Not reported

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	for timely intervention during initial phase of relapse. A mobile phone-based telemedicine solution for weekly remote patient monitoring and disease management in schizophrenia and psychotic disorders in general.		
PREDUKA programme	Aim: a preventive and educational programme against relapse of psychosis. Approach: provide patients and their families' information about the nature of schizophrenia and psychosis, their treatment and how to prevent relapses of the disease. The programme lasts 6 hours.	People with psychosis and their families. Supported by Eli Lilly ČR	Not reported
Project Change - on the national level	Aim: to fight against prejudice and discrimination of people with psychiatric illness. Approach: a web site and online initiative to raise public awareness about mental disorders and to assist those with mental health problems seek specialist help and to changes attitudes of professionals.	General public, people with mental health problems. Johnson and Johnson, s.r.o. and Eli Lilly ČR s.r.o. Some events were held under the auspices of the Mayor of Prague. The partner of the project was the Centre of Social Services Prague.	Financially supported by Johnson and Johnson, s.r.o. and Eli Lilly ČR s.r.o.
Mental Health weeks – on the national level	Aim: to improve public attitudes towards the mentally ill and create a tolerant society. Approach: Mental Health Weeks (between Sept to Oct) are a series of humanitarian and cultural events with a tradition since 1990 to inform the public about mental health issues, mental	General public, project is run by FOKUS Praha	Not known

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	hygiene as the prevention of mental illness and also about activities of organisations working in health and social sector.		
VIDA – Medial group MAJRA	Aim: to carry out awareness campaigns, in cooperation with the media (TV, newspapers, magazines, etc.). Approach: make short documentaries, and animated spots of experiences of mental illness.	Ministry of Health, project is run by VIDA	
Programme to support the integration of gypsy the community	Aim: to promote greater participation of children at risk of social exclusion in pre-school education, especially in nursery schools. Also, to support the activities that help students to overcome difficulties during the compulsory school attendance and education at the secondary school. Approach: conduct activities aimed at increasing the efficiency of cooperation of families and schools in the education of students from culturally different backgrounds; and support of teaching staff including who work with children, students from different socio-cultural environment in the preschool and basic education.	Nurseries and schools, Ministry of Education	The Programme is introduced every year by Ministry of Education, and schools across the Czech Republic can apply to get support for their projects.
Support for the integration of foreigners	Aim: to support activities such as: legal advice for foreigners, assistance in finding a job, language courses, retraining	Ministry of Social Affairs, various NGO across Czech Republic can apply for grant	The Programme is introduced every year
Integrated Operational	Aim: to support transformation and foster	European Regional Development Fund, Ministry	Allocated money is a

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Programme: Area of intervention 3.3 Services for Employment	services for better employment in the Czech Republic. Approach: to build more training centre s, employment services and support of cooperating organisations implementation and support of new active employment policy tools, development of employment service institutions and improvement of services to applicants for employment	of Social Affairs	total of: 961252698-Kč
Support for purposeful activities for seniors and senior organisations state-wide	Aim: to support activities of older people. Approach: to defend the interests and rights of seniors and organise activities focused on increasing quality of life of old people in society	Older people, NGOs working with older people; Ministry of Social Affairs.	Not reported

Financial responsibility for prevention and promotion

From the programmes listed above financial support for prevention and promotion in mental health activities appears largely to be from the Ministry of Education for school programme, NGOS.

Investments into mental health – health, education, social development and economic growth

Not reported.

Initiatives to strengthen mental health systems in relation to MHP and PMI

None reported.

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4.7 Denmark

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Summary

- In a period of 15 years Denmark has carried out a reform of psychiatric care transferring institutional care to services in the general health sector consisting of short term hospital care and out-patient care in form of community services.
- Access to health care including mental health care is free of charge and publicly funded.
- The primary health care sector with GPs, psychologists and practising psychiatrists take care of minor and moderate mental disorders.
- Since 2007, five regions are responsible for providing psychiatric care including hospital departments with emergency and acute psychiatric services, short term inpatient based treatment, outpatient treatment and care in psychiatric community centres and different Assertive community teams.
- The municipalities are in charge of social services such as counselling, social support day centres, and pension and housing for those with long term mental illness.
- Challenges to be addressed: are the excess mortality of psychiatric patients, the balance between inpatient services and outpatient services, lack of psychiatrists, the level of coercive measures and the number of forensic patients. Lack of coherence between the municipal social – and the regional psychiatric health care services provided for the patient. Many attempts have been made to counteract this problem.
- Prevention and promotion is a shared responsibility between regions and municipalities. A reported 64% of municipalities have promotion interventions of some kind for mental health. From 130 identified interventions 28% focused on children 17 years and under, 12.3% on young people 13-25 years. There are several prevention and promotion programmes aimed at the workplace, the elderly and the general population. There is no systematic data collection documenting the amount of activities in this area across municipalities.

Data for this country profile were gathered in the first instance by the research team. A draft country profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from Denmark. This expert provided additional up-to-date information and revisions where needed. The country profile was then revised accordingly by the lead researcher, checked by the Governmental expert and a final version validated by them. Completed and validated 2012.

Background information

Population (1 January 2011)	5560628
Population density Inhabitants per km^2 (2009)	128.2
Women per 100 men (2011)	101.7
GDP PPP (2010)	10.2
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	57.9
Standardised Suicide rate by 100,000 inhabitants	9.9
Gallup Wellbeing index (2010)*	
Thriving	82
Struggling	17

*Reprinted with permission of Gallup, Inc

Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Mental Health legislation in Denmark was introduced in 1938 and thoroughly modernised in 1989. It primarily regulates involuntary civil commitment, detainment and restraint use of coercive measures. The latest legislation was enacted in 2010.

New legislation reorganised the local government and the public sector in 2007 constructing five regions containing 98 municipalities, instead of the former 15 counties and 273 municipalities. At the same time some duties regarding health promotion and disease prevention were moved from the former counties to the new and bigger municipalities.

The Danish Health Act from 2006 and later amendments have a focus on citizen- and patient-oriented disease prevention and health promotion. The responsibility for this is shared between municipalities and regions, requiring a high degree of cooperation between them.

Mental health policy and inclusion of prevention and promotion

Over the past 15 years mental health policy has reformed psychiatric care from institutional care to community based services. In 2002, Danish health policy turned its attention to increasing life expectancy, improving the quality of life and reducing health and social inequality by introducing 'Healthy throughout Life'. This health policy also placed emphasis on the collective efforts needed to reduce the major preventable diseases and disorders through primary prevention as well as continuing support and rehabilitation for patients. The programme was directly linked to the government's targets for health which largely concern risk factors such as tobacco, alcohol, exercise

and eating habits, but had a broad scope for prevention and promotion. Its chief aims are to increase life expectancy, reduce social inequality in health and improve quality of life.

In January 2008, the government launched a follow-up initiative to 'Healthy throughout Life' and created a committee of experts in health promotion and disease prevention programmes and health economics. The committee represented both the public and private sector and delivered its recommendations in 2009 on how health promotion and disease prevention could be improved.

Patient's own efforts are seen as a key aspect. In 2009, The Danish National Board of Health published a national strategy of psychiatry and mental health. Focus was easy access to services, early intervention, relevant treatment and care, high quality in care, qualified staff and more evidence and research. It was highlighted that patient with mental diseases lived more than 15 years shorter than the population in general and somatic diseases and stigma were seen as important reasons. In 2010, the strategy was followed by various project activities from the government. There have been on-going debates in recent years about psychiatric services and developments in the area. The regions, municipalities and learned societies have published booklets and documents setting up clear goals and targets for the future efforts.

In 2012, the government has launched a governmental committee in mental health to advise the government on the future development of mental health in Denmark. In relation to the committee's report the government will launch a national strategy for psychiatry in 2013.

Mental health services

Organisation and functioning of mental health systems

The defining feature of the Danish health system is its decentralized responsibility for primary and secondary health care. In terms of organisation, the five regions are responsible for providing hospital, somatic and psychiatric care, and for financing private practitioners for their public health sector work. Services for people with a mental illness are provided in cross sectorial collaboration between health and social care sector. The regions are responsible for health care services, and the municipalities are responsible for social services, among others - social services for those with long-term mental illness regarding housing, social support, counseling, etc. Mental health services are delivered in the primary healthcare sector from GPs and practicing psychiatrists and psychologists. The secondary healthcare sector provides psychiatric care in psychiatric hospitals and associated out-patient care, including community mental health care services:

- Hospital inpatient services include a total number of 2,832 beds in hospital psychiatric wards (including child and adolescence psychiatry and forensic psychiatric wards) for 2011. Between 1980 and 1990 the number of psychiatric beds was reduced dramatically from 8182 to 4906. The number of psychiatric beds per 100,000 population was 57.9 in 2009.

- Out-patient services include community psychiatric mental health centres, operating within a local area to provide outpatient care and psychiatric treatment. These services are sometimes supplemented with home visits by assertive teams. A team can comprise of doctors, nurses, social workers, occupational therapists, psychologists, physiotherapists, and other relevant professionals. In some regions community psychiatric centres are connected with a day care centre. Others are located in hospital psychiatric departments. Some community psychiatric services restrict their services to those with long-term and socially disabling diseases, while others also include services for people with short-term mental illness.

- Municipalities are responsible for housing and different kinds of social care and support, especially for people with long term mental illness. These services also provide temporary residence and home care arrangements when necessary Nursing homes are much less used than previously.

Access and usage

Free access to health care is available to all those registered as a resident in Denmark. GPs are entitled to refer a person directly to a psychiatric hospital unit. The number of people contacting a doctor for psychological reasons totalled 65,462 in 2011; and much higher for women (48,548) compared to men (16,913) (Statistics Denmark, 2012).

The number of referrals to adult psychiatric services in 2010 totalled 49,024, or 11.3 referrals per 1,000 inhabitants. Over the last few years the number of patients using mental health services has steadily increased for both children and adolescents and adults. The numbers of patients using psychiatric services from 2007 to 2010 in Denmark are as follows:

	2007	**2008**	**2009**	**2010**
Children and adolescents	14.6	16.5	18.7	21.0
Adults	86.4	87.4	91.7	93.2

Increases in the number of compulsory admissions have also been noted, which have risen from 2,190 in 2001 to 3,343 in 2011.

Variation and gaps

Despite some regional variations in the organisation of health care for both general health and psychiatric services, acute psychiatric hospital 24 hours services, including emergency rooms and acute visitation wards and different outpatient clinics is available to all. Regions and municipalities are obliged to make local health agreements regarding collaboration and coordination with the purpose to establish and improve cross sectional coherence in care and services.

Financing

Health services in Denmark including mental health are nearly all publically funded through tax revenues. Eight per cent of the total health budget was allocated to mental health services in 2009. More recent figures are not available (World Health Organization, 2011).

Workforce

In 2010, the total number of professionals working in adult psychiatric services amounted to 7,582 staff. This included:

Psychiatrists	1,058
Nurses	2,703
Psychologists	463
Social workers	278
Other Staff	3,080

There is a lack of psychiatrists and specialised trained nurses.

Responsibility and delivery of mental health promotion and prevention of mental illness

Responsibility for the delivery of mental health prevention and promotion is devolved to the regions and municipalities and included within their duties.

Mental health status

Prevalence of mental health in the population

There are few studies on the prevalence of mental illness in the population. A 2004 study found a prevalence of 1.4% for depression and 3.3% for major depression (Olsen et al., 2004). Mental well-being in the general Danish population has remained largely

unchanged from 1987 to 2005, but is showing an increase in older people and a decrease in younger age groups (National Institute of Public Health, 2006).

The number of patients treated in regional psychiatric services has almost doubled over a ten year period, and the diagnostic profiles have broadened and now include a substantial number of common mental disorders, particularly depression and anxiety. The number of people who received a prescription for antidepressants has risen from 384,000 in 2006 to 462,000 in 2010. In spite of this, the general assessment is that the incidence and prevalence of these disorders have not changed.

In keeping with developments in Sweden and Norway there has been a substantial increase in the number of children, adolescents and adults diagnosed with ADHD, and the number of patients treated with medication for ADHD has increased from 8,586 in 2006 to 31,754 in 2010 (cited in Bauer et al., 2012). There is considerable regional variation in the number of those diagnosed and medication prescribed for mental health problems illustrates the need for clinical guidelines in the area.

Incidence

There is no precise information on the actual incidence of mental disorders in the Danish population. Based on the incidence of mental disorders in other Western countries it is estimated that during a one-year period 4-5% (or approximately 200,000) adults in Denmark will develop a depressive disorder and approximately 10% an anxiety disorder. It is estimated that more than 20% of the population within one year consumes a health damaging level of alcohol.

Protective and risk factors

Risk factors for poor mental health according to a 2005 mental health survey of the Danish population includes: unemployment, divorce, and 10 years or less of school/ vocational training.

Prevention and promotion programs/activities

There is a growing focus on mental health promotion. In 2012, The Danish National Board of Health launched health promotion packages on mental health with the aim of supplying municipalities with information on prevention and promotion activities.

At this time there is no official updated data on the activities regarding mental health in the municipalities. A report from 2009 showed that 64% of the 83 municipalities surveyed had interventions for promoting mental health. A total of 130 interventions were identified by a mapping exercise with 28% focused on children under the age of 17, 12.3% on young people aged between 13 and 25 years, 11.5% of programmes targeting

adults above the age of 18 years and 8.5% all citizens. A few mental health promotion activities were for those with a disability (5.4%) and those with a mental illness (3.8%).

Examples of prevention and promotion of mental health initiatives include:

Programme name	**Aim/approach**	**Stakeholders/target group**	**Duration, Cost of programme**
Schools			
Psychological counselling in schools	Aim: to prevent students from dropping out of secondary education due to personal or psychological problems. Target areas include young person's problems with self-esteem, loneliness, bullying, sadness, stress, anxiety and grief.	Students, vocational schools. Stakeholder: Danish Mental Health Fund (DMHS).	Not reported
Training courses for teachers	Aim: to teach teachers about mental health issues. Training sessions for teachers by mental health experts to increase knowledge about 'job dissatisfaction' and mental illness in children and adolescents.	Primary and secondary schools, teachers and counsellors in the Capital Region.	Not reported
Exam anxiety groups	Aim: to assist young people deal with stressful situations such as exams, presentations in class without anxiety or nervousness spoiling their performance.	Students, Schools, Psychiatry Fund Youth Project.	Not known
Psychological counselling in colleges	Aim: to offer psychological counselling to young people (minimum age 15 years) in the Copenhagen and Frederiksberg municipalities. Focus on assisting students to finish their educational programmes. For those with mild conditions deals with issues as depression, anxiety, bullying, stress, self-esteem and loneliness/isolation.	Students aged 15-30, Psychiatric Fund Youth Project.	Not known

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	delivered by psychologists.		
Teaching Youth Project	Aim: to training in mental health and how to thrive for students in primary and secondary schools. Also, to create transparency over mental health issues, build tolerance and offer specific options for students who have mental health issues.	Students, Psychiatric Fund.	Not known
The 'Happy Bus'	Aim: to promote knowledge and openness around of mental health issues and combat resulting stigma and prejudice. Host of promotion initiatives and campaigns to assist children within the school environment; subjects include eating disorders, depression, sadness, social anxiety and drug abuse.	Students and school staff.	Operating since 2002
Workplace			
Programmes on psycho-education	Aim: to ensure that any person who wishes to work is able to despite being their mental illness. Focused on depression, anxiety and stress in the workplace in particular on returning to work after a long absence, suitability of role for the employee and handling stressful situations. Delivered by professional psychologists.	Danish Mental health Fund Business Psychiatric Centre, Danish Government.	Psycho-education course currently costs 7000 Euros (including VAT).
After-work meetings for municipality and job centre advisors	Aim: to spread knowledge regarding the psycho-education and counselling of mentally vulnerable people. To enhance working capacity and employment retention.	The government, Danish Mental Health Fund, individuals who work with mentally vulnerable people returning to work, employers.	Not known
Psychiatry Supervisor Training	Aim: to offer basic knowledge on mental illness and vulnerability and an insight into the challenges that occur in the	The government, Danish Mental Health Fund, counsellors individuals in labour	On-going training costing 26,500 Euros (excluding VAT)

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	job market.	market settings, e.g. unions, pension funds, human resources, employers, employees.	
Older people in long term care facilities			
E-learning: Learning about dementia	Aim: to increase knowledge about dementia. Danish Dementia Research Centre offers four e-learning modules for people who work with dementia patients in municipalities and hospitals.	People working with those with dementia.	Not known
Active School for people with dementia	Aim: to assist people with dementia to remain active and maintain their social networks.	Government, Alzheimer's Association, people with dementia, particularly younger or early diagnosis sufferers.	Cost is currently 2,000 dollars per participant (including room and board)
Dementia Day	Aim: to offer training and present the latest knowledge in the subject. It gives an opportunity to meet colleagues and partners working in the area of dementia. Dementia Day is held over two days annually.	Managers, employees in social and health services, relatives.	Not known
Other programs			
Conversation Groups for children of parents with mental health problems	Aim: to assist adolescents deal with the potentially negative effects of having a parent(s) with a mental health condition.	Adolescents aged 11-16 years.	Not known

Financial responsibility for prevention and promotion activities

Responsibility for financing prevention and promotion activities is through taxes in the municipalities. Regional activities are tax financed by the state.

Investments into mental health – health, education, social development and economic growth

'Healthy for Life' campaign initiated in 2002 received government funding in the region of 300 million dollars. The net expenditure invested in general health promotion and prevention activities in 2010 was 80.7 (KR. Capita). In 2011, this increased to 83.0 (KR. Capita).

Initiatives to strengthen MH systems in relation to MHP and PMI

This is underlined by the public health policies launched over the past 10 to 15 years, with an emphasis on health promotion and prevention of disease. Mental health promotion has been gaining attention given its potential to reduce risk behaviour and prevent sick leave. Numerous municipal health initiatives have taken place and been mapped by a report published in 2009 by the Danish Board of Health (see section 5.7.4 above). Early intervention and early detection of mental health problems were prioritised in a psychiatry summit held in 2011.

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4.8 Estonia

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Summary

- There is no stand-alone mental health policy in Estonia.
- Psychiatric hospitals provide inpatient services, but there has been a steady decline in the number of beds.
- Outpatient services take priority over inpatient services in healthcare. This is similar to social care where community and supportive services are prioritised. Independent organisations such as the Tallin Mental Health Centre and Estonian Association of Psychosocial Rehabilitation provide and develop other mental health services, often at regional level.
- Although uniform funding in health and social care is a feature across the country, some are underfunded compared to others as a result of variations in population sizes in between municipalities. This negatively affects services such as day centres and community living.
- There is a significant lack of mental health professionals in Estonia, particularly psychiatrists and psychiatric nurses.
- Three main bodies provide prevention and promotion activities for general health. A modest amount of prevention and promotion activities were recorded for schools and just one programme (for suicide) in the general population.

Data for this country profile were gathered in the first instance by the project's country collaborator for Estonia. The research team used these data to prepare a draft country profile and supplemented with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from Estonia and validated by them.

Completed and validated 2012.

Background information

Population (1 January 2011)	1,340,194
Population density Inhabitants per km^2 (2009)	30.9
Women per 100 men (2011)	116.9
GDP PPP (2010)	0.7
Psychiatric care beds in hospitals per 100,000 inhabitants (2010) (3.4 psychiatric beds for children's services)	54.5
Standardised Suicide rate by 100,000 inhabitants	18.3
Gallup Wellbeing index (2010)*	
Thriving	17
Struggling	62

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Mental health legislation in Estonia consists of the Psychiatric Care Act (Psühhiaatrilise abi seadus, passed and implemented in 1997) which regulates psychiatric care in Estonia. Compulsory psychiatric treatment is issued by the courts according to the Penal Code and administered in psychiatric hospitals in a ward for compulsory psychiatric treatment and placed under supervision. The Social Care Act (Sotsiaalhoolekandeseadus, 1995) addresses social care services which includes specialised social care services for people with special needs (e.g. mental health problems). Neither Act deals specifically with wider mental health questions such as prevention and promotion of mental health. Other related Acts that bear some relevance to this include the Children's Protection Act, Working Place Health and Working Safety Acts, Family Act, Health Insurance Act, National Retirement Insurance Act, Healthcare Service Provision Act.

All other legislative and strategic documents mentioning mental health either do not mention prevention/promotion of mental health or only underline the need for mental health to be taken into consideration. The Development Plan for Children and Families 2012-2020 only highlight some areas for priority action but does not give any concrete indication what could be done in specific terms.

Mental health policy and inclusion of prevention and promotion

There is no stand-alone Mental Health policy in Estonia. A Mental Health Policy Framework was developed in 2002 following work by a NGO policy research centre after widespread consultations. This document the, "Eesti vaimse tervise poliitika

alusdokument" (loosely translated as the "Proposition for mental health policy in Estonia") was presented to Ministry of Social Affairs but after further consultations in 2003 was not taken further and received no state funding.

Health policy objectives are summarised in the "National Health Plan 2009-2020" which largely aims to increase life-expectancy and without disability. One of the five strategic objectives under this Plan is to increase social cohesion and create more equal opportunities. Under that strategic objective a priority area to raise awareness of mental health issues, including attention to early identification of symptoms of depression and the availability of high-quality services are listed for government action.

There is also a "Development Plan for Children and Families 2012-2020", currently in its last phase of public consultation, which intends to improve the wellbeing and quality of life of children and families, and increase of birth rate through these actions. Other priority areas for action include the development of need-based healthcare and consultation services for children with special mental health needs.

Other relevant strategic development plans are the Development Plan of Psychiatric Speciality (until 2015) and the Development Plan for Primary Healthcare 2009–2015 which has emphasised the importance of disease prevention and health promotion and the development of, for example, school health care and mental health nursing.

Mental health services

Organisation and functioning of mental health systems

The mental health system is divided between health and social care systems with additional services (such as prevention, promotion and related training activities) provided by the National Institute for Health Development (a national public health agency under the supervision of the Ministry of Social Affairs) and by local governments (in relation to social care services). Other Ministries (e.g. Ministry of Education), government institutions, NGOs and citizen/patient/specialist collaborations also play an important role in terms of mental health care.

The main types of psychiatric services include inpatient and outpatient care.

Inpatient care beds – In 2010 the number of psychiatric beds per 100,000 was 54.5 (3.4 psychiatric beds for children's services), with an average length of stay of 17.3 days. The number of psychiatric beds has declined steadily over the past few years (in 2003 the rate was 58.7 per 100,000).

The number of services that currently hold licences include:

13	Psychiatric services (hospitals)
1	Psychiatric consultations
1	Psychiatric services for court-ordered psychiatric cases
90	Adult Outpatient psychiatric services
6	Day care services
2	Children's Outpatient services

Outpatient services are prioritised over inpatient services in healthcare, particularly since Estonia regained independence in 1991. Similar trends can be seen in social care where community and supportive services have been prioritised over psychiatric asylum based services, especially in last two years. The level of mental health promotion and prevention of mental health problems in these services is unclear and it is likely to be quite low, with the exception of some services that are not funded by the state. These services can be either completely pro-bono or have varying degrees of funding from local governments or other sources such as the European Social Fund (ESF) for projects relating to, for example, prevention and promotion activities in the workplace.

Other mental health services include the:

- Tallinn Mental Health Centre (TMHC; http://www.mhcenter.ee/) - A social welfare institution that provides and develops mental health services for adults with psychiatric special needs. TMHC offers comprehensive support that is focused on individual needs and is intended to support different aspects of mental wellbeing. Examples of work to reduce stigma and increase social inclusion include information campaigns (e.g. "Be aware of mental health" etc.) and patient support groups for newly diagnosed patients.
- Estonian Association of Psychosocial Rehabilitation (EPRY; http://www.epry.ee/) - This institution has been active in popularising psychosocial rehabilitation (including the training of respective specialists). A network of regional support points has been developed for improved regional coverage of activities. Specific projects are often carried out using ESF financing for example rehabilitation and training services for people with special mental health needs, their families and people working with them (project "Increasing Social Inclusion of People with Mental Health Problems and Persons Close to Them through Support and Self-Help Groups – DUO Project", http://www.epry.ee/en/duo/).
- Foundation Mental Health Care Centre of Tartu (FMHCCT; http://www.tartuvthk.ee/) - Targets people of working age and older people with mental health needs. Services provided in addition to rehabilitation include training on readiness assessment for psychosocial rehabilitation, case management, service planning, assigning services to clients, and improving services in order to fulfil needs of the clients and/or guarantee

their rights. The FMHCCT carries out projects fully or partially funded by ESF for example project PEHIT which support of carers of people with special mental health needs and finding employment for them.

- Tallinn Children's Mental Health Centre - is currently being planned and will seek to integrate all children’s mental health services and considerably improve access and user-friendliness of such services.

Access and usage

Access to healthcare services is uniform throughout the country. There are two possible entry points to specialist services. GPs refer to most services, but specialist psychiatric care can also be accessed directly. Access to social care system is either with referral from healthcare (either GP or psychiatrist) or directly. While primary healthcare and non-specific social care services are accessible, close to, or in the community, the more specialised services tend to be more centralised. An example from healthcare is that GPs work locally, psychiatric out-patient care is centralised to regional centres while acute psychiatric in-patient care is available in two central hospitals. Thus, unequal access can arise if a person needs direct access to psychiatric care or specialised social care (e.g. specialist counselling) but lacks adequate transportation. Another possible source of unequal access can arise where non-specific social care services partially funded by municipalities.

The number of people using outpatient and inpatient psychiatric services in 2010 is listed below:

Year	Type of service	Number of persons	Days of treatment	Cost (EEK)
2010	Out-patient	59,517	989,392	79,101,002
	In-patient day care	140	5,465	1,556,515
	In-patient	7,601	184,909	210,514,367

Source: Estonian Health Insurance Fund

Variation and gaps

Funding in health and social care systems is stable and regionally distributed uniformly, but there can be significant differences in social care services funded by municipalities. This is due to the large range in size of municipalities, from 200 to approximately 400 000 people. This difference in population size has an impact on services such as day centres, supported living, community living etc. These services are not specifically targeted toward people with mental health problems but to older people who may have comorbid mental health problems.

The lack of mental health professionals, particularly psychiatrists and psychiatric nurses also represents a major gap in services is (see section on Workforce below).

Financing

Mental health care expenditure comes within the budget of the Estonian Health Insurance Fund (EHIF). Expenditure on these services is 5.78% of the total healthcare budget (World Health Organization, 2011). All specialised medical care costs are reimbursed by the EHIF. Since 2002 funds allocated to outpatient psychiatric services have been increasing. In 2007 25% of funds allocated to mental health care were spent on outpatient services.

Out-of-pocket (OoP) payments constituted 20.3% of total healthcare expenditure in Estonia in 2009. The OoP is mainly co-payment for medication which can be problematic for patients with severe mental illness. There is also a 15% co-payment for long-term care in healthcare system which can also have an effect on service use.

Workforce

Mental health care is provided mainly by psychiatrists, psychiatric nurses, nurses and psychologists. Despite an increased in the number of psychiatrists, from 174 in 2002 to 181 in 2006 and the number of psychiatric nurses working at health care providers has increased from 113 to 190 in 2006, the lack of human resources in mental health care provision is a growing problem. The number of psychiatrists in 2009 was 14.0 per 100,000. For psychiatric nurses this was 18.1 per 100,000.

Responsibility and delivery of mental health promotion and prevention of mental illness

There are three main institutions or groups that provide prevention and promotion activities in the area of health – the National Institute for Health Development (NIHD); Estonian Health Insurance Fund (EHIF); and the European Social Fund (ESF) (see section on prevention and promotion activities below).

Mental health status

Prevalence of mental health in the population

In 2008 the prevalence of mental disorders in the population was 8.4% (WHO HFA database).

Incidence of mental illness

Data from the National Institute for Health Development shows that in 2009 the registered incidence of all mental illness (F00-F99) was 4772.5 per 100,000 population.

Incidence was higher in women compared to men - 4871.4 vs. 4656.8 per 100,000 population respectively.

Protective and risk factors

One of the foremost risk factors for mental illness in Estonia is alcohol consumption. Volume of absolute alcohol per capita was 12.6 litres at its highest in 2007. Since then the consumption declined to 9.7 litres in 2010. Other risk factors for mental health in Estonia include socio-economic factors such as employment and income.

Prevention and promotion programs/activities

The following Institutes and organisations are involved in health promotion and prevention activities:

The National Institute for Health Development (NIHD) - performs almost all state funded, public health activities as dictated by national strategies. The prevention and promotion activities target population groups and not specific health areas (with the exception of cancer, cardiovascular disease, tuberculosis and HIV/AIDS where approaches are more mixed). The population group based activities usually address mental health along with other health topics relevant to these groups. The most important population groups targeted by NIHD non-disease-specific prevention and promotion activities are children (both in kindergarten and school) and working age people (i.e. workplace prevention and promotion activities).

Moreover, NIHD is the main centre for continuous training of public health, health promotion and disease prevention specialist in Estonia. NIHD additionally prepares and provides training manuals, guidelines, information materials etc. to the health promotion specialists and wider public as well. An example of training materials includes a manual for health promotion specialists working in schools that details identification of children's mental health problems with guidelines for further action ("How to identify and prevent mental health problems at school", developed by NIHD and funded by EHIF). NIHD is also responsible for supporting the development of municipal health profiles and strategies. The NIHD also provides grants for health promotion and prevention projects in municipalities targeting various health areas including mental health. Grants are provided using both state budgets and European Social Fund resources.

Projects funded through European Social Fund (ESF) - The ESF programme "Actions to support healthy choices 2010-2013" mainly targets people of working-age, but also the wider population, and delivered by municipalities and counties, health promotion specialists in municipalities, people from companies that have joined health promotion

networks, general practitioners, family nurses, physician in the area of occupational health, providers of workplace health services, specialists on workplace health, health promotion specialists other than in municipalities, community leaders and support personnel in social care system. Ministry of Social Affairs is responsible for the project as a whole while NIHD is the managing institution of the programme. Projects supported include the:

- Development of a network to prevent unemployment resulting from health related causes and to increase productivity of workforce
- Development of work environment supportive to health in order to reduce work related morbidity and to increase effectiveness of work
- Increase access to counselling that is intended to prevent morbidity and risky health behaviour and to promote healthy lifestyle with intention to support employment opportunities and health status of people and families
- Improve knowledge of Estonian population on health risks and healthy behaviour to reduce health related unemployment

Main areas of prevention and promotion are: children's safety and healthy development; healthy lifestyle; early detection of malignant tumours; cardiovascular diseases; injuries and poisoning; complex activities integrating different areas. Projects related to mental health are:

Programme name	**Aim/approach**	**Stakeholders/ target group**	**Duration, Cost of programme**
Schools			
Bereavement counselling for children who have close family members	Aim: to provide bereavement counselling for children. The concept of a grief camp was introduced and two such camps took place in 2010. More than 40 school-aged children participated in these camps. They provide support to counselling centres also continued in 2010 and 10 families were further able to participate in family support groups.	Bereaved children, EHIF	2010. Not reported
Health promotion in kindergartens and schools	Aim: to promote health in children. The project coordinates municipal action in this particular health topic. It has trained and kept active 18 health promotion coordinators for kindergartens and 16 for schools with good geographical coverage of Estonian municipalities. Consultations with 300 hundred	Children in schools, NIHD, EHIF	Not reported

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
	kindergartens and 344 schools were provided by these coordinators in collaboration with health promotion specialists from NIHD.		
Health promoting schools	Aim: to train local health promotion specialists active in kindergartens and schools. The network of health promoting kindergartens and schools expanded in 2010 as 18 new kindergartens and 16 new schools joined the network 2010.	Kindergarten and school children, EHIF	Not reported
Provision of school health service	Aim: to monitor the health of pupils, support development of healthy behaviours, prevent morbidity, improve healthiness of study environment and to provide first aid in case of health problems. School health service is provided (by school physician and/or school nurse) in all primary and secondary schools.	Schools, EHIF	Not reported
Other programmes			
Estonian-Swedish Mental Health and Suicidology Institute (ERSI; www.suicidology.ee)	Aim: to prevent suicide and promote good mental health in general. Numerous guidelines for various target groups and topics of mental health have been produced. The Ministry of Social Affairs has provided continuous financial support to their activities from state budget.	General public	Not reported

Financial responsibility for prevention and promotion activities

Responsibility for financing prevention and programmes is with Estonian Health Insurance Fund (EHIF).

Investments into mental health – health, education, social development and economic growth

Overall, it is important to note that mental health does not have a fixed budget allocation in healthcare or social funding. There is no information available on expected benefits or cost savings from the investments into promotion of mental health and prevention of mental health problems.

Initiatives to strengthen mental health systems in relation to MHP and PMI

Not reported

Data sources

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4.9 Finland

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Summary

- Since the 1990s, there has been a major shift away from institutional inpatient care towards outpatient community care. Inpatient care is provided in both psychiatric hospitals and psychiatric units in general hospitals.

- Outpatient services include Mental Health Centres which are often situated in local health centres. These are staffed by multidisciplinary teams including psychologists, psychiatrists, psychiatric nurses and social workers. Long term care includes residential homes, shared apartments and day care centres.

- There is considerable variation in service provision between municipalities, especially for outpatient services. This is apparent from regional disparities in the quality and availability of mental health services. Improved cooperation between primary health care, social health care, social welfare and occupational health would be advantageous.

- Municipalities are required to organise mental health activities to strengthen protective factors and minimise risk factors associated with mental illness. Some programmes were recorded for prevention and promotion in schools and the workplace with significantly more for the population in general.

Data for this country profile were gathered in the first instance by the project's country collaborator for Finland. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Finland. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	5375276
Population density Inhabitants per km^2 (2009)	17.6
Women per 100 men (2011)	103.7
GDP PPP (2010)	1.2
Psychiatric care beds in hospitals per 100,000 inhabitants (2011)	75.8
Standardised Suicide rate by 100,000 inhabitants	18.3
Gallup Wellbeing index (2010)*	
Thriving	75
Struggling	23

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MH Legislation and Policy

Current update and reference to prevention and promotion

The Finnish Constitution requires government to safeguard fundamental human rights, including the right to equal treatment and essential care. Public authorities must guarantee adequate social, health and medical services for everyone and promote the health of the population.

The Mental Health Act (1116/1990) provides details of the treatment of mental disorders, including the promotion of mental well-being, the ability to cope and personal growth of the individual, and the prevention, curing and alleviation of mental illness and other mental disorders. Mental health care encompassed both social and health care services provided for persons suffering from a medically diagnosed mental illness or other mental disorder. This work also includes improving the living conditions of the population to prevent mental disorders and supporting the organisation of mental health services. Despite the emphasis on prevention and community services, in practice mental health services deal mostly with institutional care and the treatment of severe illnesses and requires amendments (National Audit Office, 2009).

The Health Care Act (1326/2010, with Primary Health Care Act 66/1972 and Specialized Medical Care Act 1062/1989) and Social Welfare Act (710/1982) prescribe duties for municipalities and hospital districts with the aim of promoting and maintaining the health and welfare of the population, work and functioning ability, and social security, and to reduce inequalities in health. Municipalities organise the mental health services referred to in the Mental Health Act in their areas as part of public health care and social welfare, and joint municipal boards for hospital districts organise mental health services regarded as specialized medical care. In addition, the Health Care Act, states that

municipalities shall organise mental health work to strengthen factors that protect mental health and reduce risk factors for mental health. Mental health work includes (1) guidance and counseling on protective and risk factors, and psychosocial support for individuals and families, (2) psychosocial support in sudden traumatic situations, and (3) mental health services, i.e., examinations, mental health care and rehabilitation. The Health Care Act emphasises better and earlier cooperation between primary care and specialized medical care.

Mental health policy and inclusion of prevention and promotion

Over the past decade the Ministry of Social Affairs and Health has organised several national programmes such as the Suicide Prevention Programme, the Schizophrenia Programme, the National Depression Programme, Meaningful Life, Mental Health in Primary Services and the Masto project to reduce depression-related work disability. As a result there has been a shift in approaches from 'sickness' to 'health', from 'task and worker' to 'client and family', from institutional care towards community care and from particular themes to more broad and holistic approaches.

In the 2000´s, the goal of policy makers has been to incorporate mental health policy into general health and wellbeing policies. Although this has the advantage of being inclusive, this risks neglecting important mental health specific issues (e.g. Wahlbeck et al., 2008). Many of the present strategies and programmes deal with health and wellbeing, participation and social inclusion. These include, for example the:

- Socially sustainable Finland 2020: Strategy for social and health policy (STM, 2010) to achieve a socially sustainable society in which people are treated equally, everyone has the opportunity to participate, and everyone's health and functional capacity is supported, emphasizing everyone's right to social wellbeing, participation and the best health possible.
- Health 2015 programme (Government Resolution 2001) to extend people´s healthy and functional life and reduce health inequalities between population groups. The programme stresses the need to secure mental health services for children, but mental health issues are not otherwise prominent (Wahlbeck et al., 2008).
- National Action Plan to Reduce Health Inequalities (2008–2011) to reduce inequalities between socio-economic groups in terms of their work ability and functional capacities, self-rated health, morbidity and mortality. The main approaches are (1) adapting social policy measures to influence poverty, education, employment, working conditions and housing, (2) supporting healthy lifestyles, (3) improving the equity and need-based availability of social and health services.
- Policy programme for health promotion (2007–2011) to improve public health (e.g. to strengthen the structures of health promotion, achieve lifestyle changes, develop working and living conditions, strengthen basic social and health services and

develop new ways of promoting health, and strengthen the activities and role of organisations.

- Policy programme for the well-being of children, youth and families (2007 – 2011) for preventive work and early intervention. The aims are, e.g., to further a child-friendly Finland which supports the everyday well-being of children and families, reduces social exclusion and ensures that youth participate and are consulted more and are better informed of their rights.
- The 2009 National Plan for Mental Health and Substance Abuse Work (Mieli, 2009; 2010) to develop work that promotes mental health and substance-free lifestyles and prevents related problems, alongside the delivery of services. Key recommendations include the principle of low-threshold, single entry points for access to treatment at social and health centres and the introduction of integrated community care for mental health and substance abuse services. According to Proposal 18, the Ministry of Social Affairs and Health should update the Mental Health Act, the Act on Welfare for Substance Abusers and the Temperance Work Act and look into the possibility of consolidating the Mental Health Act and the Act on Welfare for Substance Abusers.

Mental health services

Organisation and functioning of mental health systems

Finland has a highly diversified, decentralized health care system, although the general planning, guidance and oversight of work on mental health is managed by the Ministry of Social Affairs and Health. The provision of health care has been gradually delegated to local authorities, for example, municipalities are responsible for arranging public health care and social services for their residents. Municipalities organise outpatient mental health care and rehabilitation services through the primary health care system provided at health centres and through social services. A municipality can produce the services for itself or jointly with other municipalities, by forming a cooperation area responsible for primary care. Specialised mental health services comprise inpatient services arranged through hospital districts, as well as outpatient services given by hospital districts and health centres. The country has 21 hospital districts providing specialized health care.

As municipalities have taken a greater share of responsibilities for arranging health services, the role of primary health care in organising mental health services has grown. Since the early 1990´s, there has been a major shift away from institutional inpatient care for psychiatric patients towards outpatient community care. According to Mieli 2009 (2010), more resources are needed to accomplish this transformation.

Mental health services include:

- identification of mental health problems and disorders,
- treatment of mental health problems and disorders at the primary level,
- psychiatric outpatient care,
- psychiatric inpatient care,
- psychiatric rehabilitation.

Inpatient services: are provided in psychiatric units in hospitals, some of which are located in general hospitals and others operate as separate psychiatric hospitals. The latter provide mental health examinations and treatment for people whose care is regarded as dangerous or particularly complex.

According to the World Health Organization Mental Health Atlas (2011), the number of psychiatric beds in general hospitals is 67.34; and in psychiatric hospitals is 8.42 per 100,000. This gives a total of 75.76 per 100,000 inhabitants.

Specialist outpatient services: are provided by health centres, mental health centres and psychiatric hospital outpatient departments. Mental health Centres are staffed by multidisciplinary teams with psychiatrists, psychologists, psychiatric nurses and social workers and other professionals. Many Mental Health Centres have been transferred to the administration of health centres and vary in number across the country. Long-term outpatient psychiatric care comprises of residential homes, rehabilitation homes, shared apartments, day hospital and day care centres, and sheltered housing are provided by municipal mental health and social services. In some parts of Finland these types of supported living services are provided mainly by the private sector or NGOS.

Municipalities can also arrange counselling services for mothers, children and families to support the healthy growth and wellbeing of children. These functions are implemented in collaboration with primary health- and social-care, and other service providers. The municipality is also obliged to arrange school and student health care services for pupils in comprehensive schools and upper secondary vocational schools. School and student health care also includes promoting the wellbeing of the school community. These functions are implemented in cooperation with parents, teachers and other school or student care personnel (e.g., psychologist or school welfare officer).

The precise number of services was not available but in a mapping of Finnish mental health services by Pirkola et al. (2009) in 308 municipalities in 2004 found: 69% had 24 hour emergency services, 66.9% had mobile services.

Access and usage

Access to mental health services starts at the primary care level and referral to psychiatric outpatient treatment or inpatient care as needed.

The number of psychiatric inpatient admissions was 30,600 (5.7 per 1,000 inhabitants) in 2009, 4% less than in 2008, with slightly more men (51%) being admitted. There were relatively large differences in admissions between hospital districts ranging between 7.7-7.8 per 1,000 in Eastern Finland to 4.2 per 1000 inhabitant in Central Finland.
The number of psychiatric outpatient visits in 2009 was 400 per 1,000 inhabitants (a total of 2,147,808). There has been an increase in client numbers in psychiatric housing services, and the number of clients was over 7,160 at the end of 2009. Of these clients, 51% received 24-hour care.

Variation and gaps

Mental health services vary considerably between municipalities, particularly in the development of outpatient services. The main challenge is to reduce regional disparities in the quality and availability of services and ensure comprehensive mental health planning at local levels. Better cooperation between primary health care, social welfare and occupational health care is also needed.

Financing

The proportion of the total healthcare budget spent on mental health services is 3.86% (World Health Organization, 2011).The main sources of funding are tax revenues, social insurance, out of pocket expenditure and private insurances. The Social Insurance Institute reimburses part of the private psychotherapy fees incurred by over- 16s who are threatened by incapacity to work or study, or who are unable to return to employment or studies without the support of psychotherapy.

Workforce

Figures on the number of different mental health professionals were not provided. However, according to the World Health Organization Mental Health Atlas (2011) there were 28.06 per 100,000 psychiatrists. The number of psychiatric nurses per 100,000 prior to 2005 was 180; psychologists 79; and social workers 150 (World Health Organization Mental Health Atlas, 2005).

Responsibility and delivery of mental health promotion and prevention of mental illness

Municipal social and health services are responsible for the prevention and early recognition of mental health problems. The Health Care Act obliges municipal authorities to prepare a cross-sectoral plan on measures to promote health and well-being, to prevent health problems, and monitor their implementation. Key recommendations laid out by the Quality Recommendation for Health Promotion (2009) aimed at clarifying and structuring the broad field of health promotion and establishing the promotion of health

and wellbeing as a high priority in all local municipalities, targeting particularly areas such as older people.

Employers also have a duty to arrange occupational health services based on the Occupational Health Care Act. It aims at preventing diseases and accidents, advancing healthiness and safety at work, promoting health, work ability and functional capacity of employees in every stage of their careers, and advancing well-being of work communities. One of the tasks of the occupational health staff is to give rehabilitation counselling to an employee and to guide her/him to medical or vocational rehabilitation when needed. More than 90% of all employees are cover by occupational health care. Employers receive social insurance reimbursement of the costs of preventive activities arranged by occupational health services.

Mental health status

Prevalence of mental health in the population

The proportion of the population aged between 15 to 64 years who experienced symptoms of depression was 16% (Health Behaviour and Health among Finnish Adult Population, THL, 2009). The table below shows the prevalence of depressive symptoms by age group. The highest proportion was in women aged between 15-24 years.

Age group	Men	Women
15 – 64	13	18
15-24	11	25
25-34	13	21
35-44	11	16
45-54	17	15
55-64	12	15

The table below provides the 12-month prevalence (%) of mental disorders according to DSM-IV from the Health 2000 survey (Pirkola et al., 2006).

Disorder/symptom	Males	Females	Total
Depressive disorders			
major depressive disorder	3.4	6.3	4.9
dysthymic disorder	1.9	3.0	2.5
any depressive disorder	4.5	8.2	6.5
Anxiety disorders			

panic disorder	1.4	2.4	1.9
social phobia	1.1	0.9	1.0
agoraphobia	11	1.2	1.2
generalized anxiety disorder	1.3	1.3	1.3
any anxiety disorder	3.7	4.8	4.2
Alcohol use disorders			
alcohol dependence	6.5	1.4	3.9
alcohol use disorder	7.3	1.4	4.3

Based on the Health 2000 Study, the estimated lifetime prevalence of *all psychotic disorders* was 3.5% (including schizophrenia 1%; all non-affective psychoses 2.3%), for affective psychoses (bipolar I disorder and major depressive disorder with psychotic features) 0.6%, and substance abuse psychoses 0.4% (Perälä et al., 2007).

Incidence

Not reported

Protective factors

Communal social resources and social support (Ellonen et al., 2008).

Risk factors

Having at least one childhood adversity, parents with mental health problems or alcohol abuse, being bullied at school, childhood family discord, low social support (both at work and in private life) (Pirkola et al., 2005b; Sinokki, 2011; Sinokki et al., 2009ab; 2010ab).

Prevention and promotion programs/activities

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
Schools			
The Koulumiete Project	Aim: to support pupils' mental health, prevent marginalization and promote positive development. Conducted in 7 schools (two elementary and five secondary). The programme notes school absences for early recognition and prompt help for pupils with high absence rates. The well-being profile included	Elementary and secondary school children and students.	Commenced 2002, operationalized and continues to be used

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
	components of school conditions (having), social relationships (loving), means of self-fulfillment (being) and health.		
The KiVa Program	Aim: to reduce bullying in schools. A programme with emphasis on influencing onlookers, who are neither bullies nor victims, to make them show they are against bullying and help them support the victim, rather than encourage the bully.	The activity is supported by the Ministry of Education and Culture.	Not reported
Training in mental wellbeing for teachers (Mielen Hyvinvoinnin opetus)	Aim: to provide pupils with health education. The empowerment-oriented learning material is in use in about 400 schools. Materials support pupils' growth, development, wellbeing and life skills. Also lectures planned for parents' meetings. Also training for employees in pupil welfare services to strengthen their mental health skills.	Children and young people. Teachers and Welfare services. Arranged by the Mental Health Association of Finland in cooperation with the Ministry of Education and Culture.	Not reported
Workplace			
Forum for well-being at work. Making wellbeing at work a strength - activities and opportunities for participation	Aim: to expand cooperation for promoting wellbeing at work. Also to increase health and safety, employees' physical, psychological and social well-being, meaningfulness at work, etc.	Ministry of Social Affairs and Health	2009
The Masto project	Aim: to prevent and reduce depression-related work disability by promoting: 1) practices increasing wellbeing and mental health at work, 2) prevention of depression for risk groups (e.g., psychosocial support, stress management methods, peer support and exercise), 3) early recognition of depression and early	Ministry of Social Affairs and Health	An action plan for years 2008-2011 2007

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
	support in tackling work ability problems, 4) good treatment for depression, rehabilitation and support in returning to work.		
Other programmes			
Health and Wellbeing: our Common Goal. Part of the National Development Programme for Social Welfare and Health Care 2008-2011.	Aim: to enhance social inclusion and reduce social exclusion, enhance wellbeing and health. The programme encompasses 39 national measures to support the achievement of the objectives. The objectives are sought to be achieved by: 1) preventing problems from arising and addressing problems that arise at an early stage, 2) ensuring the adequate supply and skills of employees, 3) creating integrated sets of services and effective operating models within social welfare and healthcare.	Ministry of Social Affairs and Health, municipal social welfare and health care carried out by local government and joint municipal boards. Targets all age groups.	Central government transfers have been set aside for development projects - EUR 24.8 million in 2008, about EUR 29 million in 2009 and about EUR 27 million in 2010 and 2011.
Promoting and Protecting Mental Health – Supporting Policy through Integration of Research, Current Approaches and Practices (ProMenPol) project	Aim: to promote and protect mental health. An online database & toolkit manual including experiences of field trials and the creation of a global network on mental health promotion. The ProMenPol Database contains a structured selection of more than 400 Mental Health Promotion (MHP) tools to support the practices and policies of mental health promotion in schools, workplaces and old people's residences.	Children, young people, older people and employees	EU-funded projects (2007–2009).
Training for Mental Health Promotion (T-MHP) project	Aim: to continue the ProMenPol project work and support teachers, HR professionals and care workers to understand the	Employees in schools, workplaces and older people's services	A two-year project (2009–2011). Life Long Learning Programme,

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
	factors critical for lifelong mental health maintenance and promotion in schools, workplaces and older people's services and initiate, implement and monitor policy and programme development within their organisations. A training course (face-to-face and e-learning) was developed in mental health promotion for the three settings.		Leonardo Da Vinci Funded 2009-2011
Time out! Getting Life Back on Track	Aim: to develop a psycho-social support programme for preventing exclusion among young men through research and development. Delivered as part of the health and social services organised by municipalities: 1) comprehensive support considering the developmental stage of the adolescent; 2) integration of preventive and promotion strategies; 3) client oriented, tailored support; and 4) avoiding stigmatization when seeking help.	The target group consists of men who are exempted from service at the call-up for conscripts or who interrupt military or civilian service	Commenced in 2005 and on-going
Mental Health Promotion Handbooks (MHP Hands)	Aim: to enhance the mental well-being of young people, the labour force and older people. This project will enable professionals working in these areas to acquire the appropriate skills and knowledge to address these issues through effective mental health promotion.		2010–2013
The Effective Family Project	Aim: to train welfare workers around Finland, and develop new methods for improving the situation of children whose parents have mental health problems.		Funding from the Academy of Finland

Financial responsibility for prevention and promotion activities

Not reported.

Investments into mental health – health, education, social development and economic growth

Investments in health and wellbeing programmes have been supported and funded by central government. These programmes incorporate mental health promotion and prevention of mental health problems within them. The Kaste programme has received significant amounts of funding during the course of its implementation (see section on prevention and promotion programmes for details).

Initiatives to strengthen mental health systems in relation to MHP and PMI

By investing in major health and wellbeing programmes the Ministry of Health and Social Affairs has set out to strengthen all service structures by revising and better integrating social welfare, health (including mental health) and primary health care services. Cooperation between specialised medical care and primary healthcare is to be strengthened and the collaboration and division of duties among hospitals intensified. The future development of social welfare and health care services includes the establishment of social and health centres that provide access to local services through a low-threshold single entry point. So far there are only few combined social and health centres in the country (Mieli 2009; 2010).

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4.10 France

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Summary

- The delivery of mental healthcare for adults is organised within regions of equal population based around a central coordinating hospital. These areas account for approximately 40% of psychiatric hospitals and 80% of psychiatric beds. Other services include day hospitals, clinics/units and Mental Health Centres.
- Mental health services across territories vary considerably. The Government's most recent Mental Health Plan is attempting to address this.
- There is a shortage of psychiatrists working in the public sector. This is linked to the relatively high proportion of psychiatrists working in the private sector so.
- Mental health professionals generally focus on prevention of mental illness rather than mental health promotion.
- Prevention and promotion activities focused on schools and families with a smaller number in the workplace and none for the elderly. Programmes were also aimed at the general population.

Data for this country profile were gathered in the first instance by the project's country collaborator for France. The research team used these data to prepare a draft country profile, supplemented with published data where necessary and edited. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from France but was not validated.

Completed 2012, but not validated.

Background information

Population (1 January 2011)	65075373
Population density Inhabitants per km^2 (2009)	101.4
Women per 100 men (2011)	106.5
GDP PPP (2010)	1.1
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	88
Standardised Suicide rate by 100,000 inhabitants	14.9
Gallup Wellbeing index (2010)*	
Thriving	35
Struggling	60

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

The latest Mental Health legislation in France was enacted June 1990, French Law No. 90-527. It provides governance on the rights and protection of people who require compulsory admission to hospital due to mental illness. This Law upholds a person's civil liberties, the most important being freedom of movement and the safeguarding of these rights during involuntary hospitalisation.

Two methods for involuntary hospitalisation are detailed within the Law and are based on different conditions and circumstances. Hospitalisation at the request of a third party ("HDT" - Hospitalisation à la Demande d'un Tiers) is based on the principle that a person may cause a danger to himself if the person is: a) in a state that requires immediate care and constant supervision in a hospital setting, and b) suffering from a mental disorder making consent impossible.

Mental health policy and inclusion of prevention and promotion

In 2005, the Psychiatry and Mental Health Plan 2005-2008 (Psychiatry and mental health 2005-2008 plan), a key policy initiative, was launched to: Improve coordination between psychiatric and preventive mental health care; reinforce informal carers' rights; improve the quality of care and research; and introducing targeted programmes for specific diseases or patient groups. The Plan included sought to reduce the number of suicides, reduce social exclusion and stigmatization of people with mental disorders and increase the number of patients receiving appropriate treatment. The policy was to be implemented by regional offices competent in public health, the education sector,

Judicial Protection of Youth and other relevant stakeholders. In terms of actions, the strategy to prevent suicide and depression was structured around four priority areas: promoting screening for suicidal crisis, reduce access to lethal means, improve the management of suicidal patients and to gain further epidemiological knowledge. Improving the mental health of children and adolescents included the implementation of specific programmes including enhancing the identification and management of children with psychiatric disorders (especially via the development of a repository of training on the identification of developmental disorders and manifestations of psychological suffering in children and adolescents).

For improving mental health at work the government launched in year 2009 emergency plan for the prevention of stress at work, which included the 1,500 firms employing over a thousand employees. This launched was accompanied by a legal obligation for employers to protect the physical and mental health of their employees.

The 'Ageing Well' Plan launched in 2007 aimed to identify and prevent, at the time of retirement, risk factors related to aging. Based on the report "Mental health and well-being of the elderly", commissioned in early 2011, the government will launch in 2012 the second national "Aging Well" to provide the keys to a '' successful aging '', both in terms of individual health as social relations, enhancing the organisation and implementation of appropriate preventive actions.

Other plans include a second Occupational Health Plan (2010-2014) prioritized to mental health in the workplace and combat work-related stress. It focuses on four main areas: developing research to establish a prevention approach, strengthening support for companies, especially SMEs, reform occupational health services.

Mental health services

Organisation and functioning of mental health systems

The shift towards community based mental health services took place during the second part of the 20th century. Generally services for people with mental illness are currently organised across three levels: At the local level within the territory of health: the psychiatric sector in collaboration with elected officials, social, medical and, social territorial level of hospitalization, and regional and interregional levels of expertise and specialization.

Adult public mental health care is provided within geographical areas of theoretically equivalent population size, called mental health care (care of sanity; MHC) areas (sectors). Care within each area is coordinated by a hospital (a public hospital in more

than 90% of the cases) and includes a wide range of preventive, diagnostic and therapeutic services, which are provided in both inpatient and outpatient settings. In particular, ambulatory care centres (centres psychologiques; CMP) are present in almost every MHC area. They provide primary ambulatory mental health care, including home visits, and direct the patient towards appropriate services. NGOs are also involved in providing mental health services.

Inpatient care: According to the World Health Organization Mental Health Atlas (2011) there were 22.72 per 100,000 population psychiatric inpatient beds located in general hospitals; and 101.06 in psychiatric hospitals. In 2010, this was 59.0 per 100,000 (Information psychiatric, 2010). There were 90 psychiatric hospitals with a total of 42,063 beds in 2009. Overall, MHC areas account for 40% of psychiatric hospitals and 80% of psychiatric beds. The private sector accounts for 70% of the remaining inpatient capacity and so an important provider of psychiatric inpatient care. This is not the case, however for outpatient mental health services.

Other mental health services: The total numbers of other mental health services (from the World Health Organization Mental Health Atlas, 2011) include:

Day hospitals/day treatment facilities	2193
Outpatient facilities	3600
Community residential facilities	7991

Source: World Health Organization (2011)

There are approximately, 3,117 mental health centres (2,070 for general adult psychiatry and 1,047 child and adolescent psychiatric services).

Access and use

Free access to mental health services is available. Mental health problems are also treated on an outpatient basis by GPs. The rate per 100,000 inhabitants treated in mental health outpatient facilities was 2,586.3; and 713.64 for those admitted to inpatient psychiatric hospital (World Health Organization, 2011).

Variation and gaps

The variation of mental health services across the territories is notable and the latest Mental Health Plan has attempted to deal with the heterogeneity of resources.

Financing

Government expenditure for mental health care is 12.91% of the total healthcare budget (World Health Organization, 2011). Primary sources of funding are social insurance and tax revenues. The mental health budget comprise 12% of the health budget overall in 2009.

Workforce

The number of health professionals employed within mental health services per 100,000 inhabitants include:

Psychiatrists	22.3
Nurses	86.2
Psychologists	47.9
Social workers	3.8

Source: World Health Organization (2011)

Despite the relatively high number of psychiatrists there is a shortage of those working in public sector services, as a substantial proportion of psychiatrists work in the private sector, around 50%. In 2007, there were approximately 25% full time permanent posts and 40% part time available in 2007.

Responsibility and delivery of mental health promotion and prevention of mental illness

Mental health services and professionals working in these services tend to focus mainly on prevention of mental illness rather than mental health promotion.

Mental health status

Prevalence of mental health in the population

A mental health survey of the general population (SMPG), conducted by the Collaborating Centre World Health Organization (WHO CC) and the Directorate of Research, Studies, Evaluation and Statistics (Drees, 1999; 2003) involving 36,000 people aged 18 and above over and using ICD10 diagnostic codes, found: 11% of respondents had had a depressive episode in the previous two weeks of interview. 13% a generalized anxiety, anxiety disorder; 2.8% psychotic-like syndromes in those over 18 years; 2% of adults with a high risk of suicide; a 1% lifetime prevalence of psychotic disorder which has remained largely stable over time.

Incidence

Not reported.

Protective factor

Good parenting.

Risk factors

Separation or divorce; being unemployed.

Prevention and promotion programs/activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Prevention programme for the identification and management of suicidal crises and mental suffering in adolescents	Aim: to prevent suicide and mental health problems in adolescents. As part of the "National Strategy for Preventing Suicide 2000-2005" training for the identification of suicidal crisis intended for school nurses were held. for school nurses and teachers. Trainers consisting of a psychiatrist and a psychologist trained at the national level for the organisation of training areas.	Children and young people. Directorate General of Health, regional public health groups, French Federation of Psychiatry (FFP), National School of Public Health (ENSP), psychiatrists, child psychiatrists, doctors PMI, doctors of Education, psychologists.	Funding Amount: 700,000 euros per year for teacher training and deployment in the region for training in the identification of mental suffering.
A five-year programme of prevention and health education of students	Aim: to conduct educational activities to prevent difficulties and psychological problems of adolescents. Observation of students' health and monitoring, identification of signs of psychological suffering of children and adolescents and the organisation of educational health.	Adolescents. In partnership between the Ministry of Education and the Ministry of Health.	2005
Prevention of bullying at school	Aim: to prevent bullying in schools. This programme includes several components, including: The launch of a	Schools and colleges.	Fall 2011

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	national victimization survey - Renewed every two years. The distribution of a guide on harassment Prepared by psychiatrists and made available to all education staff. It will be supplemented by a manual of procedures to prevent harassment via the Internet and social networks. A "national information campaign" to be launched for children and parents through a website and a telephone-helpline for victims.		
Distribution of a guide on risk behaviours	Aim: to raise awareness on and prevent risky behaviour. A guide on risk behaviour for children and adolescents. Several thousand copies have been distributed by the National Institute of prevention and health education (Risk behaviours and health: acting school-INPES - collection). This guide offers prevention strategies recognized among professionals involved in prevention in schools.	Children and adolescents. National Institute of prevention and health education	
Workplace			
The Nasse Légeron report	Aim: to guide mental health promotion and prevention in the workplace. This report on "the identification, measurement and monitoring of psychosocial risks at work," is a tool for identifying and analysing mental health at work. Report provides 9 proposals, including the implementation of training.		2008
Welfare and work efficiency guidelines	Aim: to promote mental health in employees. The involvement of senior management and its	Employers, employees, occupational health	2010

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	board of directors are essential: the performance assessment should incorporate the human factor, and thus the health of employees. Guides employers in managing and promoting mental health of employees and advice to occupational health staff.	staff	
Older people			
None relevant reported			
Other programmes			
The programme CAPEDP - (Parenting and attachment in infancy: lower risk of mental health disorders and promotion of resilience).	Aim: to provide early years support and guidance for mothers to be and with young children. An action research programme initiated in the Paris region to intervene early, during pregnancy and up to 2 years. This study is carried out on the initiative of Pediatric teams (under the leadership of the Department of Psychiatry of the hospital Bichat-Claude Bernard in Paris). The intervention aims to promote CAPEDP, via a home visit professional coaching, positive health behaviours during pregnancy and early life of the child and to assist the mother in situations of social vulnerability, develop parenting skills and build relationships with the health care system, the social and professional environment.	Mothers to be and mothers with children up to 2 years	2009 to mid-2011. Possible extension to 2012. Supported by a budget of 1, 5 million euros (INPS + hospital programme for clinical research).
Plan "Youth Health"	Aim: to prevent suicidal crises and psychological problems in young people. Launched by the Minister of Health, Youth	Young people aged 16 to 25 years	2008

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	and Sports, the plan includes a series of measures to better protect the health of young people. The key measures consist of a tracking device and prevention of suicidal crisis and psychological suffering among young people, especially among young gay men.		
The creation of "houses of adolescents'	Aim: to provide knowledge on health issues for vulnerable adolescents. These structures to manage the psychological suffering of young people. To be distributed throughout France. The homes of adolescents (MDA) are reception areas whose mission is to provide answers to health questions. For adolescents in difficulty and provide appropriate support. They can make care proposals, with involvement of the families when needed. They can make proposals for care, with family involvement in case of need.	Adolescents	June 2007. Public funds given. 39 MDA were helped by public funds. The services of the State have also partnered with the foundation hospitals of Paris hospitals of France to coordinate financial interventions while respecting the priorities of each.
Repository for physicians for early identification of mental and developmental disorders in children and adolescents	Aim: to detect early mental and developmental disorders in children and adolescents. Developed in 2006 by the French Federation of Psychiatry at the request of the Ministry of Health. It is designed to train physicians who train other practitioners.	Children and adolescents. Physicians. Ministry of Health.	Since 2006
Programme against mental suffering associated with homosexuality	Aim: to prevent mental health problems in homosexuals. Two educational tools have been launched, in addition to government support to associations fighting against homophobia, one on the Internet with the support of a filmmaker the other via an		Budget: 400,000 euros.

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	editing tool INPES.		
Combat social exclusion and stigma	Aim: to combat social exclusion and stigma. A major campaign against depression was conducted by INPES (Institut national de prévention et d'éducation pour la santé).	General public.	2007

Financial responsibility for prevention and promotion activities

Not reported.

Investments into mental health – health, education, social development and economic growth

Financing of the Psychiatry and Mental Health Plan has included Means of operation, psychiatry and mental health 2005-2008 plan has 287.5 million. In addition, the plan has received an annual grant from the Fund for the modernization of public health facilities and private (FMESPP) of €22.3 million in 2005, € 59.6 million per year in 2006 and 2007, €47 million in 2008 and €35 million in 2009-2010.

Investments for the prevention of depression and suicide are for improving the management of depression, including through better identification of major depression (€100,000), to better inform the public and professionals (€7 million), and development of research on the determinants of depression and practices of care (€35,000). The Perinatal period, children and adolescents Perinatal and Pediatrics Plan aimed at developing collaboration in perinatal, medical and psychological services to strengthen the prevention of psychological developmental disorders in children (€18 million over 3 years for 6 clinics). And investments in infant and child psychiatry have also been provided since 2005.

Initiatives to strengthen mental health systems in relation to MHP and PMI

Another 'Psychiatry and Mental Health' policy is planned for the fall of 2011/2012 to cover the period 2012-2015. So far, no information is available on this plan or whether resources will be allocated towards it. Other relevant plans include tackling bullying in schools (Fall, 2011) and to prevent isolation in older people (2012).

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4.11 Germany

Authors

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Summary

- Over the last 25 years there has been a shift from traditional psychiatric hospitals to community based inpatient facilities. The health and social care system is mainly decentralised across 16 Federal States. Psychiatric wards in general hospitals form the main part of community based inpatient care. Psychiatric hospitals still exist although decreased in size and emphasis on treatment.
- The provision of community mental health care is characterised by the prominent role of GPs, outpatient psychotherapists and outpatient psychiatrists.
- Most inpatient facilities offer outpatient departments for specific disorders. These facilities, with their multidisciplinary teams, have increased hugely in number over the past three decades. Outreach activities and home visits are also provided through these departments. Social psychiatric services also offer wide provision.
- There is said to be variation in structure and organisation of mental health services across Federal States. Lack of national data and the disjointed nature of the country's national health system however, make this difficult to assess. Gaps in mental health care include poor identification of those with depressive disorder and poor access to psychological therapies.
- In 2004, the Federal Government submitted general health proposals which included provision for mental health prevention and promotion. Fully 52 examples of prevention and promotion programmes are listed in schools and 8 in the workplace. The former tend to focus on conflict management, stress reduction, eating disorders and drug and alcohol awareness. No examples of activities with the elderly were recorded.

Data for this country profile were gathered in the first instance by the project's country collaborator for Germany. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from Germany. This expert provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by the Governmental expert and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	81,751,602
Population density Inhabitants per km^2 (2008)	229.9
Women per 100 men (2011)	103.8
GDP PPP (2010)	1.1
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	49
Standardised Suicide rate by 100,000 inhabitants	9.5
Gallup Wellbeing index (2010)	
Thriving	43
Struggling	50

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Federal Government plays an important role in setting legislation, particularly for social and welfare legislation which is documented in Social Code Books. Federal States are responsible for special legislation, planning and coordinating mental health policy. Each Federal State defines their own terms, including regulations on involuntary admission to hospital and treatment. The last mental health legislation was enacted in 1999.

Section Three of the Social Code (SGB) Book V (V) - Public health insurance - (Article 1 of the Act of 20 December 1988, Federal Law Gazette I p 2477) deals with services for disease prevention, health promotion and prevention of work-related health hazards and promotion of self-help (§ 20 SGB V Social Code Book). This Law assigns Statutory Health Insurance companies with the task of preserving the health of those insured, improving health, providing advice and encouraging healthy lifestyles. The regulatory framework of the Statutory Health Insurance Funds (SHIs) also focuses on mental health promotion and prevention of mental illness in some settings. SHIs have a system of recording and managing their national health prevention and promotion targets and evaluation procedures (Ministry of Health, May 2012).

Mental health policy and inclusion of prevention and promotion

The Lander Ministry of Health is an agency central to mental health policy for all 16 Länder (Federal States). By 2004, 13 out of 16 Länder had a policy document describing the ethical, political and structural basis on which mental health policy should be based on their territory. Though not legally binding, these documents provide guidelines for

mental health policies. Measures for the prevention of mental illness and promotion of mental health have been included in the mental health policies of 5 Länders - Baden-Württemberg, Berlin, Mecklenburg-Western-Pommerania, Saxony and Thuringia.

More recently several other declarations and action statements have emphasised the importance of prevention and promotion. For example, a Joint Declaration by the German Society for Social Medicine and Prevention (DGSMP) and the Statutory Accident Insurance institution (DGUV) published in 2010 listed six national health objectives. This includes the prevention, early detection and treatment of depression. The Health and Safety Strategy has also set national targets in maintaining and promoting mental health by seeking to reduce mental strain in the workplace.

Mental health services

Organisation and functioning of mental health systems

The German mental health system has undergone major transformation over the past 25 years. Much of this change has involved the shift from traditional psychiatric hospitals to community based inpatient facilities. The health and social care system is predominantly decentralised across 16 Federal States which creates significant challenges to the effective coordination of mental health service provision.

Mental health care in the community is predominantly delivered by general practitioners, outpatient psychotherapists and outpatient psychiatrists. The types of mental health services available include:

Inpatient care: General hospital psychiatric wards/departments or units form the main basis of community-based inpatient care. Psychiatric hospitals have been transformed in their infrastructure, staffing levels, therapeutic culture and procedures. Very few psychiatric hospitals have been closed, but most have decreased significantly in size and changed their focus towards regionalised acute hospital care, alongside a growing number of psychiatric wards at general hospitals. Beds in psychiatric hospitals outnumber general hospital psychiatric ward beds. Specialized psychiatric care includes child and adolescent psychiatry, forensic psychiatry and psychosomatic hospital care. In 2010 there were 245 psychiatric hospitals. There are currently 66,795 psychiatric beds in Germany, approximately 12,760 of those are situated at general hospitals (Federal Office of Statistics, 2010)

Outpatient care: Many inpatient facilities (general hospital psychiatric wards and psychiatric hospitals) run psychiatric outpatient departments (''Institutsambulanz'') for specific mental disorders, particularly for patient groups with severe mental illness, i.e. ongoing psychotic disorders, and patients for whom multi-professional community

care is required. These services were first implemented in psychiatric hospitals in the late 1970s. A revision of the Social Security Act in 2000 extended the permission to provide community care in such psychiatric outpatient departments to general hospital psychiatric wards. The number of outpatient departments increased from 27 (in three federal states) in 1980 to 304 in 2002. Outpatient departments were complemented by 219 similar services (labelled ''Ermächtigungsambulanz''), which are only eligible to treat patients with specific problems, referred from psychiatrists in office practice. As a rule, psychiatric outpatient departments provide psychiatric treatment for patients with severe and persistent mental disorders. In order to be able to provide comprehensive care packages, teams include nursing staff, social workers and other professional groups (e.g., occupational therapists), along with psychiatrists. Outreach activities and home visits are provided. Psychiatric outpatient departments may, in some instances, be seen as competing with psychiatrists in office practice, who dominate medical outpatient care for people with mental illness in Germany.

Social psychiatric services: Social Psychiatric Services (''Sozialpsychiatrische Dienste'') are additional specific outpatient services for people with chronic mental illness. These services were first implemented during the mid-1970s to bridge the gap between hospital care and psychiatric outpatient treatment. Although being specialised in limited tasks, social psychiatric services are functionally integrated into community mental health care. They differ from community mental health centres (CMHC) in other European countries in that they do not focus primarily on psychiatric treatment, which is in the responsibility of psychiatric outpatient departments and psychiatrists in office practice. The role of social psychiatric services is complementary to other (inpatient and outpatient) services, and their aims include long-term rehabilitative care. Social psychiatric services in most German federal states are directed by psychiatrists and staffed by social workers or psychiatric nurses. They provide a wide range of care and support for patients and their families, including outreach or day care activities. Care offered by social psychiatric services is essential in the case-management of people with chronic mental illness, particularly in view of the fragmentation in the mental health care system. In 2000, 586 social psychiatric services were provided in Germany (Arbeitsgruppe Psychiatrie 2003). Team size is 5 or 6 staff members, on average; the overall number of professionals working in these services is not available.

Other outpatient services also include: outpatient psychiatrists, general practitioners and family doctors in mental health care, outpatient psychotherapy, sheltered accommodation and residential care, day care and rehabilitative care.

Access and usage of services

There is limited activity data on the use of mental health services in Germany which is a major obstacle to mental health service planning and evaluation. The exception to this is the hospital sector where a number of indicators are described in annual reports published by the Federal Statistical Office. The complexity and fragmentation of Germany's outpatient mental health care system is a serious obstacle to the identification of trends, the quality of care, interdependencies, overlapping care systems, or undersupply. In community (or complementary) care, documentation systems with a potential to cover the whole range of services in outpatient mental health care have been developed (Kallert and Becker, 2001; Salize et al., 2000; Aktion Psychisch Kranke, 2005). However, as documentation takes a lot of time, few staff are able to do this. High documentation standards are found in a small number of regions. Apart from regular hospital data, there are annual reports on the nationwide consumption of pharmaceutical drugs, which may allow changes in psychopharmacological drug use or cost to be assessed (Schwabe and Paffrath, 2004). These reports are essential for mental health care since psychiatrists (and of course their patients) are faced with serious restrictions limiting their prescriptions of atypical antipsychotics. Compared to the US or the UK, the rate of prescription of traditional neuroleptic drugs is still high in Germany, and prescribing practice does not always comply with guidelines (Berger and Fritz, 2004).

Access to most services is free, with the exception of referral slips to specialised care which must be issued by a general practitioner before any specialist may be contacted.

Gaps and variations in services

The lack of national data and the fragmented nature of the German mental health system make it difficult to quantify variations and gaps in mental health services. The system is likely to differ widely across Federal States in the structure and organisation of psychosocial services. Another important concern is the number of people suffering from mental health problems who are not diagnosed by GPs. For example, only 50% of people with a depressive illness are identified and diagnosed correctly by GPs. Also, the proportion of the general population who develop depression (ICD 10 - F32 and F33), according to one study, is 9% yet only 6% receive psychological therapy; for older people aged over of 60 years the figure is 2% (Barmer-GEK, 2007). This is a notable gap compared with guidelines set in 2009 by a network of professional organisations and societies including the German Society for Psychiatry, Psychotherapy and Neurology and the Federal Chamber of Psychotherapists (PTK-Newsletters SPEZIAL, 2010).

Financing

According to the World Health Organization Mental Health Atlas (2011), 11% of the total healthcare budget is spent on mental health services. The primary sources of mental health financing are statutory or private health insurance. Rehabilitation is financed

through health insurance, the statutory pension insurance or where necessary the social welfare system. Self-employed psychiatrists are paid on a fee-for-service basis which is strictly regulated with semi-statutory professional associations and health insurance organisations.

The 2010 Act for Sustainable and Socially Balanced Financing of Statutory Health Insurance was introduced to deal with the potential future difficulties associated with an ageing population, shrinking workforce (due to ageing and falling birth rates) and the subsequent increase in healthcare spending. This legislation aims to reorganise the way healthcare is financed. From January 2011, the health insurance contribution rate has been fixed at 15.5%. This allows the insured people to choose the best SHI-fund with the best price-performance ratio (Ministry of Health, Jul 2012).

Mental health workforce

The number of mental health professionals includes (per 100,000; World Health Organization, 2011):

15.23	Psychiatrists
56.06	Nurses

Responsibility and delivery of mental health promotion and prevention of mental illness

Federal State Ministries are responsible for the development, planning and implementation of illness prevention and health promotion activities. At municipal level these activities are coordinated by Public Health Departments and delivered by hospitals and rehabilitation services. Semi-governmental (e.g. Public Health Insurance fund) and NGOs are involved in illness prevention and health promotion, and help the development, financing and dissemination of these programmes.

In the Social Code and special legislation prevention of illness and health promotion is mainly the responsibility of the Federal States, which have their own mental health laws. These also contain provisions on Preventing Mental Illness (PMI) and Mental Health Promotion (MHP). Due to the federal system there are substantial differences in the structure and organisation of psychosocial services in Germany which makes it difficult to have an overview of the entire spectrum of services and institutions involved. Although the diversity and complexity services make comparisons between Federal States difficult, it is possible to describe the institutionalised health system in Germany.

Some organisations and institutions are engaged with health promotion and prevention of illness at national, federal state and municipal level. Those organisations and institutions include governmental, semi-governmental and non-governmental types. The most important governmental institution at national level is the Federal Ministry of

Health which directly cooperates with a council of experts, discussion forums concerning illness prevention and health promotion issues. The Federal Ministry of Health is also responsible for the work of many Federal Institutes in this area, for example, the Robert-Koch-Institute which is directly responsible for the Federal Centre for Health Information. Other Ministries that share responsibility in this area are: the Federal Ministry of Education and Research, the Federal Ministry for Family, Old People, and Youth, the Federal Ministry for Consumer Protection, Nutrition and Agriculture or the Federal Ministry for the Environment, and Nature Conservation and Nuclear Safety.

Federal State Ministries (of Education, Health, Employment and Social development) are responsible for developing, planning and implementing illness prevention and health promotion policies, programmes and activities at the respective Federal State or Federal City State. The programmes and policies are implemented in each Federal State by the respective State Public Health Department which is responsible for the network of Public Health Departments at county level.

Administrative bodies at the community level are charged with the preventing illness and health promotion at schools, kindergarten or long term facilities for older people. Semi-governmental institutions at national level, such as the Public Health Insurance, Federal Professional Associations, Federal Physicians Associations and the Public broadcasting companies are responsible for developing, financing, disseminating and implementing prevention and promotion programmes and activities. Those institutions have counterparts at Federal State level. Health promotion and prevention measures at municipal level are delivered by hospitals and rehabilitation clinics and health insurance funds.

There are many non-governmental organisations (NGOs) involved in prevention and promotion at federal level. The most important are: the National Association for Health, the Federal Association for Social Welfare, the Central Office for Addiction issues, the German Nutritional Society, the Network of Healthy Cities, and the Federal Consumers Advice Centre. Other Federal NGOs include self-help organisations, sport organisations, private health insurance funds, private corporations/companies and mass media like journals and internet. All these institutions play an important role in the development, financing and dissemination of health promotion and prevention programs, policies and activities in Germany. At Federal State and community level several other institutions also implement prevention and promotion activities, such as the Federal State Central Corporations for Health Promotion, Federal State Associations for Welfare and Care, self-help associations, consumers aid associations, sport associations and clubs, advice centres, foundations and firms which play a very important role in the implementation of promotion and prevention activities at community level.

Mental health status

Prevalence of mental illness in the population

Mental illness: In 2009, 1,151,390 people were diagnosed with a mental illness (F00-F99 ICD10 codes), amounting to 1,405.8 per 100,000 population:

- F10-F19 Mental and behavioural disorders due to psychoactive substance use. Life time prevalence: Alcohol abuse n=224, 6.3%, SE=0.5; Alcohol dependence n=44, %=1.5, SE=0.3; Any substance use disorder n=228, 6.5%, SE=0.6
- F20-F29 schizophrenia, schizotypal and delusional disorders - Prevalence: Approx. 800,000 schizophrenia cases in Germany 2008; Incidence: Approx. 13,000 new cases per year in Germany 2008.
- F30-F39 Mood [affective] disorders - Life time prevalence: Any mood disorder n=398, 10.7%, SE=0.7.
- F40 Neurotic, stress-related and somatoform disorders - Life time prevalence: Any impulse-control disorder-n=31, 3.1%, SE=0.8.

ICD Code:	Hospital statistics for 2009 (total numbers)	Prevention and rehab services statistics 2009
F00-F03 Dementia	26,950	248
F10.5-F19.5 Psychotic disorders due to alcohol and substance use	433,182	1,263
F20-F29 Schizophrenia, schizotypal and delusional disorders	136,251	1,406
F30-F39 Mood [affective] disorders	237,774	65,635
F40 Neurotic, stress-related and somatoform disorders	48,373	101,551
F90–F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence) (Conduct disorders)	30,375	9,708

Source: World Health Organization World Mental Health Survey 2008 (Pop=67,058,890), (Sample size=3,555)*

Incidence

See above

Protective and risk factors

Not reported.

Prevention and promotion program/activities

Schools: Examples of twenty nine school mental health prevention and promotion programmes listed which cover conflict management, stress reduction, eating disorders awareness, drug and alcohol misuse prevention to target children and young people. In the workplace eight examples across various Federal States are described. These target school teachers, aim to reduce or prevent workplace stress and promote resilience in private sector employees. No examples of prevention and promotion activities were reported for older people in long-term facilities. A list and description of programmes appears below.

Name	Aim(s)	Stakeholders /target group	Methods or approach used	Main results of any evaluation	Duration, cost of programme or finances allocated
School programs					
1 Programme "Stark.stärker. WIR." Baden-Württemberg Ministry of Education.	Aim: Conflict management and prevention at school	Teachers and School directors	Seminars to promote social competence and resilience, with schools.	n. a.	Starting 2011, costs n. a.
2. Programme "Aktive Teens", Ministry of education, youth and sport, BKK. www.aktive-teens.de	Aim: Mentoring for pupils. Personality skills development, tobacco and alcohol prevention.	Pupils at school	Seminars in mentoring. Qualified pupils form "Aktive Teens" teams to support peers at school.	Evaluated 2006/7, http	Starting 2006, costs n. a.
3. Programme "Bauchgefühl", BKK-Betriebs Krankenkasse, in Bavaria, Baden-Württemberg and Nord-Rhine-Westphalia.	Aim: To inform and prevent against the dangers of eating disorders	Pupils at the school	School seminars to the theme eat disorders	n. a.	Starting 2011, costs n. a.

Name	Aim(s)	Stakeholders /target group	Methods or approach used	Main results of any evaluation	Duration, cost of programme or finances allocated
4. Programme "Lions Quest-Erwachsen werden", Ministry of education, youth and sport,	Aim: Prevention school violence and addiction	Teachers and pupils at school	Seminars for teachers on personality, skills and training for pupils at school.	n. a.	Starting in school year 2009/10, costs n. a.
5. Programme "Mobbingfreie Schule-Gemeinsam Klasse sein!" Ministry of education, youth and sport, Techniker Krankenkasse.	Aim: Bullying / Mobbing prevention at school	Pupils, teachers and parents	Information and training Seminars, films and manual book	n. a.	Starting in 2007/8 Hamburg, 2009 in BW and Schleswig-Holstein, 2010 in Rhineland-Palatinate and Mecklenburg-Western-Pommerania, 2011 in Berlin and Saxony-Anhalt.
6. Schulprogramm und Gesundheitssiegel im Bodenseekreis, Ministry of Employment and Social security BW, Gesundheitsamt Bodenseekreis.	Aim: Create a quality standard for schools on physical exercise, nutrition, health promotion, violence, addiction prevention.	Pupils, teachers and school staff.	Promotion and evaluation of programmes and activities, quality control of conditions and implementation measures at school.	n. a.	Starting 2011, estimated costs 94.000€
7. PräRIE II Gesamtkonzept zur Sucht-und Gewaltprävention Freiburg, Ministry of Employment and Social security BW,	Aim: Addiction (alcohol) and violence prevention at school.	Pupils at school	Creation of a network to promote preventive measures against addiction and violence.	n. a.	Starting 2011, estimated costs 122.000€

Name	Aim(s)	Stakeholders /target group	Methods or approach used	Main results of any evaluation	Duration, cost of programme or finances allocated
8. Project "Crazy? So what!" Verein Irrsinnig Menschlich e. V. (Madly Human;	Aim: Sensitise adolescents for mental health, to promote prevention and to exercise understanding and tolerance in interpersonal relations	Pupils at school	The project uses experiences of people with mental illness who have overcome crises and social exclusion. They act as "experienced experts" and role models for pupils with special needs. They bring the experiences, motivations and the dilemma to at risk pupils.	2001: the project reduced prejudice to mental illness. 2006/7: contact with mentally ill people had positive effects on attitudes. In mental health crises pupils would turn to peers, then parents, teachers and professionals. After the project pupils, were more likely to talk to a teacher. Most pupils wished to learn about help-seeking possibilities for mental crises.	Starting 2001 in Germany; costs n. a.
9 Programme „Papilio", LAKOST-Landeskoordinierungsstelle für Suchtvorbeugung Mecklenburg-Western-Pommerania.	Aim: Educational programme for primary prevention of behavioural problems (violence and substance abuse) and promoting social, emotional resilience	Kindergarten children, educators and parents	Learning by playing for children, advanced training and Seminars for educators and information for parents.	www.papilio.de/download/papilio-ergebnisse.pdf.	n. a.
10. "PeP- School programme to promote health and prevent violence and substance abuse". LAKOST and Bertelsmann Foundation.	Aim: Violence and substance abuse prevention at school	School children	Life-skills training, teaching units to substance abuse prevention	n. a.	Conducted at Federal States of Hamburg, Bremen, Schleswig-Holstein, Lower-Saxony and Mecklenburg-western-Pommerania

Name	Aim(s)	Stakeholders /target group	Methods or approach used	Main results of any evaluation	Duration, cost of programme or finances allocated
11. “SNAKE-Coping with stress”, Techniker Krankenkasse,, Fakultät für Psychologie und Sportwissenschaft Bielefeld.	Aim: Stress coping training for teenagers	Pupils at school	Cognitive-behaviour training method at the school and accompanying internet based training. The programme is conducted Germany-wide.	Evaluation study conducted. Positive results are documented. Internet based training was a major aspect for the participant’s adherence to the program.	n. a.
12. “IPSY-Information Psychosoziale Kompetenz = Schutz”, Friedrich Schiller Universität Jena/Institut für Psychologie.	Aim: Prevention of substance abuse at schools	School pupils	Based on WHO Life competence/skills training	Project being continuously evaluated	Starting 2003 in Thuringia, costs for manual 110€. Finances allocated n. a.
13. “BASS-Bausteinprogramm schulischer Suchtvorbeugung”, Lower-Saxony Federal State Office for abuse prevention.	Aim: Substance abuse prevention at school	School pupils	Teaching modules for teachers and parents to support/promote the development of life skills and resilience by pupils	Evaluated 2005/06 positive effects were found by pupils. Lack of support from school administration in integrating of the project into teaching was a major obstacle.	Starting 2002, manual costs 27€, allocated finances n. a.
14. “Praevikus- Health prevention concept for children and teenagers”, Praevikus	Aim: Mental Health promotion at school through nutrition, physical exercise and coping with stress	School pupils	Duration 1 year, 3 phase model	n. a.	Starting 2006 North-Rhine-Westphalia, programme cost 225€ / pupil and 55€ / teacher. Project financed by private donors, firms or foundations.

Name	Aim(s)	Stakeholders /target group	Methods or approach used	Main results of any evaluation	Duration, cost of programme or finances allocated
15. Programme "Klasse2000", Association Klasse2000 e. V.	Aim: Health promotion, violence and substance abuse prevention	Teachers, parents and pupils	Teaching units	n. a.	Programme is financed by sponsors, 220€ per sponsorship.
16. Adipositasprojekt an Hauptschulen, Health Office Düren	Aim: Preventing Eating disorders and promotion of resilience by pupils	Pupils (11-14 years)	Advanced training	Evaluated 2005, positive results were documented	Duration 2004-2005, it will be extended to other schools, costs n. a.
17. "Triple P-Positives Erziehungsprogramm", PAG Institut für Psychologie AG,	Aim: Prevention of mental illness, promotion of resilience, stress and violence prevention	Parents, pupils, kindergarten children	Seminars, teaching units, advanced training and information	Reduced prevalence and incidence of mental illness in children. Prevented stress and depression in parents	Start 1999, costs n. a.
18. Project "SIGN", Lower-Saxony Ministry of Education, agency Prevent Oldenburg and EWE,	Aim: Prevention of violence and substance abuse, promotion of resilience	Pupils, teachers and parents	Teaching units and advanced training	n. a.	Start 2000, end 2017, costs n.a.
19. Intervention programme POPS prävention von Essstörungen", University Potsdam, Ministry of Education and research, Warschburger 2009	Aim: Prevention of eating disorders at school	Pupils	Teaching units	Significant Reduction of risk factors for eat disorders	Duration 2008/9, costs n. a.
20. Project PEERaten Office for substance abuse prevention	Aim: Bullying / Mobbing and substance abuse	Pupils	Advanced training for pupils to act as peer mentors	n. a.	n. a.

Name	Aim(s)	Stakeholders /target group	Methods or approach used	Main results of any evaluation	Duration, cost of programme or finances allocated
Chemnitz,	prevention at school				
21.“Blau ist nur als Farbe schön”, NOVITAS BKK,	Aim: Alcohol abuse prevention at school	Pupils (11-14 years)	Alcohol abuse, prevention and help for people who are abused will be discussed in the classroom; anonymous and personal consultations for pupils	n. a.	Start 2004, costs n. a.
22. “Psychoedukation durch Kooperation zwischen Schule und Gesundheitsamt”, Gesundheitsamt Heinsberg,	Aim: Prevention of violence, mental illness, stress coping training	Pupils at school and young adults	An intensive cooperation of the school with the Health Department in the area of primary and secondary health prevention. The innovative aspect is the systematic and continuous interaction between the various disciplines of school and health department with teachers, social worker, doctor, nutritional scientist, drug prevention specialist. The psychological issue is taken up in	Good performance of Betty Rice comprehensive school and the high number of graduates from educationally weak family backgrounds demonstrate the effectiveness of the concept.	Start 2003, costs n. a.
23. “SaM – Schüler als Multiplikatoren”, Garitasverband Tecklenburger	Aim: Prevention of substance, alcohol, game and drug abuse, eat	Pupils and young adults	“peer education” (training lasts 1 year), young people should develop a positive attitude to addiction and	n. a.	Start 01.2004, costs n. a.

Name	Aim(s)	Stakeholders /target group	Methods or approach used	Main results of any evaluation	Duration, cost of programme or finances allocated
Land,	disorders		distribute them in school.		
24. “Trau Dich Trauern”, Zentrum für Palliativmedizin, Malteser Krhs. Bonn/Rhein-	Aim: Stress coping training, prevention of eat disorders, mental illness	Kindergarten children, pupils and young adults	Group activities (break isolation, mutual support) – establishing a "psychosocial emergency service" – on going regular open family afternoons - consultations - conferences and workshops	n. a.	Start 04.2005, costs n. a.
25. “Prävention für Kinder 2006”, Kommunale Gesundheitskonferenz (KGK) Duisburg, Arbeitsgruppe Prävention,	Aim: Stress coping training, prevention of alcohol addiction, eat disorders, violence and mental illness	Kindergarten children and pupils	Strengthening and expanding existing networks, - use existing and new partnerships, - commitment of all members of the Working Groups prevention, - cooperation meetings, - gathering and publishing of information	n. a.	Start 11.2005, costs n. a.
26. “Zukunft ohne Sucht”, Gesundheitsamt der Landeshauptstadt Düsseldorf,	Aim: Prevention of substance, alcohol, game and drug abuse, eat disorders, stress coping training	Kindergarten children, pupils at school	Different modules have been summarized	n. a.	Duration 01.2007/12.2009, costs n. a.
27. “Partizipation –Wege der	Aim: Prevention of	Pupils (age 11-	Pupils choose a topic and	Change in the attitude of	Start 11. 2003, costs n. a.

Name	Aim(s)	Stakeholders /target group	Methods or approach used	Main results of any evaluation	Duration, cost of programme or finances allocated
Gesundheitsförderung in der Sekundarstufe 1, Gesundheitsamt Heinsberg,	substance, alcohol, game and drug abuse, eat disorders, mental illness, stress coping training	18)	prepare it by consulting outside experts and interested lay people. School doctor and teachers help pupils	students to their own health, change in their behaviour	
28. "Netzwerk für Kinder psychisch kranker Eltern in Duisburg", Gesundheitsamt, Psychosoziale Arbeitsgemeinschaft Duisburg,	Aim: Prevention of mental health problems, stress coping training	Pupils at school	Four space-oriented social networks with at least two meetings per year to improve cooperation between youth welfare and psychiatry, using a jointly developed medical history sheet, consultations in two hospitals, lesson units, art therapy	n. a.	Start 08. 2006, costs n. a.
29. "MOVE – Motivierende Kurzintervention bei konsumierenden Jugendlichen", ginko – Landeskoordinierungsstelle Suchtvorbeugung NRW,	Aim: (Secondary) prevention of substance, alcohol, game and drug abuse, eat disorders	Pupils at school (15-18 years old), young adults at vocational school (19-29 years old)	Working with at risk teenagers. With the incorporation of the various target groups. "Tandems" consisting of staff from the youth services and prevention specialists, will be trained to spread this concept in NRW.	Staff at schools are qualified in early detection and early intervention of risky consumption behavior	Start 2001, costs n. a.

Workplace programmes – see also work health promotion best practice (http://www.bmg.bund.de/praevention/betriebliche-gesundheitsfoerderung/best-practice-beispiele-im-ueberblick.html)					
1. Occupational and health safety for teaching staff, Baden-Württemberg Ministry of education, youth and sport.	Aim: to provide educational and health training, psychological counselling, group consulting services	Teachers at school	Services are provided by the psychological information centres at school, by the supervisory school authorities or the medical occupational health supervision.	Cutbacks or financial shortages are not planed. Because of data protection and confidentiality we have no information about the programme costs, allocated finances or results.	
2. Workplace health management programme for teaching staff, Ministry of education, youth and sport.	Aim: Primary prevention measures to promote mental health by teaching staff.	Teachers at school	In-service training for new teachers, mental health training for school directors. Prevention 10+ following the "Constance Training Model", teacher coaching following the "Freiburg Model", Professional occupational health counselling, focus groups to risk evaluation, Speech training programmes and research projects.	n. a.	Start 2011/2012
3. Project Lehrergesundheit, Ministry of education of Bavaria	Aim: Implementation of preventive measures against psychosomatic disorders and stressed teachers.	Teachers at school	Seminars, training (Gordon-training), stress-management techniques, conflict resolution training and information about treatment/Therapies.	n. a.	Starting 2007, costs n. a.

Workplace programmes – see also work health promotion best practice (http://www.bmg.bund.de/praevention/betriebliche-gesundheitsfoerderung/best-practice-beispiele-im-ueberblick.html)					
4. "Recognition of psychological stress at the work place", Ministry of Social Security, women, Family, health and Integration and Factory inspectorate of Lower-saxony	Aim: Recognition, diagnosis and documentation of psychological stress at the work place	Workers	Screening instrument SPA-S to analysis and appraisal of stress situations at the work place	27 firms participated in the study; stress situations were detected in 22 firms. Firms and departments a major lack of sensibility for such issues like stress prevention or promotion of mental health at the work place.	Duration 2003/4, costs n. a.
5. "Counselling and support system "Workplace security and health management at school", Lower-Saxony Federal school Office and Ministry of Education. www.lehrergesundheit.de	Aim: Mental health prevention and promotion counselling and support for school teachers and directors	School teachers and directors	Seminaries and training to stress prevention/ management, psychological counselling.	Evaluation being conducted at the present time	1 million €
6. "Gesund Pflegen", Institut für Betriebliche Gesundheitsförderung-BGF GmbH,	Aim: Prevention of mental illness	Nurses at long-term care facilities for Older people	Counselling, seminaries	n. a.	Start 2004, costs n. a.
7. "Netzwerk gesunde Betriebe OWL", Technologieberatungsstelle beim DGB NRW e. V.,	Aim: Promotion of resilience and prevention of stress at the work place	Workers	Seminaries, information campaigns, counselling	n. a.	Start 2008, costs n. a.

Workplace programmes – see also work health promotion best practice (http://www.bmg.bund.de/praevention/betriebliche-gesundheitsfoerderung/best-practice-beispiele-im-ueberblick.html)					
8. "Prävention und betriebliche Gesundheitsförderung für Beschäftigte in der IT-/Software-Branche" gaus GmbH medien bildung politikberatung,	Aim: Mental health and stress prevention at work	Employees computer sector /software industry	Counselling, seminaries	n. a	2005-2007
9. "Betriebliche Gesundheitsförderung im deutschen Steinkohlenbergbau", Deutsche Steinkohle AG,	Aim: Mental health prevention and promotion of health	Workers and employees at coal mines	Seminaries, information campaigns, counselling	n. a.	Start2004, costs n. a.
10. "Mit Migranten für Migranten – Interkulturelle Gesundheit in NRW", Bundesverband der Betriebsklassen, Ethno-Medizinisches Zentrum.	Aim: Prevention of alcohol and drug addiction, mental illness, stress coping training	Adults at working place	Specialists from the regional health departments, health funds, hospitals, medical practices, etc. teach migrants to become intercultural health mediators (50 hours training). Mediators reach migrants from socially disadvantaged backgrounds (36%).	Mediators are trained, information campaigns are performed. Mediators can be contacted for health issues in communities.	Duration 08.2003/07.2007, costs n. a.

Financial responsibility for prevention and promotion activities

See above.

Investments into mental health – health, education, social development and economic growth

Mental health services received 10.3% of total healthcare expenditure in 2007 (Policies and Practice 2008). Investments into MHP and PMI programmes at national and Federal State level are unknown. Individual projects indicate the funding allocated to them and the benefits expected.

Initiatives to strengthen mental health systems in relation to MHP and PMI

Mental health policy is strengthening prevention and mental health promotion initiatives. The number of mental health prevention and promotion activities listed above provides some indication of the emphasis placed on school initiatives.

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4.12 Greece

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Summary

- The Government has a long term plan 'Psychargos' to promote mental health care and social integration of people with mental health problems.
- Four large psychiatric hospitals have been closed with the remaining five targeted for closure by 2015-2020. These have mostly been replaced with community mental health services.
- A network of community based mental health care has been developed with a range of services (psychosocial, residential and occupational).
- Mental health prevention and promotion is part of the Government's planning within the context of European Mental Health Pact and various mental health promotion programmes are implemented.
- Although mental health care has been developed greatly since the inception of Psychargos in 1999, services are still reported as inconsistent, ill-coordinated and sometimes inadequate. Further, distribution and lack of trained staff is a concern.
- There are gaps in services are primarily in child and adolescent services, services for older people, those with intellectual disabilities, eating disorders and forensic psychiatric services.
- There is a lack of integration with other sectors of government policy (police, education, employment and social welfare)
- Lack of monitoring and evaluation of services.

Some data for this country profile were gathered in the first instance by the country collaborator for Greece. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from Greece. This expert provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by the Governmental expert and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	11,309,885
Population density Inhabitants per km^2 (2008)	86.2
Women per 100 men (2011)	102
GDP PPP (2010)	0.9
Psychiatric care beds in hospitals per 100,000 inhabitants (2011)	23.8
Standardised Suicide rate by 100,000 inhabitants	3
Gallup Wellbeing index (2010)*	
Thriving	31
Struggling	57

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

The most recent Mental Health Act (Law 2716/1999) outlines the principles underlying the psychiatric reform, the architecture of mental health system (sectorization) and the range of the community mental health services.

This was supplemented by the 2005 Act (article 28) Code of Medical Ethics which outlines the ethical requirements for psychiatrists and their behaviour towards people with mental illness.

Following a lengthy consultation process a revised 10-year action plan, 'Psychargos' C (2012-2021), was introduced aiming at the continuation of the mental health reform. The main priorities for action are the promotion of community mental health, the abolition of the remaining asylums, the prevention and promotion of mental health, the improvement of organisation and integration of services and the protection of rights of people with mental disorders and the promotion of personnel training and research. In addition, the legal and policy framework for the 'development and modernisation of mental health services' makes direct reference to the State's responsibility for the promotion of mental health and the prevention of mental disorders. Two general Acts are expected to facilitate such activities the: "Act on Organization and operation of the Services for Public Health" and the White Paper on the ''Quality of Health Services and the National health Information System''.

Mental health policy and inclusion of prevention and promotion

The National Plan for Mental Health-"Psychoargos" C (2012) aims to improve the mental health of population and promote the social integration of people with mental health

problems. The current Mental Health Action Plan has included a wider range of mental health promotion actions in accordance with the European Mental Health Pact and existing needs. The relevant actions aim to strength protective factors and reduce risk factors for mental health.

In particular, the main mental health promotion priority areas included in the National Plan are as follows:

1. Prevention of depression
2. Early detection and prevention of psychotic disorders
3. Early diagnosis and treatment of autism
4. Mental Health in childhood and education
5. Mental Health of older people
6. Mental health in workplace settings and occupational integration of people with mental problems
7. Combating stigma and community sensitization

Furthermore, mental health promotion actions are included in the remaining priority areas of the National Plan such as the expansion of community mental health services and the promotion of self-advocacy of people with mental health problems.

Mental health services

Organisation and functioning of mental health systems

A post evaluation of the Psychargos programme published in 2010, showed the major advances made in mental health services since its introduction. According to this evaluation the public mental health service is delivered from Mental Hospitals, District General Hospitals and NGOs. Other systems of healthcare are delivered by army forces, state controlled insurances, some local and education authorities the Church and the Private Sector which is prominent and growing in size and function.

The current mental health system is organised into 58 sectors. To date four mental health hospitals have been successfully closed, with the remaining five on target for closure by 2015-2020. There are a total of 2,125 beds in psychiatric hospitals (World Health Organization, 2011). The development of community mental health services has been to a great extent achieved.

Among the 13 regions of Greece there are:

46	Psychiatric units in general hospitals (33 are psychiatric units for adults and 7 for children and adolescents) with a total of 570 beds
40	Community Mental Health Centres
18	Mental Health Centres for Children and Adolescents
29	Mobile Units
50	Day Centres
450	Psychosocial Rehabilitation Units (residential services)
10	Alzheimer Centres
17	Social Cooperatives
14	Autism Centres

There are 66 NGOs providing mostly residential care, day care and mobile units. A number of the NGOs are small in capacity providing 1 or 2 services either residential or day care.

Access and usage

There is no national research concerning the equity of access to health care. However, following nation-wide expansion of mental health services and functioning of mobile mental health units it is estimated that access to mental health care has been improved.

Variation and gaps

Despite the huge developments in mental health care over the past 10 years variations and gaps in services are evident. Findings from the Psychargos evaluation report that services are 'patchy, ill-coordinated and often inadequate'. Some geographical areas have good provision while others have little or none, and this appears to be determined more by 'opportunistic and entrepreneurial initiatives than according to real needs'.

Administrative and legal issues and a misuse of funds have hampered the full implementation of the Psychargos Plan. Some of the biggest gaps are in child and adolescent mental health services, services for older adults, specialist mental health services and forensic psychiatric services. Coordination between services is lacking with many having adopted their own operational criteria. There is also a lack of appropriately trained personnel. For example, in 2002, out of 2300 new posts submitted by the Ministry of Health and Social Solidarity for the staffing of new mental health units, the Ministry of Finance approved only 700. The private sector is prominent in Greek mental health care issues the operational relationships between the private and public sectors still needs to be addressed. According to one review there is a large demand for integrated primary care and the need to integrate mental health care within this as a matter of urgency.

Other issues include residential services that are isolated and risk becoming new "institutionalized" facilities for people with chronic mental illness. There is a need to shift the focus from deinstitutionalization towards addressing the mental health needs of the community and the promotion of mental health. However, cutbacks in public spending have placed mental health provision low on the agenda.

Financing

A total of 4.43% of the health budget is spent on mental health by the government (World Health Organization, 2011). Health expenditure is mostly through tax revenues, social insurance and private insurance. Greece spends about 10% of the gross domestic product (GDP) on health expenditure.

Workforce

According to Mental Health Atlas (World Health Organization, 2011) the following professionals were working in the mental health sector (per 100,000 population):

12.9	psychiatrists
26.8	psychologists

Responsibility and delivery of mental health promotion and prevention of mental illness

According to the Psychargos evaluation, mental health promotion activities aim to raise community and general public awareness and have been carried out by community mental health centers, NGOs and other organisations. In addition, mental health promotions actions are implemented in the context of the current National Plan by the aforementioned agencies and other government sectors (ministry of education, employment etc.). Although, current planning has developed priority areas, the implementation of the relevant actions occurs mostly in a fragmented and uncoordinated way.

Mental health status

Prevalence of mental health in the population

According to a recent pan-hellenic study (2009), 14% of the adult population suffer from mental disorders, of whom 7% are severe enough to require psychiatric treatment (Skapinakis et al., 2010).

Protective and risk factors

Not reported

Prevention and promotion programs/activities

Promotion of mental health activities has been initiated in Greece. The main mental health promotion areas are for prevention of depression and suicide, actions in childhood and education, workplace inclusion, combating stigma, integration with health care and prevention of relapse of people with severe mental disorders. The relevant actions are funded by European Union funds in the context of the Cohesion Policy of E.U. Most programmes last 2 years apart from certain services (e.g. Day Center, helpline) which will be incorporated into the existing community mental health network. Furthermore, existing planning includes additional actions which will be finalised in the forthcoming period. Further information for promotion actions is as follows:

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Other programs			
Anti-stigma programme by - NGO Society of Social Psychiatry and Mental Health and Pan-hellenic Federation of Families For Mental Health	Aim: to raise awareness of stigma and discrimination towards people with mental illness. Sensitization of the public psycho-educational training.	General public Specific professional groups (e.g. families affected by mental illness, police officers, social services' professionals)	2011-2014 €630,000
- Helpline for Prevention of Depression by NGO - University Mental Health Research Institute - Action for suicide prevention by NGO Klimaka	Aim: to prevention depression and suicide. A programme providing: a. A helpline for the prevention of depression Sensitization of the public on depression b. Day Centre in Athens for people with suicidal behaviour.	General Public, People with mood disorders Patients with suicidal behaviour	Started in 2012- a. €620,000 b. €300,000 /per year
Pilot programme for the Assertive Community Treatment of People with Severe Mental health disorders by 4 NGOs	Aim: Four Day Centres provide services in Athens to prevent hospitalization of people with severe mental health problems. Training of mental health professionals. Integration with social services, home treatment, psychosocial	People with Severe Mental health disorders and recurrent hospitalisations	2013-2014. €1,600,000 (€400,000x4)

	rehabilitation of patients.		
Programme for the promotion of workplace inclusion of people with mental health problems by NGO "Pan-Hellenic Union for Psychosocial Rehabilitation and Work Integration" (PEPSAEE)	Aim: to promote workplace inclusion for people with mental illness. Approach: a. Establishment of a pilot occupational counselling centre b. Actions for the promotion of supported employment.	Unemployed people with mental health problems	2012-2014 a. €600,000 b. €985,000
Self-advocacy programme by the National Confederation of People with Disabilities (ESAmeA) and NGO "Pan-Hellenic Union for Psychosocial Rehabilitation and Work Integration" (PEPSAEE)	Aim: to promote self-advocacy of mental health service users by Establishment of local users associations Empowerment of mental health patients Self-help groups.	Users of mental health services	2010-2012 €855,000
Mental Health promotion programme in childhood and education by NGO Association for the Psychosocial Health of Children and Adolescents, NGO-SOS Children's Villages	Aim: to promote mental health for young children. Approach: a. Action to tackle school bullying b. Early prevention of child neglect.	Students, teaching staff High risk children 0-5 years old	2011- 2014 €715,000 €400,000
Promotion of integration with health care and early detection of mental disorders by Mental Hygiene Centre - Vocational Training Centre	Aim: to promote integration through training of health professionals aiming at early detection of mental disorders & early referral to specialists.	Health professionals of public health services	2011-2012 €2,800,000 2011-2012

Furthermore, relevant actions have been implemented by other government sectors but were omitted due to lack of adequate information.

Investments into mental health – health, education, social development and economic growth

Not reported

Initiatives to strengthen mental health systems in relation to MHP and PMI

See above.

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4.13 Hungary

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Summary

- Mental healthcare is integrated within general health and social care systems. There is an on-going major restructuring of the healthcare system in Hungary.
- Following the inappropriate closure of the National Institute of Psychiatry and Neurology in 2007, a National Policy for Mental Health is being finalised to establish a new 21st century national institute of mental health.
- Decreasing funding for mental health research and the lack of transferring evidence into practice (e.g. better psycho-pharmacy and psychological therapies) are hindering developments in mental health.
- In 2009, 32.8 psychiatric beds per 100,000 population were available, with 7.2% located in general hospitals.
- Each municipality of 10,000 inhabitants or more is required to provide community care for people who do not need inpatient services. Residential social care, mainly for older people is available, with over a quarter of residential homes provided by NGOs. There is a lack of day-care facilities for people suffering from dementia.
- Treatment of severe cases of mental ill health at primary level is partially available in Hungary. Delivery of treatment is mainly via mental health care centres distributed across the country. Integration of this system to community based approaches, as well as to primary care system are the future challenges.
- The Government has placed emphasis on promoting healthy lifestyles, increasing life expectancy and reducing avoidable death in the population. Prevention and promotion programmes recorded include a small number in schools and workplaces and several more for the general public. Initiatives listed for older people are mainly by NGOs.

Data for this country profile were gathered in the first instance by the project's country collaborator for Hungary. The research team used these data to prepare a draft country profile and supplemented with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Hungary. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	9985722
Population density Inhabitants per km^2 (2009)	107.7
Women per 100 men (2011)	110.5
GDP PPP (2010)	169.2
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	32.8
Standardised Suicide rate by 100,000 inhabitants	21.8
Gallup Wellbeing index (2010)*	
Thriving	13
Struggling	53

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Legislation on mental health falls within the Fundamental Law (Constitution). Since the previous version, adopted in April 2011, the Fundamental Law has stated that every person living in Hungary has 'the right to the highest possible level of physical and mental health'. The 1997 Act 154 on Health is devoted to Public Health, with four Sections (37 to 40) detailing health promotion and the prevention of 'psychological pathologies'. Special mention is made of the need to promote healthy physical and emotional development for children and young people. Other sections cover psychotherapy and specialised clinical psychology in relation to the treatment of psychological or psychosomatic disorders.

Mental health policy and inclusion of prevention and promotion

The Public Health Programme "For a Healthy Nation" (2003), was devised to address concern about the high number of people with alcohol and drug use problems, it focused on promoting healthy lifestyles, increasing life expectancy and reducing avoidable death in the population. This goal was to be achieved partly by using educational institutes to provide opportunities for healthy living (e.g. by creating a low-stress environment for students and employees). Reforms to the healthcare system have been initiated recently by the 'Semmelweis Plan' – a health care strategy introduced in July 2011. This plan seeks to reform the organisation of hospitals and their operation, change the ownership and operation of pharmacies, and reduce waiting lists.

Specific mental health programmes have not yet been officially approved. The National Programme of Mental Health in 2009 (with the addition of an alcohol strategy) was to serve as the basis of professional development for mental health, although this programme remains to be finalised, and to be accepted by the Government. The Programme of Mental Renewal adopted in 2010 and initiated by the Hungarian Alliance of Mental Hygiene, focuses on the determinants of mental health outside the health care sector, by involving various institutes such as schools, churches and the media. The 'National Childrens' Health Programme' prioritises the need to strengthen the mental health of children and adolescents in schools.

Suicide prevention is also a high priority. Several suicide prevention programmes have been launched both at regional level (EAAD, OSPI), through internet (Predi-NU). These programmes are co-funded by the EU.

Mental health services

Organisation and functioning of mental health systems

Mental health care is integrated, both organisationally and financially, within the main health and social care systems. Inpatient care is split between acute and long term care. Day hospitals are also available. Attempts to reform health service delivery structures during 2006-7, (including a failed attempt to privatise healthcare) led to the reduction of acute and rehabilitation psychiatric beds. Through the Hospital Law of 2006, the Government made further reductions to the number of psychiatric beds (from 4.8 to 3.1 active/acute psychiatry beds per 10,000 population). The same Hospital Law also led to the closure of the National Psychiatry and Neurology Institute, which was the country's largest in-patient mental hospital, and essential research, information-gathering and training centre (Kurimay, 2010). In the same year other psychiatric provision, including outpatient services were also reduced. The Law, and its implementation, were heavily criticized by professional bodies and the political opposition (now the governing parties). The Constitutional Court annulled significant parts of the Law, but the loss of psychiatric service provision and and research capabilities could not be retrieved.

However, the former leadership of the National Institute and representatives of the psychiatric profession prepared alternative plans for the development of psychiatry, in which the planning of more approapriate deinstitutionalization has been proposed (Bitter and Kurimay, 2012). A new National Centre for Psychiatry (a Centre without direct inpatient or outpatient clinical services) was established as part of the organisation of the National Centre for Healthcare Audit and Inspection. By 2009 there were 32.8 psychiatric beds per 100 000 population; and 7.2 per 10 000 psychiatric beds in general hospitals.

Psychiatric ambulatory and inpatient care: This is provided by departments of psychiatry within the four universities that have medical faculties. Furthermore, at 42 Regional settlements, psychiatric ambulatory and inpatient care (including child and geronto-psychiatric care, addiction services and rehabilitation) is also provided by 86 hospital departments.

Outpatient centres: These are available at almost all departments of psychiatry (or psychiatric dispensaries) and provide care for long-term patients. Outpatient care delivers services, depending on the supply obligation of the territory, either at the surgery or in the patient's home. In 2008, there were:

- 140 psychiatric dispensaries (departments of psychiatry)
- 35 child and adolescent psychiatric dispensaries
- 111 addiction dispensaries

Community based social services: These are available for particular groups of people, including those with mental illness. The service provides care locally for those who do not need admission to residential homes or institutions. Every municipality is required to provide community care where its inhabitants exceeds 10,000. In 2007 there were 4.6 (per 10,000 inhabitants) such community based services (HiT, 2011; Mester, 2010). Residential social care is also provided. In 2007, there were 999 residential homes with a total bed capacity of 88,525 beds (88.1 beds per 10,000 inhabitants); 35.7% of these were provided by NGOs. These residential homes mainly care for older people (59.7%), but 9.5% were for those with mental illness. Around 1,040 people with mental illness also received daytime social care (Mester, 2010). There is a lack of day-care facilities for people suffering from dementia.

Telephone help-lines service: The telephone hot-line services are maintained by NGOs, with limited (or no) support from the central health care budget. Currently, there are 20 hotline services operating for the whole country, organised as one service network. These telephone hotlines are staffed by well-trained professionals' and form a fundamental part of mental health support, crisis intervention and suicide prevention. However, the hotline service has not been integrated within the clinical practice.

Access and usage

The average number of consultations at psychiatric dispensaries in 2008 was 7.7 for adults and 8.2 for children and adolescents in 2008 (HCSO, 2010).

Variation and gaps

Treatment of severe mental illness is available at primary care level. Prescription regulations authorise primary health care doctors to prescribe and/or to continue

prescribing psychotherapeutic medicines but with restrictions (World Health Organization, 2011). The role of primary care is crucial for screening major depression, and preventing suicide, especially those who screen positive for a family history of major depression (Rihmer et al., 2011). Continuous medical education/training is available for general practitioners and nurses. Officially approved treatment protocols for the major mental disorders are available on the website of the National Resource Ministry, for professionals as well as for the public (World Health Organization, 2011). Basic outpatient treatment for severe mental illness is delivered via mental health care centres. These centres have been operational since the 1950's and are distributed across the country; one in every district. Each centre includes a psychiatrist, nurse, social worker and psychologist - a minimum compulsory staffing level for these centres. The challenge is to ensure that the existing system maintains its efficacy, develops further and becomes more integrated within community based approaches and within primary care services. Primary care usually comprises of one GP and one nurse, and not a large group practice or bigger team of health professionals. In moving towards community-based care both primary and secondary health care services will need to become integrated.

Financing

In 2009, Hungary spent 7.4% of its GDP on health, or a total of HUF 1,940 billion (€7.0 billion). Mental health expenditure by the Ministry of Health is 5.1% of the total health budget (World Health Organization, 2011). Funding for mental health is mainly through social insurance, tax expenditure, and out of pocket payments by patients or families account for 23.7% of total health expenditure (World Health Organization, 2005).

Workforce

Health professionals working in the mental health sector (rate per 100,000 population) include:

Psychiatrists	6.52
Medical doctors, not specialised in psychiatry	0.13
Nurses	21.93
Psychologists	2.47
Social Workers	2.98
Occupational Therapists	N/A
Other health workers	14.76

(World Health Organization, 2011)

Responsibility and delivery of mental health promotion and prevention of mental illness

This ranges from staff working in NGOs, local health, mental health and educational services.

Mental health status

Prevalence of mental health in the population

According to the results of the European Health Interview Survey (2009) the prevalence of chronic depression was 6%, and the prevalence of other mental diseases was 3%. A similar proportion take medications due to their mental disorders. The proportion of those who take sedatives regularly was around 6%. The Hungarian Epidemiological Panel survey conducted in 2002 found a prevalence of depressive symptoms at 15% among 15-29 year olds, and 2.8% suffered from serious depression, 12% thought about suicide and 3% had attempted suicide. Prevalence of the major mental diseases is similar to that of Europe with the exception of depression among men, alcohol abuse, bipolar disorder and completed suicide, all being less favourable (NPMH, 2008).

The prevalence of suicide was 24.6 per 100,000 inhabitants in 2009 (World Health Organization, 2011)

The prevalence of mental disorders for patients registered at psychiatric dispensaries in 2009 was:

	Men	Women	Per 100,000 population
Mood (affective) disorders	11,372 (26.7%)	31,149 (73.3%)	424.6
Neurotic and somatoform disorders	7,569 (28.7%)	18,789 (71.3%)	263.2
Alcohol induced psychosis	269 (74.1%)	94 (25.9%)	3.6
Drug induced psychosis	26 (83.9%)	16.1 (31%)	0.3
Schizophrenia, schizotypal disorders etc	12,371 (39.2%)	19,165 (60.8%)	314.9

Incidence

The rates per 100,000 newly registered patients at psychiatric dispensaries for 2009 were:

	Men	Women
Mood (affective) disorders	36.4	67.8
Neurotic and somatoform disorders	28.0	51.2
Alcohol psychosis	1.0	0.4
Drug induced psychosis	-	-
Schizophrenia, schizotypal disorders etc	22.0	24.2

Protective and risk factors

The main risks for mental illness include alcohol and alcohol addiction and attempted suicide.

Prevention and promotion programmes/activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Hungarian Association for Counselling in Higher Education	Aim: to improve the mental health of students, staff members and volunteer students The centres provide a range of counselling services for groups and individual students.	Students in higher education	Since 1995. Financed by Higher Education Institutes
The Holistic School Health Programme	Aims: to promote social, personal and emotional health and wellbeing in the school curriculum: contains everyday physical activity, relaxation and developing advanced personality through teaching methodology and arts.	Children and adolescents	Commences September 2012
Workplace			
„Work: in tune with life"	Aim: To promote mental health at work. Two companies chosen as Hungarian models for best practice. European Network for Workplace Health Promotion (ENWHP) initiative.	Supported by the National Institute of Health Development	2007-2010. EU funded
EC project PROMISE -	Aim: to develop and disseminate multi-disciplinary mental health	Adults of working age. Supported by	

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Promoting Mental Health, Minimising Mental Illness and Integrating through Education	promotion training guidelines and training programmes for professionals. 8 partners, include the Hungarian Institute of Occupational Health (OMFI). To identify and disseminate public policy guidelines for best education practice and generic training for professionals on mental health promotion and illness reduction for adults (18-65). Applications developed for preventing suicide, depression, alcohol and drug abuse.	the National Institute of Health Development	
TÁMOP 6.1.2. Operative Programme for Social Renewal: Grants from EU Structural Funds for programmes	Aim: to promote healthy lifestyle and form health attitudes at work, including writing/updating workplace health plans. One of the 8 priority areas was mental health promotion.	Adults in the workplace. Supported by the National Institute of Health Development	
Older people in long term facilities			
HUNGARIAN ALZHEIMER SOCIETY (HAS) Society of Relatives of Persons with Alzheimer's and other dementia diseases	Aim: to increase the quality of nursing. Non-governmental and local authorities, civil organisations - as members of Voluntary Sector - are playing an increasingly significant role in health and social care. HAS was established in 1999 for this reason, but – the number of dementia diseases sufferers is growing. Formerly the Society operated as a Self-Help Fellow Sufferer Club, beginning in 1996.	HAS assists of all family members with the tasks of, skill improvement and nursing.	
Other programmes			
János Selye Mental Health Programme	Aim: to educate groups and individuals at risk of Stress. Providing interventions (presentations and trainings) to reduce stress, and investigating their effectiveness. The following activities are available: brief stress-reducing programme, targeted stress-reducing programme (Williams LifeSkills Programme), training trainers	A joint effort of the Health Care Research Group of the Hungarian Academy of Sciences and the Department of Behavioural Sciences of the Semmelweis University	Ministry of Health provided financial support to the Programme in 2009 which made stress survey and management for workplaces

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	and facilitators, stress survey and management for workplaces, organisational development.		freely available after an application procedure
Mental Health Programme of the Healthy	Aim: to promote health, prevent disease and increase healthy life years. The municipal government of Hódmezővásárhely (a mid-size Hungarian city with 48,000 inhabitants) agreed a 10-year strategic public health programme which links to the National Programme of Mental Health calling for collaboration of local health, mental care and educational professionals. The programme includes parental training to expecting couples, mental health programme for children including personality development and coping skills to resist alcohol and drug abuse and conflict resolution training.		
Awakenings Foundation	Aim: to decrease stigma against people with mental problems. The Foundation initiated a network of over 15 NGOs in Hungary (Anti-stigma Initiative) and joined the 'Open the Doors' programme of the World Psychiatric Association.	General public. NGOs	
Moravcsik Foundation The Budapest Art Brut Gallery	Aim: to diminish prejudice in society against people living with psychosocial disabilities, and improve their quality of life. The mission of the Art Gallery is exhibiting the artwork of artists with psychosocial illnesses, and individuals at the periphery of society, to gain recognition and acknowledgement from broader levels of society.	General public with all age groups	
European Alliance Against Depression (EAAD) network and the	Aim: To create community-based networks, using an evidence-based approach to improve the care of depressed persons and prevent suicide.	The Institute of Behavioural Sciences of the Semmelweis University joined the programme from	2004 onwards, European Commission funded

Programme name	**Aim/approach**	**Stakeholders/target group**	**Duration, Cost of programme**
Depression stop – OSPI Europe programmes	Aim: to prevent depression and suicide. Adapted educational materials for specialists and the public, a national multilevel intervention protocol and programmes with the participation of local professionals in 3 Hungarian sub-regions and one district of Budapest - (Székesfehérvár, Kiskunhalas, Józsefváros district in Budapest, Health portal, and the Department of Family Medicine of the Semmelweis University). This formed the background for the "Optimised suicide prevention programmes and their implementation in Europe" (OSPI).	Hungary, and launched the first intervention in Szolnok city and its sub-region in 2005.	
Preventing Depression and Improving Awareness through Networking in the EU (PREDI-NU)	Aim: to implement an Internet-based self-management system for young people with mild depression in 6 European regions.	The Institute of Behavioural Sciences of the Semmelweis University joined the programme from Hungary	2011-2014, European Commission funded
Promotion of Young People's Mental Health through Technology-enhanced Personalization of Care (PRO-YOUTH)	Aim: to implement an internet-based way of personal care for young people with eating disorders in 7 European countries.	The Institute of Behavioural Sciences of the Semmelweis University joined the programme from Hungary.	2011-2014, European Commission funded
Saving and Empowering Young Lifes in Europe (SEYLE)	Aim: to gather information on health and well-being in European adolescents, to perform interventions in adolescents leading to better health trough decreased risk-taking and suicidal behaviours. To recommend effective culturally adjusted models for promoting health of adolescents in different European countries.	Vadaskert Child and Adolescent Hospital, Budapest, Hungary	2009-2012, European Commission funded

Financial responsibility for prevention and promotion activities

Financial sources of prevention and promotion programme appear to come from the Ministry of Health and NGOs. Information on amounts allocated was not reported.

Investments into mental health – health, education, social development and economic growth

Funding for research is decreasing due to the economic crisis. Technology transfer is also dysfunctional after the closure of the National Institute of Psychiatry and Neurology (Bitter & Kurimay, 2012).

Initiatives to strengthen mental health systems in relation to MHP and PMI

Relevant health and mental health legislation and policies have underpinned the need to focus attention on health promotion and the prevention of disease, particularly in relation to reducing drug and alcohol misuse, suicide and improving the mental health of children and adolescents. Reforms to mental health services have taken place with a great reduction the number of psychiatric beds and the creation of more community based services, although the range of such services may still be limited.

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4.14 Republic of Ireland

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Summary

- Ireland has taken major steps away from its institutional past and is guided by a comprehensive policy in *A Vision for Change*. In recent years a number of large mental hospitals have closed or have closed to new admissions and this closure programme is on-going. Increasingly short term inpatient acute care is provided in Psychiatric units in general hospitals.
- A comprehensive range of community based mental health services is available and further services will be developed as hospitals close and the resources transferred to the community. Community mental health services are delivered by multidisciplinary teams including consultant psychiatrists, registrars in psychiatry, nurses, clinical psychologists, social workers and occupational therapists. There are 63 registered approved centres for in-patient care and approximately 800 centres providing community based services. The services include day centres, day hospitals and high, medium and low hostel provision.
- The financial and economic circumstances facing Ireland continue to present many and difficult challenges for the health services. A total cost reduction of €750m is required of the HSE in 2012; this follows substantial budget reductions of €1.75bn in the past two years and a reduction in the number of health service staff from a peak of 111,000 in 2007 to less than 102,000 in 2012, with a further 6,500 to depart by 2014. The HSE is required to deliver its mental health services within this decreasing budget and headcount.
- Protecting and enhancing the population's mental health and well-being, as outlined in *A Vision for Change (*2006), requires the implementation of evidence-based mental health promotion and prevention programmes to be incorporated into all levels of mental health and health services. A wide range of activities in mental health prevention and promotion is available, including suicide prevention initiatives.

Data for this country profile were gathered in the first instance by the research team. A draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from the Republic of Ireland. This expert provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by the Governmental expert and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	4,480,858
Population density Inhabitants per km² (2009)	65.2
Women per 100 men (2011)	101.8
GDP PPP (2010)	1.1
Acute Public Psychiatric beds per 100,000 inhabitants end (2011)	25.4
Standardised Suicide rate by 100,000 inhabitants (2011)	1.4
Gallup Wellbeing index (2010)*	
Thriving	49
Struggling	49

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

The public health system in the Republic of Ireland is governed by the Health Act 2004. The Act established the Health Service Executive (HSE) which began operating in 2005. The HSE manages and provides health and personal social services in Ireland including mental health services. Mental health services include a broad range of primary and community services and specialised secondary care services for children and adolescents, adults, and older persons. In recent years there has been increased specialisation, including rehabilitation and recovery, liaison, forensic, mental health services for people with an intellectual disability, and suicide prevention initiatives. Services are provided by the HSE and voluntary sector partners in a number of different settings including the service users' own home, acute inpatient facilities, community mental health centres, day hospitals, day centres, and supported community residences.

The Mental Health Act 2001 was fully implemented from 1st November 2006 and provides a modern framework within which people with a mental disorder needing treatment or protection, can be cared for and treated. The Act initiated mechanisms by care standards and treatment in mental health services can be monitored, inspected and

regulated. The Mental Health Commission was established by the 2001 Act as an independent statutory body, responsible for promoting, encouraging and fostering the establishment and maintenance of high standards and good practices in delivering mental health services and protecting all persons involuntarily detained under the Act.

The Act has six parts: Preliminary and general (with definitions of mental disorder); involuntary admission of persons to approved centres; independent review of detention (ensuring good standards and practice), consent to treatment); approved centres (guidelines and maintenance of a register of centres); miscellaneous (to deal with remaining issues such as clinical trials, seclusion/restraint and civil proceedings.

The '**Programme for Government**' has a commitment to *"review the Mental Health Act 2001 in consultation with service users, carers and other stakeholders, informed by human rights standards".* The review is underway an Interim Report was published in June 2012.

Mental health policy and inclusion of prevention and promotion

'A Vision for Change' the Report of the Expert Group on Mental Health Policy, was launched in 2006 and accepted by Government as the basis for developing mental health services in Ireland. The Report proposes a holistic view of mental illness recommending an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. It recommends a person centred treatment approach to addresses each of these through an integrated care plan, reflecting best practice, evolved and agreed with service users and their carers. Interventions should be aimed at maximising recovery from mental illness, and build on the resources in service users and their immediate social networks, to allow them to achieve meaningful integration and participation in community life.

The Report outlines a comprehensive mental health policy framework that seeks to address the mental health needs of the whole Irish population. The policy embraces the wider health and social importance of mental health and makes recommendations for improving population mental health and well-being across the lifespan and improving the spectrum of services. Recommendations are made for fostering well-being and promoting positive mental health, preventing mental health problems and improving the functioning and social inclusion of people experiencing mental health problems.

In relation to the promotion of positive mental health *'A Vision for Change'* focuses on four key issues;

1. Promoting positive mental health and well being
2. Raising awareness of the importance of mental health

3. Enhancing the capacity of service providers and the general community to promote positive mental health
4. Suicide prevention

The Report proposes the adoption of a lifespan approach to mental health promotion, supported by a national research, evaluation and monitoring programme. In order to increase protective factors and decrease the risk of mental illness, mental health promotion programmes should be integrated into all levels of mental health services. It is recommended that designated health promotion officers should have responsibility for mental health promotion and work in co-operation with local voluntary and community groups and with formal links to the mental health services. The report adds that training and education programmes should be put in place for the development of capacity and expertise in evidence-based prevention and promotion campaigns.

'Reach Out' the National Strategy for Action on Suicide Prevention sets out a series of specific actions and calls for a multi-sectoral approach to preventing suicidal behaviour to foster cooperation between health, education, community, voluntary and private sector agencies. The National Office for Suicide Prevention is implementing the *Reach Out* Actions in a four way strategy - delivering a general population approach to mental health promotion and suicide prevention; using targeted programmes for people at high risk of suicide; delivering services to individuals who have engaged in self-harm and providing support to families and communities bereaved by suicide.

Mental health services

Organisation and functioning of mental health systems

Considerable changes to mental health services have taken place in Ireland over the past forty years with the closure, or closure to acute admissions, of a number of large mental hospitals and the development of community based services. The number of patients resident in Irish psychiatric units and hospitals over the last 47 years has fallen from 19,801 in 1963 to 2,812 in 2010. This represents a reduction of 86% in in-patient numbers since 1963 and a reduction of 17% since 2006.

The HSE has developed a strategy for the phased closure of the remaining old psychiatric hospitals. Closures will take place on a phased basis with wards closing sequentially; hospitals will only close when the needs of the remaining patients have been addressed in more appropriate settings such as community residences, day hospitals and day centres.

Community services: A comprehensive range of secondary care community-based mental health services are available, delivered by multidisciplinary teams; currently (October 2012) there are 124 adult and 61 child and adolescent multidisciplinary teams. While the composition and skill mix of each team should be appropriate to the needs and social circumstances of its sector population, each multidisciplinary team should include the core skills of psychiatry, nursing, social work, clinical psychology and occupational therapy. Community based mental health services are provided by the HSE and voluntary sector partners in a number of different settings including the service users' own home, community mental health centres, outpatient clinics, day hospitals, and day centres. Residential hostel accommodation at high, medium and low support are also provided, however current policy is to discontinue the direct management and staffing of low and medium support accommodation. Specialist community mental health services are also available such as outreach services and crisis interventions.

Acute Inpatient Care: There are currently (September 2012) 63 approved centres for the care and treatment of persons suffering from mental illness with a total number of 25.4 public beds per 100,000 at end 2011. Approximately 800 other centres provide community based services. Acute Psychiatric in-patient units, primarily attached to general hospitals, provide short term inpatient acute care. Bespoke acute inpatient provision is also available for children and adolescents in age appropriate facilities. Specific psychiatry of old age services are also available including acute inpatient provision and continuing care options for older people with mental illness. There are also specialist community mental health teams for old age psychiatry. However this provision is not universal as yet.

The National Forensic Mental Health Service is based at the Central Mental Hospital (CMH), Dublin. The CMH admits patients from the criminal justice system and from the psychiatric services and provides psychiatric treatment in conditions of maximum and medium security.

A number of prominent NGOs provide a wide range of activities on behalf of the HSE (including mental health promotion and anti-stigma campaigns) and support for people with mental health problems. These include: Mental Health Ireland which is represented by 106 local mental health associations, Young Mental Health Ireland, Headstrong, Shine, Console, Bodywhys, Glen, BeLong and AWARE.

Access and usage

Access to mental health services is normally through the GP or Primary Care team. For adults, the waiting time for a routine referral from primary care is approximately 6 weeks although an emergency assessment can usually be offered with 24 hours. Whilst the preferred route to treatment is via a closed Primary Care referral pathway, many

individuals present in crisis via the Emergency Department in a local hospital. Research suggests that over 12,000 cases of self- harm present to Emergency Departments each year in Ireland; it has been estimated that a further 60,000 self-harm cases go untreated.

According to statistics produced by the Health Research Board (HRB 2010), in 2010, there were 19,619 admissions to Irish psychiatric units and hospitals (462.7 per 100,000 population). First admissions increased from 140.9 per 100,000 in 2009 to 147.8 in 2010. Readmissions dropped slightly from 14,223 in 2009 to 13,353 in 2010. The number of involuntary admissions has also declined by 27% from 2,830 in 2005 to 2,057 in 2011.

In 2010 the average length of stay for under-18s admitted and discharged was 33.2 days (median 23.5 days), with discharges from specialist child and adolescent units having the longest average length of stay, at 47.1 days (median 41 days), followed by private hospitals, at 27.9 days (median 25 days), psychiatric hospitals, at 7.4 days (median 5 days), and general hospital psychiatric units, at 11.4 days (median 4 days) (HBR 2010).

The number of patients resident in Irish psychiatric units and hospitals on 31 March 2010 totalled 2,812, representing a hospitalisation rate of 66.3 per 100,000 total population. This is a reduction of 577 in the number resident in units and hospitals since the last psychiatric in-patient census in 2006 (3,389) and also a reduction in the rate of hospitalisation in the 2006 census, at 80.0 per 100,000.

Variation and gaps

Approved Centre (public) bed capacity in the West and South is greater and varies from 28.3 beds per 100,000 population in the South, to 20.6 in Dublin Mid-Leinster. First admission rates for adults vary from 31.9 per 100,000 in the South to 22.1 in Dublin Mid-Leinster, whilst involuntary admission rates vary from 10 in the West to 6.6 in Dublin Mid-Leinster. There are similar variations in relation to staffing with 136.82 mental health nurses per 100,000 in the South compared to 76.93 in Dublin Mid-Leinster, whilst there are 23.99 Allied Mental Health Professionals per 100,000 in the West and only 12.97 in Dublin North East.

A key recommendation of *A Vision for Change* is to develop a population based resource allocation model. In this regard, the HSE has established a Resource Utilisation and Resource Access in Mental Health Working Group to further develop a population-based resource allocation model. Its objective is to maximise equal access to mental health resources across the country by applying an equitable model of resource utilisation.

Financing

In 2012, 5.3% (€707 million) of the Health Service Executive Budget will be spent on specialist mental health services. This is a lower percentage than in previous years as prior to 2012, the figures in the Revised Estimates for Public Services for Health Care Group Areas such as Mental Health included an allocated share in relation to both

pension and corporate costs; these costs are now shown separately. It should also be noted that approximately 35% of people who attend primary care have a mental health problem and expenditure on these services is not captured in this percentage.

The National Service Plan 2012 published on 16th January 2012, set out the type and volume of health and social care services that the HSE will provide both directly and indirectly, through a range of funded agencies and organisations, within its allocated budget of €13.317bn. A total cost reduction of €750m is required of the HSE in 2012. This follows substantial budget reductions of €1.75bn in the past two years and a reduction in the number of health service staff from a peak of 111,000 in 2007 to less than 102,000 in 2012, with a further 6,500 to depart by 2014. While a special allocation of €35m was provided for mental health in 2012, budget reductions, as a consequence of the impact of efficiency, procurement and staff moratorium savings, apply in mental health just as in other care areas. When the additional investment is factored in, the cost reductions applying in mental health in 2012 will be on average just less than 1%.

Workforce

The number of psychiatrists working in the mental health sector in 2011 was 6.06 per 100 000 inhabitants. In the same year there were 113.0 psychiatric nurses, 3.5 psychologists, 3.16 occupational therapists and 3.84 social workers per 100, 000 population (World Health Organization Atlas 2011, Central Statistics Office for Ireland 2011).

Responsibility and delivery of mental health promotion and prevention of mental illness

The promotion of positive mental health represents a cost effective and evidence based approach to protect the population's mental health. The National Office for Suicide Prevention supports this role along with other Health Promotion staff within the HSE. A number of NGO partners are also funded by HSE, either on a once-off or recurring basis, to deliver specific mental health promotion activities.

Mental health status

Prevalence of mental illness in the population

The prevalence of mental disorder in the general population was not obtainable. However, results from a number of surveys of the adult population capture psychological wellbeing or distress. 'The National Psychological Wellbeing and Distress Study' was published by the Health Research Board in 2007 and involved a telephone survey of a nationally representative random sample of 2,711 adults aged 18 years and over, living in

private households (Health Research Board 2007a). Results showed that 12% of the sample [one in eight] exhibited signs of 'current' distress on the General Health Questionnaire (GHQ-12), while 14% of the sample reported experiencing mental health problems in the previous year.

A similar survey carried out in 2007, provided comparable data for the North and South of Ireland. This survey found a higher prevalence of self-reported mental health problems in Northern Ireland (22%) and a greater proportion perceived their mental health status as less than good (20%) compared with the Republic of Ireland (12% and 15%) even after taking into account demographic characteristics such as marital status, education, employment and income (Health Research Board, 2007b). Statistics on depression show for example that over 450,000 people experience the condition at any one time in Ireland or that 1 in 10 adolescents aged 13 - 19 experience a depressive episode (AWARE).

The prevalence rates of psychiatric disorders from one study in population of Irish adolescents aged 12-15 years in a defined geographical area found that 15.6% of the total population met the criteria for a current psychiatric disorder, including 2.5% with an affective disorder, 3.7% with an anxiety disorder and 3.7% with ADHD. Significant past suicidal ideation was experienced by 1.9%, and 1.5% had a history of parasuicide (Lynch et al., 2006).

The following table from the Activities of Irish Psychiatric Units 2010 (HBR 2010) provides figures for the number of people admitted to psychiatric hospitals and units by diagnosis and gender in 2010:

Diagnosis	**Men**	**Women**	**Admissions per 100,000 pop**
Organic Disorders F09	273	267	12.7
Alcoholic Disorders F10	1,115	683	42.4
Other Drug Disorders F10-19	705	261	22.8
Schizophrenia, schizotypal & Delusional Disorders F20	2,291	1,531	90.1
Depressive Disorders F32.9	2,373	3,256	132.8
Mania F30	895	1,199	49.4
Neuroses F48	735	856	37.5
Eating Disorders F50	7	210	5.1
Personality and Behavioural Disorders F60	326	704	24.3
Intellectual Disability F79	72	41	2.7
Development Disorders F80	21	4	0.6
Behavioural and Emotional	24	5	0.7

Diagnosis	Men	Women	Admissions per 100,000 pop
Disorders (youth) F90			
Other and Unspecified F99	1.018	747	41.6
Total	**9,855**	**9,764**	**462.7**

Incidence

Not available.

Protective factors

A Vision for Change identifies the following protective factors for mental health

- secure attachment
- positive early childhood experiences
- good physical health
- positive sense of self
- effective life/coping skills
- basic needs being met
- opportunities to learn

In addition, the Slan 2007 survey (Barry et al., 2009) concluded that having access to a job, income and good education are all critical to positive mental health as is having close supportive relationships.

Risk factors

A Vision for Change identifies the following risk factors for mental health

- physical illness or disability
- family history of psychiatric problems
- low self-esteem
- low social status
- basic needs not being met, e.g. homelessness
- separation and loss
- violence or abuse
- substance misuse
- childhood neglect

The results of the Slan 2007 (Barry et al., 2009) survey confirms that markers of social disadvantage i.e. low education, low income, holding a medical card and being unemployed are all associated with poorer mental health and social well-being.

Prevention and promotion programmes/activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Beat the blues	Aim: to increase awareness and understanding of depression and mood disorders. Also to assist young people to become more open about their emotional issues and nurture a more positive attitude. The programme targets stigma over mental health issues and examines suicide rates, particularly amongst young men. It seeks to identify sources of support for young people.	AWARE, schools, parents, Transitional Year and Senior students.	On-going
National public speaking project	Aim: to introduce students to public speaking and within that promote awareness and build knowledge in young people about the importance of positive mental health and the causes of mental illness. Mental Health Ireland's promotional programmes for schools feature the National Public Speaking Project. It has a parallel objective to reduce negative attitudes, prejudices and stigma which can be associated with mental illness.	Mental Health Ireland, YMHI, young people in senior classes in Post Primary Schools.	In its 31st year
Zippy's Friends programme	Aim: to increase emotional literacy for young children within schools in the west of Ireland as part of its overall programme for mental health promotion and enhancing coping skills for later life. The programme encourages children to understand and work things out for themselves rather than take a prescribed view in telling the participants what is 'good' or 'bad'.	Health Service Executive, schools, children of 5-7 years and teachers.	from 2008 to 2010
Please Talk.	Aim: to encourage young people experiencing problems to talk to others and identify the supports available to those	Third level students	Since 2007

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	in need. An initiative, running in third level colleges.		
Workplace			
Health and Safety Authority's Workplace Health and Well-being Strategy (2008),	Aim: to (i) develop a service delivery model that will support small and micro enterprises in implementing workplace health prevention, promotion and rehabilitation programmes; (ii) develop support service; (iii) establish a structure that facilitate such support.		
Mental health and wellbeing: A line manager's guide. The Irish Business and Employers' Confederation	Aim: to provide information and direction for line managers in promoting mental wellbeing for all and understanding and supporting employees experiencing mental health problems while in the workplace.	Employees experiencing mental health problems while in the workplace.	
Look after Your Mental Health during tough economic times; National Office for Suicide Prevention	Aim: to inform the general public and organisations on mental health issues related to unemployment and financial difficulties through public leaflets and guidance to organisations. The National Office for Suicide Prevention is also supporting the delivery of mental health promotion programmes targeted at unemployed people.	Programme targeted at workplaces and agencies working with and representing unemployed people	Commenced in 2009
The Veterinary Assistance Programme	Aim: to provide information resources, counselling and health promotion services. This programme consists of a 24 hour Free phone Professional Counselling Helpline; access to Face to Face Professional Counselling; anonymous or "low-stigma" online Professional Counselling accessed through e-mail and real-time "Live Connect"; and a dedicated "Wellnet" internet website, containing over 5,000	The National Office for Suicide Prevention provides this Suicide Prevention Programme targeted at The Veterinary profession;	

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	articles and resources on health, wellbeing, parenting, finances, legal information, consumer rights and workplace issues.		
Older people			
Befriending	Aim: to create supportive and positive relationships. Mental Health Ireland run the befriending project which helps to bring people together for positive, supportive relationships to reduce the isolation often felt by those with mental health difficulties	Mental Health Ireland, the HSE. The scheme is intended for adults over 18 years with mental health difficulties, living in the community	On-going
HSE Senior Help Line	Aim: to provide a listening service for older people. A national peer to peer confidential listening service for older people provided by older volunteers, for the price of a local call.	The service is aimed at isolated and lonely older people.	On-going
Other programs			
OSPI Europe – Optimising prevention programmes and their implementation	Aim: to address the determinants of mental health and risk factors for suicide and depression. A European project in which Ireland is one of four collaborating countries. A community based prevention intervention to train community facilitators such as GPs, teachers, priests, policemen, geriatric caregivers and provide self-help activities.	Members of the community	2009 to present, EU funded
Mental Health Matters project is run by Mental Health Ireland	Aim: to address the mental health in a realistic and relevant manner that is particularly appropriate to young people. And, to challenge young people's attitudes towards mental health and to discuss and correct misconceptions. A further aim is to ensure that young people have an awareness of the mental health services and facilities. A	Young people, 14-18 years.	2011

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	resource pack and a free structured course with six units, each with its own theme, using a series of exercises.		
Jigsaw	Aim: to address the mental health needs of young people. Jigsaw is a community model of youth mental health. It is an innovative approach which brings together existing community supports to meet the mental health needs of young people. Jigsaw works actively with services and local health managers in an effort to use existing resources in a more efficient way.	Young people aged between 12-25 years and their families. Developed by *Headstrong*, The National Centre for Youth Mental Health.	On-going. Funding sources include the HSE, and philanthropy
Caring for the carer	Aim: to address the mental health needs of carers. Mental Health Ireland designed a scheme to address the mental health needs of carers with an emphasis on mental health promotion.	Mental Health Ireland, Care Alliance Ireland, carers, those using the services of carers.	
See Change -the National Stigma Reduction Campaign	Aim: to reduce stigma. *See Change*, was, and is working to change attitudes about mental health, create a greater understanding and acceptance of people with mental health problems and end stigma.	The reduction of stigma requires a targeted, multifaceted, community-led approach. The campaign's activities and messages are therefore tailored to specific audiences, identified through baseline attitudinal research as being key audiences for stigma reduction. A network of over 50 national and local organisations across the country are working in partnership with *See Change* and are carrying the anti-stigma message through local broadcasts, local print media and a range of other activities.	Launched in 2010 and on-going. The campaign is funded by numerous organisations including the Department of Health through the National Lottery, The Mental Health Commission and The HSE National Office for Suicide Prevention.

Programme name	**Aim/approach**	**Stakeholders/target group**	**Duration, Cost of programme**
Think Big programme designed by O2 and *Headstrong*	Aim: to promote positive mental health and wellbeing for young people in Ireland. Grants of up to €300 are available to enable young people to undertake projects in their community that make a difference to young peoples' mental health.	Adolescents aged between 14 and 25	On-going
Suicide Prevention in the community: A practical guide	Aim: to prevent suicide. Launched by the National Office for Suicide Prevention, HSE West and Console the guide is the first of its kind in Ireland. It contains useful and practical advice on how best to set up a community response group to suicide. It lists the 'do's' and 'don'ts' of how best to support a grieving community and reduce the risk of further suicides in an area.	Good practice guidelines are outlined for schools, third level colleges, youth clubs and centres, workplaces and sports groups.	March 2012
'Your Mental Health' awareness campaign	Aim: to improve awareness and understanding of mental health and well-being in Ireland	The National Office for Suicide Prevention in partnership with many voluntary organisations provide information and support in times of emotional difficulty. See www.yourmentalhealth.ie	On-going
Let Someone Know' campaign	Aim: to promote awareness of mental health issues and to encourage young people to talk about their problems.	The National Office for Suicide Prevention campaign is aimed at youths.	Started in 2007
National Farm TV Mental Health Awareness Campaign,	Aim: to increase mental health awareness. This advertisement campaign commenced in 2009 and is disseminated through Farm TV. Farm TV is a media outlet specifically targeted at the agribusiness sector. The campaign is on-going and is shown in marts throughout the country on a weekly basis. The campaign has been supported with mental health awareness literature distributed at Farming markets.	Members of the farming community.	Funded by the National Office for Suicide Prevention

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Men's Health Forum	Aim: to develop and implement a suicide prevention programme targeted specifically at young men. This programme commenced in 2011 and links with all island sporting organisations to deliver part of the intervention and deliver key messages during major sporting events.	Young men.	The National Office for Suicide Prevention is funding the *Men's Health Forum*

Investments into mental health and MHP/PMI

Included within the HSE's National Service Plan 2012 is a ring-fenced investment of €35m for mental health (HSE, 2012). Funding from this special allocation will be used primarily to strengthen Community Mental Health Teams in both Adult and Children's mental health services. It is intended that the additional resources will be rolled out in conjunction with a scheme of appropriate clinical care programmes based on an early intervention and a recovery approach. Some of the funding will also be used to advance activities in the area of suicide prevention and response to self-harm presentations and to initiate the provision of psychological and counselling services in primary care specifically for people with mental health problems. 414 additional staff will be recruited to support these initiatives and to ensure that at a minimum, at least one of each mental health professional discipline is represented on every Community Mental Health Team.

The National Office for Suicide Prevention has implemented most of the *Reach Out* recommendations in a four way strategy - delivering a general population approach to mental health promotion and suicide prevention; using targeted programmes for people at high risk of suicide; delivering services to individuals who have engaged in self-harm and providing support to families and communities bereaved by suicide. The annual budget for this work has been increased to over €12million.

Initiatives to strengthen MH systems in relation to MHP and PMI

Since the launch of *Reach Out* and the establishment of the National Office for Suicide Prevention, there has been a significant amount of cross-sectoral working which has resulted in considerable advances in the development and implementation of information and education campaigns to increase awareness of mental health and

suicide prevention. Work has been undertaken in a multi-faceted manner and working in partnership with all key stakeholders. The increased funding and the quadrupling of funded projects in the last two years has enhanced the existing supports to the most at risk groups and the general population.

Skills based and awareness training has formed a significant part of the response to reduce levels of suicide, with ASIST and SafeTALK pivotal in this; training has been provided to over 25,000 people. Given the volume of training now available nationally, the National Office for Suicide Prevention has established a sub-group to develop a National Training Strategy.

A number of initiatives aimed at maximising the capacity of existing Child and Adolescent Mental Health (CAMHS) teams to respond to demand are underway. These include the establishment of a Service Improvement Working Group to develop additional activity measures, outcome measures and service quality measures for inclusion in a CAMHS Minimum Dataset which will inform local and national service planning and performance measurement.

In 2011 the HSE and the Irish College of General Practitioners partnered in the development of a skills-based training programme for general practitioners, practice staff and Primary Care Teams. The specially commissioned *Team Based Approaches to Mental Health in Primary Care* course at Dublin City University, aims to provide primary health care staff with necessary knowledge and skills to respond to mental health care issues in primary care. It is proposed to extend the programme further in 2013.

A HSE funded Mental Health Project Officer promotes mental health issues within the Irish College of General Practitioners.

The National Mental Health Network was established in 2011 with the underpinning ethos based on partnership between the HSE and a range of NGOs working in the sector. The main purpose of the group is to review and make recommendations on current information content developed by the network members to ensure that it is in line with the recommendations of '*A Vision for Change'*.

The Samaritans recently announced a ground-breaking agreement with the six telecom companies in Ireland on the provision of a new free-phone helpline number which will provide support for people experiencing feelings of distress or despair. It is expected that the new helpline number, 116,123 will be operational in the first half of 2013.

School Guidelines addressing the issues of mental health and suicide prevention are currently being finalised for post primary schools. These have been informed by

feedback received from key stakeholders. It is hoped that the finalised guidelines will be circulated to post primary schools in the near future.

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4.15 Italy

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Summary

- A radical programme of deinstitutionalisation in mental healthcare took place following the 1978 legislation. All of the former 76 mental hospitals have been closed.
- Inpatient care is provided by General hospital psychiatric units with a maximum of 15 beds.
- Community mental health centres are central to mental health services operating between 5- days per week for 12 hours a day in most Regions offering daytime and domiciliary care for those with severe and enduring mental illness. Other community mental health services include residential facilities for long-term psychiatric care and day hospital/centres.
- Variations in community mental health service provision exist across the Regions
- Recent government National Health and Prevention Plans have emphasised prevention and promotion of mental health, particularly for children and younger people
- There are an enormous number of regional and local examples of prevention and promotion of mental health programs

Data for this country profile were gathered in the first instance by the project's country collaborator for Italy. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Finland. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	60,626,442
Population density Inhabitants per km^2 (2009)	204
Women per 100 men (2011)	106.1
GDP PPP (2010)	1.0
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	10.6
Standardised Suicide rate by 100,000 inhabitants 2008	5.4
Gallup Wellbeing index (2010)*	
Thriving	39
Struggling	54

* Reprinted with Permission of Gallup, Inc.

Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Major psychiatric reform was initiated following the enactment of Law 180 in 1978 and General health Reform, Law 833/1978. This legislation set out four principal components: (1) a gradual phasing out of Mental Hospitals, and prohibiting all new admissions to them; (2) the establishment of General Hospital Psychiatric Units for acute admissions, each having a maximum of 15 beds; (3) more restrictive criteria and administrative procedures for compulsory admissions (solely to meet patient's needs for care, and reduce harm); and (4) the setting up of Community Mental Health Centres (CMHC) to provide care in geographically defined areas. Mental health services are now organised through 211 Departments of Mental Health, covering the entire country, each responsible for a geographically defined area.

Regions were entrusted with drafting and implementing the norms, methods and timetables for operationalising the principles of the Legislation. Over time this has led to uneven distribution of mental health services, with Regions adopting different standards of service provision and organisational frameworks (De Girolamo et al., 2007).

Mental health policy and inclusion of prevention and promotion

National Health Plans

The most recent National Health Plan for 2011-2013 is currently under approval and includes a section on mental health. The Plan refers specifically to an 'Action Plan on Mental Health' that has been approved and is to be issued shortly.

Prior to this the National Health Plan for 1998-2000 aimed to provide objectives and intervention strategies to monitor progress and create uniformity in levels of healthcare. Later, the National Health Plan (2006–2008) outlined the policy programme, A New Deal for Health 2007 – 2009. This aimed to promote health equality, public health and re-frame the Italian Health System by giving more precise responsibilities to the Regions. It lists several areas of work including: Raising awareness about healthy lifestyles, the introduction of new models of public health management; promoting inter-ministerial action to promote equity in health; four priority areas for improved safety (e.g. safe healthcare; safety at home and the workplace; safe environment; food safety); and a number of actions/projects such as mother and child health care, mental health, disability, older people and disadvantaged groups.

Mental health plans and strategies

A two year National Mental Health Plan' (NMHP) was launched in 1994 and principally directed towards deinstitutionalisation and the creation of community based mental health services. The policy included advocacy, promotion, prevention, treatment and rehabilitation. A National Mental Health Strategy in 2008 was approved by the State and Regions. A key strategic objective is to increase the coordination and integration between mental health services and in particular collaboration with addiction services (Linee di indirizzo nazionali per la salute mentale).

The Ministry of Health's key priorities for adults with mental health problems include:

- More epidemiological research to examine the causes of mental illness
- Swifter referral to services for easier access and earlier management of people with severe conditions, such as schizophrenia and bipolar disorder
- The establishment in the Italian NHS of diagnostic, treatment and caregiving programmes based on evidence-based practices, particularly in the psychotherapy and rehabilitation sector
- Inclusion within essential levels of care of feasible caregiving programmes based on real needs.

For children and adolescents:

- The implementation of programmes for primary prevention of mental disorders and promotion of mental health from infant and primary school age, involving the family;
- Dealing with the topic of emergencies related to mental disorders during adolescence;
- Improving the collaboration and coordination between child neuropsychiatric services, mental health departments and general paediatric care networks, supporting the development of continuity pathways between child neuropsychiatry and adult psychiatric services
- Reviewing the essential levels of care in the mental health for children and adolescents. (Source: Ministry of Health website, 2012)

Prevention plans and public health

The first Project Objective for the Protection of Mental Health (Progetto Obiettivo per la Tutela della Salute Mentale, 4080, 22 December 2000) was issued to initiate primary, secondary and tertiary prevention by giving funding to the Department of Mental Health.

In 2004, the Ministry of Health introduced the National Centre for Disease Prevention and Control (Centro Nazionale per la Prevenzione e il Controllo delle Malattie, CCM). From 2006 a number of mental health projects have been financed by the CCM, including, for example, an intervention programme with General practitioners for the prevention of depression and suicide funded in 2008.

The most recent National Prevention Plan was issued in 2011 and for the first time includes mental health, focusing on the prevention of depression, suicide and eating disorders. Each Region now has a defined Regional Prevention Plan.

Mental health services

Organisation and functioning of mental health systems

Following the 1978 legislation (Law 180) the process of deinstitutionalisation in Italy was both radical and revolutionary in terms of the culture and practice of psychiatry. To date all 76 mental hospitals have been closed (achieved by the end of the 1990s) and many former long-stay and elderly patients transferred to various types of residential facilities such as nursing homes.

Health care in Italy is shared by the State and the 20 regions. The National Health Service (NHS) through 'Local Health Units' (LHU) has responsibility for a geographically defined catchment area. The present mental health system includes Departments of Mental Health (DMH) in a network of population-based health management organisations, 'local

health units' (azienda sanitaria locale, ASLs). These departments are responsible for providing specialist mental health care in the community, as specified by the Progetto Obiettivo "Tutela Salute Mentale 1998-2000". DMHs include a range of mental health services: community mental health centres (CMHCs), Day Care Facilities (DCF), acute inpatient care through General Hospital Psychiatric Units (GHPUs) and Residential Facilities (RFs). DMHs are also expected to plan, coordinate and promote mental health prevention and rehabilitation within defined catchment areas (Lora, 2009). In 2009 there were 208 DMHs, reduced from 214 in 2007, partly because of mergers within ASLs.

Healthcare is predominantly provided by the public sector, whereby private sector healthcare is usually accredited and contracted by statutory (public services). Integration and close collaboration between different mental health services has been an important priority, as set out in the Progetto Obiettivo 1998-2000.

National data from the Ministry of Health for 2009 lists the following types and number of inpatient and community-based mental health services:

Inpatient psychiatric beds: Inpatient care, based in General hospital psychiatric wards, includes an emergency department (SPDC Servizio psichiatrico di diagnosi e cura). Inpatient facilities have a maximum of 15 beds and keep close links with community mental health centres to ensure continuity of care (Lora). Inpatient care consists of short term crisis interventions in which patients are referred back to community mental health centres for outpatient care or other types of intervention. Very few admissions are compulsory with the majority being on a voluntary basis. Psychiatrists working in these wards are usually involved in consultation programmes with medical and surgical wards in general hospitals. Prior to 2005, there were 0.92 per 100,000 psychiatric beds in general hospitals and 4.63 per 100,000 psychiatric beds in Italy. The Table below lists the number of public and private (accredited) inpatient psychiatric beds for Italy in 2009:

Total number of public beds	Beds per 10 000 population (18 years +)	Total private accredited beds	Beds per 10 000 population (18 years +)	Total number of public and private beds	% of public beds	Total number beds per 10 000 population (18 years +)
4630	0.93	1750	0.35	6380	72.6	1.280

Source: Ministero della Salute - Sistema Informativo Sanitario (2009)

The total number of psychiatric inpatient beds in General Hospital psychiatric units was 6,380 (1.28 per 10,000 inhabitants) in 2009; and down from 6,780 beds in 2007. The number of both public and private inpatient psychiatric beds across the twenty-one regions ranged from 0.42 per 10 000 inhabitants in Fruili Venezia Guilia to 2.39 per 10 000 inhabitants in Piedmonte.

Community mental health services: Community mental health centres (CMHCs) are at the heart of mental health services covering all activities concerning adult psychiatry in outpatient settings and those delivered by day care services and residential facilities. In most Regions they operate 12 hours a day for five or six days a week; and the majority of CMHCs have multidisciplinary teams that include psychiatrists, psychologists, social workers, nurses and educators.

For 2009, the total number of community mental health centres was 1,387 or 4.17 per 150,000 inhabitants for adults (18 years and above); an increase from 708 in 2007. The number of these varied widely from 1.53 per 150,000 inhabitants in the region of Basilicata to 11.27 per 150,000 inhabitants in Valle d'Aosta (see Table below):

Regional distribution of Centres for mental health and Departments of Mental Health – figures for 2009

Region	Mental health centres (CSMs)		Departments of Mental Health (DSMs)	
	Number	CSMs per 150 000 population (18 years+)	Number	Average catchment area size per DSM
Piemonte	77	3.07	25	150,347
Valle d'Aosta	8	11.27	1	106,462
Lombardia	309	5.71	29	280,084
Prov. Auton. Bolzano	9	3.38	-	-
Prov. Auton. Trento	10	3.53	1	424,605
Veneto	82	3.03	21	193,478
Friuli Venezia iulia	17	2.43	6	174,819
Liguria	22	2.37	5	278,775
Emilia Romagna	130	5.31	11	333,620
Toscana	129	6.14	12	262,791
Umbria	14	2.77	4	189,294
Marche	23	2.61	13	101,490
Lazio	119	3.81	12	389,980
Abruzzo	18	2.41	6	186,736
Molise	2	1.11	3	89,954
Campania	61	1.98	15	307,646
Puglia	63	2.85	10	332,089
Basilicata	5	1.53	5	97,938
Calabria	34	3.10	11	149,639
Sicilia	206	7.59	10	407,302
Sardegna	49	5.19	8	176,884
Italia	**1,387**	**4.17**	**208**	**239,645**

Source: Ministry of Health – Sistema Informativo Sanitario (2009)

Community residential facilities: Residential facilities based in the community provide long-term psychiatric care following the closure of mental hospitals after 1978. Residential facilities promote psychosocial rehabilitation and integration. Each facility is

permitted to have a maximum of 20 beds. Admission to these facilities is generally based on an individualised care program.

The Italian National Institute of Health launched the PROGRES project (PROGetto RESidenze) over a decade ago to evaluate the residential care system. At this time the study found 17,138 beds in residential facilities (2.9 beds per 10,000 population), with around half having opened after 1996 (de Girolamo et al., 2005)

The number of residential facilities for adults aged 18 and above has increased steadily over time. In 2007 there were 1,577 facilities rising to 1,679 in 2009 with 19,299 beds. Some 30,375 people used the facilities, with an average length of stay of 187.52 days.

Day Hospitals and day centres: Semi-residential facilities (or day hospitals) provide complex diagnostic intervention and short to medium term care. These facilities can be located either in a hospital or in the community but always linked to community mental health centers. These facilities also increased in number from 755 in 2007 to 763 in 2009. There were 32,030 clients who used these facilities with an average length of stay of 67.01 days.

Day centres are community semi-residential facilities that work in cooperation with social and voluntary organisations, but under the direct responsibility of the DMH. They deliver individual treatment and rehabilitation programmes to develop daily life skills and personal care.

Access and usage

Health care is provided free at the point of access. Patients can directly access community mental health services without GP referral. Data from the National Statistics Institute (Istat) admissions to inpatient psychiatric wards increased from 2005-2008, from 4.16% of all psychiatric patient discharges in 2005 to 4.55% in 2008. The figures were slightly higher for males compared to females and for those aged between 25-44 years. Length of stay during admission varies between inpatient facilities, but the median number of days is 11.4 in General Hospital Psychiatric Units, 17.8 in University Psychiatric Clinics, 21.1 in 24-hour Community Mental Health Centres and 37.6 days in Private Facilities (de Girolamo et al., 2007).

Usage of Community mental health centres over a three month period during 2005-2006 was 90.8 per 10,000 population, with women making up 57% of the entire sample surveyed and 42.5% under the age of 44 years (PROG-CSM survey cited in Lora, 2009).

Variation and gaps

There is significant variation in mental health service provision and in the quality of care between the regions as noted above. A focus on better integration and closer

collaboration between different mental health services at local level is emerging with the introduction of the 'Community Pacts for Mental Health' strategy. This essentially promotes the integration of various service agencies (health, social, economic and vocational resources in both the public and private sector). Under this framework, prevention and treatment interventions may be offered to individuals throughout their life by taking into account their specific needs.

Financing

The mean value is around 5% of regional health expenditure, with regional variability even if there has been an informal agreement on this value in the past. Total expenditure on health as a proportion of gross domestic product (GDP) has increased since 1990 by 0.8% to 8.7% in 2007. Tax revenues accounted for 77% of the total amount spent on healthcare in 2007. In 2004, cost-sharing and direct payments by users represented 19.6% of total health care expenditure and 83% of all private health care expenditure. The proportion of expenditure on mental health varies across the different Regions who have responsibility for allocating resources to specific sectors.

Workforce

In 2009 there were 18.0 psychiatrists per 100,000 population. In 2005, the total number of psychiatric nurses was 32.4, 3.2 psychologists and 6.4 social workers per 100,000 population. In terms of staff employed in facilities within the DSM, a decline was recorded in 2009 for almost all professional profiles, with the exception of doctors and social workers, which increased slightly since the 2007 Health Information System survey (Ministry of Health).

Responsibility and delivery of mental health promotion and prevention of mental illness

The responsibility for prevention and promotion in mental health is mainly at Regional level in which there are a large number of local programs. Delivery of prevention of mental disorder is expected to be performed by people working within mental health services, often in cooperation with other Organisations, such as Cooperatives and Associations.

Mental health status

Prevalence of mental health in the population

On a sample of over 4,700 people a study conducted between 2001 and 2003 found the following prevalence of mental illness in the general population. The table below provides a breakdown according to gender, total 12 month and lifetime prevalence.

Diagnosis	Men %	Female %	Total 12 month prevalence %	Total lifetime prevalence %
Any mental illness	3.9	10.4	7.3	18.3
Any mood disorder	2.0	4.8	3.5	11.2
Major depression	1.7	4.2	3.0	10.1
Generalised anxiety	0.1	0.9	0.5	1.9
Panic disorder	0.3	0.9	0.6	1.6
Alcohol misuse	0.2	0.0	0.1	0.8
Alcohol dependence	0.0	0.1	0.0	0.3

Source: ESEMeD study (de Girolamo et al., 2005)

The annual prevalence of mental disorder in the general population is approximately 8%. Recent data from Istat for 2009 show a self-reported prevalence of mental health problems (classified as "nervous disorders") of 4.4% for the total population under the age of 65 years. Broken down by gender the prevalence for men is 3.3% and higher for women at 5.5%. For those over 65 years, the prevalence was much greater – 9.8% for the total population, 7.3% for men and 11.6% for women. A proxy indicator of the prevalence of mental health problems in the population concerns levels of psychotropic medication use. Data published by the National Observatory (OSMED) monitoring centre show that during 2000-2009 the consumption of antidepressants rose on average by 15.6% per annum, from 16.2 per 1000 inhabitants to 34.7 by 2009.

In 2007, Project PASSI (a system of national health surveillance), using the Patient Health Questionnaire (PHQ-2) on a sample of 20 850 people, found that 9.4% of the people interviewed reported having symptoms of depression in the past 2 weeks. Only 52.8% of these sought help. The reported symptoms were higher in women compared to men (12.8% vs. 5.9%) and in people between the ages of 50-69 years (12.1%).

Incidence

Incidence data (i.e. the number of new cases in the general population) were not found. However, the SEME project, funded by the Ministry of Health and coordinated by the ISS (Istituto Superiore di Sanità) aims to detect new cases of severe mental illness that come into contact with mental health services. Twenty-two mental health centres were involved to survey 2,082,368 citizens. Between March 2009 and December 2010, 407 new cases were admitted: 168 (or 41.2%) had psychotic disorders (schizophrenia, schizophreniform disorder, schizoaffective disorder and delirious disorder), 120 (29.5%) bipolar disorders (bipolar disorder I and II), 80 (19.7%) had severe major depression and 39 (9.6%) with anorexia nervosa. It was discovered that despite the severity of their conditions, this was the first time that they had contacted the mental health centre, at a median interval of 4 years from the onset of the disorder.

Protective factors

Not available.

Risk factors

According to the ESEMeD study some key risk factors for mental illness include alcohol; being separated, divorced or widowed, unemployment and having a physical disability.

Investments into mental health and MHP/PMI

Financial sources/responsibility for prevention and promotion

The entire budget for the CCM, which is a structure of the Directorate General for Prevention at the Ministry of health, was 32.65m in 2004, 25.45m in 2005 and 31.9m from 2006 onwards. There are funds for research purposes from the Directorate General for Research also the Ministry of health, varying according to the projects presented every year. A large number of projects are financed by Regions, Provinces and Municipalities. Some funds come from joint financing of health and education sectors.

Prevention and promotion programmes/activities

There are numerous examples of regional and local prevention and promotion activities. A selection of programmes and activities are included below:

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Community Prevention Strategies for Youth	Aim: to develop tools and implement actions in the field of comprehensive community prevention of adolescents' mental problems, with special attention to dependence. Approach: Promotion of prevention actions in schools, using tools such as "life skills education", "peer education", "education to legality".	Adolescents, schools. Toscana region	Commenced 2008 and on-going. Financed by the Ministry of Health and coordinated by the Region Toscana, involves 10 Italian Regions
Workplace			
No specific programmes found, but see section below			
Older people in long term care facilities			
No specific	In Italy these kinds of facilities		

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
programmes found, but see section below	are generally social facilities. Unless you refer to specific cases, such as, dementia.		
Other programmes			
Programme for the inclusion of people with mental health problems in the workplace	Aim: to support employees with mental disorders and (re)integration into the main job market. Approach: Through development of community networks, training of professionals working in community services, support for people while in work. So far the project has set regional guidelines, engaged a network of Labour Associations.	People with mental health problems. Employers. Ministry of Labour and Social Policy and Regional Administrations.	Started in 2006, financed by the Ministry of Labour and Social Policy and coordinated by the "National Institute for training and orientation to work" (ISFOL), and the Observatory on Social Inclusion.
Detection and Treatment of Depression in Physically ill patients	Aims: to 1) involve physicians working in General Hospitals to raise awareness of depression and emotional disease, using the active model of Liaison Psychiatry; 2) create and test a model for screening and specific treatment of depression in physically ill patients; 3) develop informative packages for patients and relatives, flow-chart and screening instruments for physicians; 4)propose and test an on-call service for pharmacological questions regarding depression and medical illness.	People with physical illness. Physicians working in hospitals	Started in 2007 and on-going. Financed by the Ministry of Health and coordinated by the Units of Psychosomatics and Clinical Psychology, Section of Psychiatry and Clinical Psychology, Verona University
Prevention of Depression in the "National Health Prevention Plan 2010/2012", Italy	Aim: to identify best practice for preventing depression. Approach: Through a definition of a guideline for classifying best; dissemination of information and exchange of experiences; the creation and implementation of a national interactive database	Ministry of Health	2012
Protocol for the prevention of suicide in hospital settings (*)	Within the framework of the National Strategy for "Clinical Governance", carried out in cooperation by the Ministry of Health and the Regional	Interdisciplinary health professionals. Regional administrations and the Ministry of Health	2008.

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	Administrations, a specific Recommendation has been issued in 2006 promoting actions to prevent suicide and suicide attempts in hospitals.		
"Guadagnare salute" (Gaining health)	Aim: to promote healthy lifestyles, increase wellbeing for all age groups. Approach: Encouraging physical activity, consumption of healthy diets, preventing eating disorders, preventing and combating smoking, and alcohol use/misuse. Includes a specific project on Eating Disorders (ED), which focuses both on social prevention and care.	All age groups, with a focus on young people.	2007 to 2010. Promoted and coordinated by the Italian Ministry of Health, conducted in collaboration with other Ministries and Regions, and co-financed.
SOPROxi Project: a research-intervention project for suicide survivors	Aim: to prevent suicide survivors developing psychiatric disorder. The project works along 5 stages: involvement, welcoming and initial assessment, assessment of psychological distress, intervention and follow-up. Agencies involved are GPs, mental health professionals, child neuropsychiatrists and social services. Cooperation with police was also established to reach out to survivors.	Survivors of suicide	
SUPREME: Internet and Media-based Suicide Prevention	Aim: to enhance and improve the mental health and well-being of European adolescents. Approach: Developing, implementing and evaluating an Internet and Media-based, multi-language, culturally adapted, peer facilitated Mental Health promotion and Suicide Prevention intervention programme. Using an interactive website accessible to the general public, targeted at adolescents and young adults and a set of published guidelines, aimed at Media that targets young audiences, such as newspapers and magazines.	General public with a focus on young people between 14-24 years	2010. The project is part funded by the Health Programme of the Executive Agency for Health and Consumers (EAHC) and by participating centres.

(*) There is a National programme for the Prevention of suicide in prison, approved in 2011

Initiatives to strengthen MH systems in relation to MHP and PMI

Initiatives to strengthen prevention in mental health have been mainly through recent health policy directives and government funding for a number of programmes (see section above).

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4.16 Latvia

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Summary

- Mental health care is mostly hospital based, with 74% of the mental health spending allocated to psychiatric hospitals. Long-term inpatient care is largely provided by six psychiatric hospitals
- Community-based mental health services are lacking with some availability of outpatient and day inpatient services, but these are inadequate in number.
- There remains a lack of financial support to develop community-based mental health services, so institutional care continues to dominate.
- GPs are reluctant to provide mental healthcare at primary care level due to heavy workloads and insufficient knowledge and training.
- The Government set a target to reduce suicide by 25% by 2010, which has been achieved compared to the rate in 2001. However, Latvia continues to have one of the highest suicide rates in Europe.
- The Government has expressed a duty and commitment to mental illness prevention and mental health promotion but activities in these areas are very limited, due mainly to the limited health care budget.

Data for this country profile were gathered in the first instance by the project's country collaborator for Latvia. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from Latvia. This expert provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by the Governmental expert and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	2229641
Population density Inhabitants per km^2 (2009)	36.3
Women per 100 men (2011)	116.6
GDP PPP (2010)	0.5
Psychiatric care beds in hospitals per 100,000 inhabitants (2011)	115.5
Standardised Suicide rate by 100,000 inhabitants (2010)	17.5
Gallup Wellbeing index (2010)*	
Thriving	11
Struggling	64

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Legislation for mental health falls within existing general health legislation; there is no separate law for mental health. A key document is the *Medical Treatment Law,* adopted by Parliament on June 12 and enforced on October 1, 1997. The legislation emphasises the importance of good cooperation between mental health and other sectors to enhance the service. Here, the law stresses the importance of mental health by stating that health is 'physical, mental and social well-being' and crucial to the nation and State's survival. Section 1 of article 5 states: 'Everyone has a duty to take care of, and everyone is responsible for, his or her own health, the health of the nation, and the health of his or her relatives and dependants'. It reiterates each individual's responsibility to maintain their mental health as a part of society's fabric.

Section 11 of this law refers to mental health and illnesses and their consequences. It specifies the rights of the mentally ill, the ideology and legal procedures for the provision of psychiatric assistance without consent, particularly involuntary admission. This section also gives guidance on working with the police. The Medical Treatment Law also describes all parties' responsibilities, including healthcare professionals, State ministries and local governments, with regard to the promotion of mental health.

Other relevant legislation includes:

Public Health Strategy for 2002-2010 (Approved by Cabinet of Ministers on 6 March 2001, Order No. 513 of 23 July 2004, to facilitate the implementation of public health policy and improve public health indicators. http://www.lm.gov.lv/text/549

Public Health Strategy for 2011-2017 Framework Policy Document "Improvement of Inhabitants' Mental Health for 2009-2014" (Order No. 504, approved 5 October 2011, the Cabinet of Ministers of the Republic of Latvia). http://www.likumi.lv/doc.php?id=237269

Poverty Reduction Strategy (Approved by Cabinet of Ministers on August 28, 2000, on July 15, 2004), Cabinet of Ministers accepted Latvia's *National Action Plan for Reducing Poverty and Social Exclusion (2004-2006*). http://polsis.mk.gov.lv/view.do?id=1394

Ministry of Health developed the *Framework Policy Document "Improvement of Inhabitants' Mental Health for 2009-2014"* and approved by Cabinet Direction No 468, Riga, August 6th, 2008 (Prot. No 55, §57). http://polsis.mk.gov.lv/view.do?id=2753

The Law on Social Services and Social Assistance (implemented in 2003) defines principles of providing and receiving social work, social care, social rehabilitation, professional rehabilitation and social assistance services and define the persons eligible for these services and assistance (including persons suffering from mental disorders). The law includes financing principles for these services. http://www.likumi.lv/doc.php?id=68488

Guidelines for municipalities in health promotion, approved by The Ministry of Health (12 December 2011, Order No. 243).
http://phoebe.vm.gov.lv/misc_db/web.nsf/626e6035eadbb4cd85256499006b15a6/8a03f52e8e639356c225792e00364f3b/$FILE/Vadlinijas_pasvaldibam_aprilis_2012.pdf

Mental health policy and inclusion of prevention and promotion

Public Health Strategy for 2002-2010: under the 5th objective of the strategy, stipulates that 'achieving the objectives requires a multi-sector strategy directed to promoting mental health'. The Public Health Strategy notes that public health policy should concentrate on creating home and work environments to support improvement of mental health, and create mental healthcare services focused on early intervention.

The Public Health Strategy for 2011-2017, under point 3.2.4., lists current mental health indicators and identified problems. Latvia is the one of the countries with the highest suicide rates in Europe; suicide is the fifth most frequent cause of death. The strategy also highlights stigma of those with mental illness that impedes their successful integration into society, early intervention and a decrease in the suicide rate. Tasks to improve mental health care and conduct prevention include to:

- carry out a study by the World Health Organization concerning the experience of young people of violence in childhood (inclusion in 2010/2011 and 2014/2015);
- organise educational events to prevent violence in families, work places and schools;

- develop an Action Plan of mental Health improvement and prevention (implementation date Dec. 2012).

Poverty Reduction Strategy 6, which would also positively affect mental health. The strategy also anticipates training healthcare and other professionals (especially teachers) in the early detection of mental health problems, actions to take, and improving stress-management skills (at schools, during attending general practitioner, at work, etc.).

In 2004 the government adopted the *National Action Plan for Reducing Poverty and Social Exclusion (2004-2006)*, had an impact on mental health issues. The main activities were in the spheres of employment and education. The plan stressed that significant problems in mental healthcare are leading to the deterioration of the social conditions of patients, which limits their access to satisfactory treatment. The plan also noted an increasing trend in the social alienation and isolation of mentally ill persons.

The framework policy document, *"Improvement of Inhabitants' Mental Health for 2009-2014"* includes a separate section on mental health promotion. It concluded that there is no implementation of a national and regional level mental health prevention programme to educate the public and professional groups, create a positive and non-judgemental attitude towards the mentally ill and their treatment and increase inter-sector cooperation for resolving problems. This policy document noted that the public had not been sufficiently and regularly informed of suicide risk factors and the options for receiving healthcare assistance in crisis situations. Similarly, healthcare workers had not been sufficiently trained in the early detection and treatment of depression, which contributes to the high number of suicides. The framework policy document also revealed that there was no system, available in all regions, for helping sufferers of long-term stress, loss or depression, or 24-hour counselling for people in crisis. The framework policy document intends to educate and inform the public about mental healthcare promotion and preventive measures, to conduct two monitoring studies in the mental health sphere (in 2010 and 2013). Additional preventive mental healthcare measures will be planned in accordance with the monitoring results. Although an implementation plan for the framework policy document has not been finalized, the Public Health Agency (PHA) has carried out some mental healthcare promotion and preventive measures. *(The PHA ceased operating on 1 September 2009, transferring its functions to a number of other bodies: the Ministry of Health, the Health Inspectorate, the State Agency "Latvian Infectology Centre," the Disasters' Medicine Centre and the Health Economy Centre)*.

Riga City Council action plan 2006-2018: Document on Health promotion is due to be enacted from 2012. One section of this will be dedicated to mental health.

Guidelines for municipalities in health promotion - section 8.10 includes limited description of the situation and practical recommendations for local municipalities on mental health promotion in different population groups: pre-school children, adults, pregnant women, new mothers, young families and the elderly.

Mental health services

Organisation and functioning of mental health systems

Mental healthcare services in Latvia comprise mostly of hospital based care with some community mental health services. For 2010 inpatient care included:

- 6 psychiatric hospitals (under the Ministry of Health, 5- for adults, 1- children's hospital) with 2,127 beds (including 140 for children) (including acute, chronic, forensic psychiatry beds) – Riga, Jelgava, Daugavpils, Strenci, Akniste, Ainazi
- 3 psychiatric departments in other hospitals (under the Ministry of Health) with 271 beds (including 56 for children) – Riga, Liepaja, Olaine
- 30 psychiatric beds in prison hospital
- 1 children's department in general hospital with 41 beds in Riga
- 4 day inpatient services in 4 areas – Riga, Liepaja, Daugavpils, Jelgava.

The table below provides a breakdown of the number of psychiatric inpatient care beds for 2011 by type:

Type of inpatient beds (2011)	Number of beds	Beds per 100,000 population*
Psychiatric care beds in psychiatric hospitals	2,135	102.9
Psychiatric care beds in general hospitals	261	12.6
Beds for substance abusers in substance abuse hospitals	70	3.4
Beds for substance abusers in substance abuse departments of general hospitals	63	3.0
Beds for substance abusers in psychiatric hospitals	97	4.7
Beds for substance abusers in private facilities	29	1.4

*Population at 1 January 2011 – 2,074,605 (data from census)

Source: Centre for Disease Prevention and Control of Latvia (CDPC)

Community based mental health care in 2010 comprised of:

- The Riga Psychiatric and Narcology Centre (drug and alcohol abuse) outpatient mental health care centre *Veldre,* in Jugla commenced service in the City of Riga, providing outpatient psychiatric and psychological assistance, occupational therapy and consultations of social worker, as well group activities and day inpatient (25 beds) services. Continuing the development of outpatient

psychiatric assistance services in Riga, in autumn of 2009 the Riga Psychiatric and Narcology Centre outpatient branch *Pārdaugava* was opened to provide services for the inhabitants of the Pārdaugava district of Riga.

- 4 outpatient mental care units (including children's) in mental care hospitals – Riga, Jelgava, Liepaja, Daugavpils.
- 1 children's outpatient mental care unit in regional multi- profiled hospital in Riga.
- 69 private psychiatric practices.
- 23 outpatient's psychiatric care rooms in primary care centres by regional municipalities (including children's mental care but are not sufficient).
- 28 day care centres mainly offer services for persons with intellectual disabilities. Day centres for people with mental illness operate only in Riga and Jelgava.
- 24 specialised social care homes for persons with mental disabilities (under the Ministry of Welfare).
- 12 group homes/apartments for persons with mental disabilities operate nationwide (capacity for 152 persons), of which 11 group homes also received state co-funding.
- 6 Halfway houses with capacity for 116 persons.
- 1311 General practitioners – mostly dealing with mild mental disorders.

Access and usage

Although Latvia's healthcare system is based on a network of GPs who 'open the gates' to secondary health care, a person can turn directly to a psychiatrist if he or she has a mental illness (in accordance with ICD-10: F00-F09; F20-F62; F63.1-F99). According to Paragraph 76.2.1. of Cabinet Regulation No. 1046 of 19 December 2006 "The organization and financing arrangements for health care", psychiatrist is a direct access specialist. A monthly fixed payment (estimated funding) is applied to the salary of a direct access specialist consisting of payment for work and expenditure relating to maintaining of consulting rooms. Therefore the most important factor in payment for this service is not the number of treatment episodes conducted by the specialist, but rather access to specialist services in an agreement signed with the Health Payment Center, in a stipulated place and amount of visits. If the amount of visits is less than 6 per day, psychiatrists are paid for visits (1 visit=4.63 LVL (6.61 EUR) for psychiatrist and 6.32 LVL (9.02 EUR) for a children's psychiatrist). Private bodies/private medical practices with psychiatrists on staff are also involved in treatment of patients with mental disorders. In such cases, the patient pays all the costs associated with the treatment.

Due to the heavy burden on general practitioners and insufficient knowledge, GPs try to avoid providing healthcare for patients with mental and behavioural disorders. The basic functions of a GP are to assess the health condition of a patient, carry out diagnostics

and treatment of disease, and if necessary, involve other specialists in patient healthcare. Although, in the last few years mental health care specialists have drafted informative materials for general practitioners and other specialists working in mental health care. However, these materials are not enough to ensure sufficient guidance for general practitioners. There are no formal networks to disseminate information.

In 2009, in total 148,361 people with mental illness sought outpatient help (paid for by state) with different specialists (6.5% of population) *(136,743 persons after* excluding persons with diagnoses from F10 – F19 group). Of those 36% had seen a GP and 64% visited other specialists.

Variation and gaps

Treatment for mental illness is mainly in hospital. Community-based day care centres for persons with psychiatric illnesses are available but their numbers are insufficient. Good outpatient care is expensive and its development is very slow.

From 1998 to 2006 the number of psychiatric hospitals' beds was reduced by 28.2% (from 4,371 to 3,139 beds) and this number is still decreasing. In 2010 there were 2,127 beds in psychiatric hospitals, but there remains a lack of financial support for the creation of community-based mental health services. Institutional care, in the form of psychiatric hospitals and specialised social care homes for persons with mental disabilities, continue to dominate in 2010.

Financing

In 2008, 5.9% of the state health care expenses were channelled into mental health and 74% funded psychiatric hospitals. Although the financing of outpatient medication has increased, the bulk of resources are still channelled towards inpatients. Alternative ways of providing and financing mental health services are still evolving.

According to data from the Health Payment Centre[4] medications reimbursed by the State included:

- 9.54% of all resources in 2006, thus providing medications to 17,509 patients in the amount of 4,243,376.15 LVL (6,037,780 EUR) or approximately 242.35 LVL (345 EUR) per patient;
- 7.94% of all resources in 2007, thus providing medications to 18,130 patients in amount of 5050,910.51 LVL (7186,798 Euros) or approximately 282.84 LVL (402 EUR) per patient;

[4] From 1st November 2011 – National Health Service

- 6.35% of all resources in 2008, thus providing medications to 19,142 patients in the amount of 4,883,084.59 LVL (6,948,003 Euros) or approximately 255.10 LVL (363 EUR) per patient.
- 5.9% of all resources in 2009, in amount of 4,225,583.87 LVL (6,012,498 EUR)
- 5.74% of all resources in 2010, thus providing medications to 24,198 patients in amount of 4,236,942 LVL (6,028,660 EUR) or approximately 175 LVL (249 EUR) per patient.

Psychiatric expenses are covered by the State and are free of charge for the patient. This applies to cases where the primary diagnosis of the patient is a mental illness, but does not apply to cases if the patient needs different help, for example a surgical consultation. The patient has to pay the full patient payment for the surgical consultation. However, should the patient belong to another category that does not have to pay patient payments, (for example if the patient is under the care of a state social care home or local government's elderly home, or he or she has the status of low-income as defined by laws and regulations), the other specialist services for this person is covered by the state in the full amount, from 1 October 2009 *(Up to 1 March 2009 persons with low-income were exempted from patient payments. Due to a decline in state budget revenues, from 1 March 2009 to 1 October 2009 persons with low income also had to pay 50% of the patient's payment set by the state)*. The state does not pay for psychotherapeutic and psychological help (except assistance provided in psychiatric wards or specialised hospitals, treatment in drug and alcohol rehabilitation programmes and outpatient palliative care for children). Although the state does not pay for specialist home visits, one of the two exceptions to this rule is state-funded psychiatrist's home visits to psychiatric patients chosen by the psychiatrist.

From 1st April 2011, there are patient fees for each prescription (reimbursed medicines) for the amount of 0.50 LVL (0.71 EUR).

Funding for non-institutional care is also important. An allowance of 100 LVL (142.28 EUR) per month was introduced on 1 January 2008, for caring for a disabled person, and the amount of the allowance for a disabled child was raised from 50 LVL (71.14 Euros) to 150 LVL (213.43 Euros) per month.

Workforce:

According to the World Health Organization Mental Health Atlas (2011) the number of mental health professionals per 100,000 population includes:

10.8	Psychiatrists
30.8	Nurses
UN	Psychologists
UN	Social workers
0.4	Occupational therapists
15.0	Other health workers

Data regarding staff working in the private sector is unavailable.

Responsibility and delivery of mental health promotion and prevention of mental illness

In general the State is responsible for delivering health (including mental health) promotion and prevention of illness. The Ministry of Health of the Republic of Latvia is responsible for health promotion policy and its implementation, development of health promotion recommendations, programmes and its methodological management, but one of the function of municipalities is to provide access to health care and promote healthy lifestyle and sport activities.

(http://phoebe.vm.gov.lv/misc_db/web.nsf/626e6035eadbb4cd85256499006b15a6/4264c361d5969252c2257310004ab503/$FILE/VM%20nolikums%20no%202010.marta.pdf)

Mental health status

Prevalence of mental health in the population

According to data reported by psychiatrists (published in Mental Health Care in Latvia (2009)), there were 69,716 individuals registered with mental and behavioural disorders. The highest proportion of registered patients (75%) suffers serious, long-term and chronic diseases as schizophrenia, schizotypal and delusional disorders (27.5%), mental retardation (24.1%) and organic mental disorders, including symptomatic ones (23.2%). Absolute rates for suicide were reported as 516 (22.9 per 100,000 inhabitants).

A breakdown by diagnoses of first time and previously registered patients in 2009, is as follows:

Diagnosis	*First time registered*	*Previously registered*
Dementia (F00-F03)	637	3,802
Mood [affective] disorders (F30-F39	454	5,160
Neurotic, stress-related and somatoform disorders (F40-F48):	942	5,993
Schizophrenia, schizotypal and delusional disorders (F20-F29	518	19,145
Conduct disorders (F90–F98):	391	2,431

Analysis of Health Behaviour among Latvian Adult Population survey revealed that 48.4% women and 42.2% men, in their opinion, had experienced depression during the last year, but the symptoms of depression were reported even worse than before in 6.2% women and 6.4% men (15 – 64 years old people) (CHE, Health Behaviour among Latvian Adult Population survey questionnaire data, 2008).

Incidence

According to data reported by psychiatrists between 2007 and 2009 there was a slight increase in first time registered patients with mental illness (from 5,045 patients in 2007 to 5,264 patients in 2009). Only data on patients with mental and behavioural disorders (F00-F98 in ICD-10) were processed and excludes information on patients with substance misuse (F10-F19 in ICD-10) who are recorded on a separate database.

There has also been an increase in organic mental disorders, including symptomatic ones (from 78.8 patients per 100,000 inhabitants in 2008 to 83.1 patients per 100,000 inhabitants in 2009); neurotic, stress-related and somatoform disorders (from 38.4 patients per 100,000 inhabitants in 2008 to 41.8 patients per 100,000 inhabitants in 2009); and disorders of psychological development (from 18.4 patients per 100,000 inhabitants in 2008 to 21.8 patients per 100,000 inhabitants in 2009). The highest incidence rates in 2009 are seen in the 5-9 and 10-14 year age groups (more than double that of other age groups) and in people aged 70 years or older.

Protective and risk factors

Given the high suicide rate in Latvia (20.7 per 100,000 population) the risk factors that can be targeted include restricting alcohol use, reducing access to the means of committing suicide, paying attention to high-risk groups e.g. young men with excessive debt; improving the role of the media in preventing suicides; and improving and expanding services of psychiatric assistance. Increasing protective factors include strengthening socio-economic circumstances, support people at high risk (e.g. those with high debt), increase the role of the mass media in reducing the stigma of depression and increase public awareness of symptoms and improve mental health care.

Prevention and promotion programmes/activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools (prevention programmes)			
Suicide Prevention	Aim: to prevent suicide. Promises to prevent suicides in Public Health Strategy 2001 and Framework policy document "Improving Inhabitants' Mental Health for 2009-2014", approved in 2008. An objective was to reduce suicide by 25% by 2010. Suicide mortality for both genders in 2009 decreased by 25% compared with 2001, but suicide mortality rate is still high comparing with other EU countries (3rd place).	Young people, wider public. Government.	Initiated 2001 (on-going).
Education on decreasing stress	Aim: to reduce stress. Programmes in 100 schools concerning health promotion. But, this does not include anything specific on mental health.	Children, schools in Riga, Riga City Council.	Not reported.
Access to psychologists in schools.	Aim: to provide educational or school psychologists in schools. Reported as 1 psychologist per 520 educators.	Children, schools, psychologists, Government.	Not reported.
Educational materials in schools	Aim: to provide information to families of children in school. Includes educational material containing information about promoting psychological welfare of children, substance abuse and other addictions, feelings and emotions, solution of conflicts, management of anger.	Children and families.	Not reported.
Education on mental health related issues in	Aim: to promote and educate on issues of mental health. Lessons on the effects and	Children and teenagers, schools	Routinely, mostly funded by state

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Latvian schools	impact of stress, conflict resolution, substance abuse, violence related issues etc.		
Activities in Riga and other municipalities	Aim: To provide various information materials on mental health promotion. Discussions, lectures, group activities for pupils, parents and professionals (social pedagogues, psychologists, teachers, and police) on addiction problems. Activities, and events organised by the financial support of municipalities (socializing activities for groups at risk etc.).	Children, teenagers, schools.	Routinely provided, mostly funded by municipalities.
Example of good practice - Youth Initiatives and Health Centre in municipality "Dobele"	Aim: to support physical, mental and social well-being improvement by offering educational and interactive activities for children and young adults, lectures and classes for parents, teachers, etc., psychiatrist, psychotherapist, health promotion consultant and other specialist consultations, special education for new parents, support groups for adolescents with a computer addiction, cigarette smokers, supervision for teachers, classes for parents in child's emotional management, psychological diagnostics.	Children and young adults aged 3 to 25.	1999 onwards, funded by local municipality "Dobele". Psychologists and speech therapists funded by state.
Educational opportunities for children with mental disabilities.	Aim: to support special education institutions provided by the Government. Reported to number 63 facilities with total of 9,202 pupils (2.7% of Latvia's Pupils).	Children, Government.	As at 2008.

Workplace (prevention)			
Training of work safety specialists in workplaces.	Aim: to increase knowledge among safety specialists on the risk factors for emotional difficulties in the workplace. Seminar for 250 specialists. Educational brochures 'Psycho emotional risk factors of work environment' were printed (1000 copies) and distributed.	Institute of Occupational and Environmental Health of Riga Stradins University.	2010
European Social Fund project "personnel of institutions involved in health care and health promotion further education for sustainable development of this sector"	Aim: to implement training programmes to improve the competence of health workers (nurses, doctors, medical assistants) on mental health issues.	Doctors, nurses, medical assistants	2008 -2013
The campaign "*Openly about schizophrenia*"	Aim: to reduce stereotypes and stigma by informing the public about schizophrenia in discussions and creating an art exhibition made by people with schizophrenia.	General public, employers.	2012
Anti-smoking Promotion.	Aim: to reduce smoking in the workplace. Government anti-smoking promotion implemented through employers.	Employees, employers, Government.	Not reported.
Older people in long-term care facilities			
None reported			
Other relevant prevention and promotion programmes			
Assistance for residents in crisis.	Aim: to provide advice to children and young people in crisis situations. A Children's and Youth Confidential Hotline (toll-free). In April 2007, 16 Child and Youth Confidential Hotline	Children, young people and the wider public.	Not reported.

	employees and potential volunteer telephone counsellors received training on crisis intervention for persons with suicidal tendencies as part of Soros Foundation-Latvia supported project.		
Assistance for residents in crisis.	Aim: to provide crisis support. The Skalbes Crisis Centre's hotline is provided along with individual psychologist counselling in addition to support groups.	Residents in crisis	
'A Step Ahead' support group.	Aim: to provide support for the unemployed. Provided by *Skalbes* Crisis Centre.	Unemployed people.	Operates once a week Nov 2009 - February 2010.
Raising public awareness and training of particular target groups.	Aim: to raise awareness on mental health and mental illness. Training target groups, distributing information materials and campaigns: Handbook on mental health in (2007). In 2007, TV3 broadcasted PHA video *Anna* to facilitate integration of people with mental health problems. Information materials on depression, schizophrenia, eating disorders and suicide risk entitled *To be or not to be*. In 2009, responding to the economic crisis, the PHA started the campaign *Think positively*, includes online consultations by mental health specialists.	General public, Public Health Agency, TV3.	2007-2009.

Activities in Riga and other municipalities	Aim: to reduce stigma against people with mental disorders, mental health problem in the media. Support groups, practical training and social rehabilitation for the unemployed, young parent's schools.	Unemployed, young parents	Routinely, mostly funded by municipalities.
aining of the media.	Aim: to raise awareness among journalists of mental health issues. The Latvian Centre for Human Rights in cooperation with *MediaWise* (Great Britain) organised a two day training seminar for journalists from the Baltic States titled *Reporting on Closed Institutions (prisons, police cells, psychiatric institutions, detention cells for illegal migrants)*.	Journalist in the Baltic States,	Two-day seminar, May 2006.
Training of prison employees (suicide reduction).	Aim: to reduce suicide in prisoners. Twenty eight participants from eight prisons attended seminars for prison employees on Suicide and suicidal behaviour problems in prisons. : Run by The Latvian Centre for Human Rights	Prison staff, prisoners, Latvian Centre for Human Rights, Latvian Prison Administration Social Rehabilitation, The Ministry of Justice's Latvian Prison Administration Training Centre	2005/2005.
aining for General Practitioners.	Aim: to increase GPs knowledge on preventing suicide. The Public Health Agency translated materials released by the WHO in 2000 for general practitioners titled *Preventing suicide: a resource for general physicians*.	General public, GP's, Public Health Agency, WHO.	2009.
Day Centres for Adults	Aim: to maintain and develop	General public, older people, Riga City	Not reported.

	of social skills.	Council.	
Help for children in crisis situations.	Aim: to offer crisis support to children and adolescents. A Confidential Hotline to provide psychological help to children and teenagers and support in crisis situations. Hotline is staffed by psychologists.	Children and teenagers. Government.	2006 onwards

Financial sources/responsibility for prevention and promotion

The State is mainly responsible for financial resources for mental health prevention and promotion. Educational brochures in schools were funded by Riga City council.

For raising awareness in society about mental health promotion, the Ministry of Health is planning awareness campaigns every year (starting from 2009 to 2014) with a finance allocation of 52,200 LVL (74,270 EUR) per year.

Investments into mental health – health, education, social development and economic growth

Welfare Department of Health administration, Riga City council funded pensions, homes, day-centres for adults (old people) (budget unknown).

Initiatives to strengthen mental health systems in relation to MHP and PMI

As well as initiatives listed above the Framework Policy Document 'Improvement of Inhabitants' Mental Health for 2009-2014' is to organise educational seminars about prevention of violence in school, workplace and family, starting from 2010.

Data sources

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4.17 Lithuania

Author

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Summary

- Lithuania has a range of mental health services, focused on a combination of hospital and community-based services, including mental health centres (the majority of which exist as units in primary care centres).
- Mental health services are reasonably well distributed across the country. However, there is a serious issue with the unequal distribution of medical personnel due to population imbalances. There is no current policy to address this.
- Prevention and promotion is delegated to primary health services with no specific designated budget and is a low priority.
- A large training scheme to improve skills of mental health workers in outpatient facilities exists.
- Prevention activities tend to be small in scope and focused in schools. Some promotion activities exist in schools, but there is no evidence for these in the workplace or for older people.

Data for this country profile were gathered in the first instance by the project's country collaborator for Lithuania. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Lithuania. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	3,053,800
Population density Inhabitants per km² (2011)	49.3
Women per 100 men (2011)	115.3
GDP PPP (2010)	2.01
Psychiatric care beds in hospitals per 10,000 inhabitants (2011) (105.0 per 100,000)	10.5
Standardised Suicide rate by 100,000 inhabitants (2011)	31.6
Gallup Wellbeing index (2010)*	
Thriving	25
Struggling	57

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

The law on Mental Health Care was adopted in 1995. This regulates the provision of psychiatric services, assures civil rights to the mentally ill and plans for the establishment of new local institutions providing outpatient mental health services, known as municipality mental health centres. In 1999 the State Mental Health Centre was founded, with the primary function of coordinating national mental health policy implementation.

In 1999, the State Programme on the Prevention of Mental Disorders (for the period 1999–2009) was also approved. This programme planned for the improvement of mental health care services at primary, secondary and tertiary levels. However, in its fourth year of implementation, the programme's ability to target basic priorities such as de-institutionalization and de-stigmatization has been questioned. In 2000, the State Mental Health Commission (under the Government) was established with the primary task of coordinating mental health policy and ensuring intersectoral collaboration.

There were also several documents aimed at specific problems at different levels which, taken together, reflect the state's mental health policy since 1999. These include the: State Programme on the Prevention of Mental Disorders, 1999; National Drug Control and Drug Addiction Prevention Programme, 1999, 2004–2008, 2010–2016; National Alcohol Control Programme, 1999-2011; National Tobacco Control Programme, 1998–2010; National Suicide Prevention Programme, 2003–2005; The Conception of Drug and Psychotropic Substances, Narcotics and Psychotropic Substances, Precursors, Tobacco

and Alcohol Control, 2011; and the National people with disabilities social integration programme 2003-2012, 2002.

The main goals of mental health policy stated in these documents are to decrease disabilities due to mental illnesses, reduce the number of suicides and reduce substance abuse and alcohol consumption. Mental health policy, as presented in these various national programmes, covers all components of mental health care including promotion, prevention, treatment and rehabilitation. Most Laws pertaining to the health care system prioritize health (in some cases mental health) promotion and prevention of illness.

In 2004, Lithuania became a member of EU and ratified the World Health Organization Framework Convention for Tobacco Control; and in 2010 ratified the UN Convention on the Rights of Persons with Disability.

The National Health Programme is probably the most important policy document defining the direction for achieving better population health, health targets and principles for their achievement. The first National Health Programme 1998-2010 had several specific mental health goals: creating community mental health services, quality of life monitoring, control of alcohol related harm, reduction of suicide rates, reduction of alcohol psychoses, and reduction of smoking and alcohol consumption among school children. Some of the planned activities were implemented, such as the successful development of municipal Mental Health Centres. However, many programme goals were not achieved, such as efforts to achieve effective alcohol control. Instead, alcohol control became more relaxed and the prevalence of alcohol related problems and illnesses increased during the period. There is a new National health programme under development by a team of experts.

In order to establish a coherent healthcare system and create a more efficient and competitive health care process the Seimas of the Republic of Lithuania adopted the Lithuanian health care system development framework, 2011-2020. The document pays particular attention to strengthening of primary health care, the implementation of modern evidence-based public mental health promotion and prevention methods, together with the development of day centres, outpatient rehabilitation and mental health services, with the intention to provide more mental disorder prevention and treatment services in the community.

Another new document is the *Outline for the Development of the National Health Care Service System in 2011-2015* produced by Health Care Ministry (February 3rd, 2011). In the Outline the first stated goal (among others) is: "to set a comprehensive and targeted development of health care system, seeking to create more effective and competitive health system, which would facilitate health promotion and education, and disease

prevention. The document appears to prioritize health promotion and disease prevention, over treatment. However, this document has not yet been adopted by the government.

National Public Health Care Strategy and action plan 2006-2013 (since 2001) gives attention to the early detection of mental and behavioural disorders risk factors, effective prevention and intervention programmes at primary health care level, in both the education and social protection sectors. The plan mentions the need to reduce alcohol consumption in the population, given the lack of success from previous goals. This led to a Report by National Health Board calling for an increase in the qualifications of public mental health specialists, improvement in the understanding of health education and promotion, and increased involvement of NGO's in public health service delivery.

These events helped to develop the *State programme for development of public health care in municipalities, 2007-2010*. This programme facilitated the creation of a network of municipal Public Health Bureaus, which is responsible for the promotion of mental health and prevention of mental disorders, through interaction with schools, institutions and the public. In 2010, there were 32 Bureaus in Lithuanian municipalities. This is an intramural, horizontal policy/programme and partnership between state and municipal governments, funded by Health Care Ministry. The effectiveness of this programme has been evaluated in 2010 by the Institute of Hygiene, which stated that public health is improving in regions with Bureaus**.** The specific legal document devoted to the organisation and administration of public health services is the *Law for Public Health Care*. A further asset is a new Law on monitoring of public health revised in 2011.

Mental health policy and inclusion of prevention and promotion

The most important document for the promotion of mental health and prevention of illness is the *Mental Health Strategy (MHS)* adopted in 2007, based on the WHO declaration and Action plan for Mental Health in Europe (2005). The MHS outlines problems, that contribute to alarming levels of mental ill-health in Lithuania and commits to addressing the challenge of improving mental health through a comprehensive action plan and seeking to integrate different approaches for achieving better health: using systems of public health, primary health care, education, social care and other sectors. In 2008, the first Intramural programme was adopted for the implementation of the mental health strategy, 2008-2010. In 2011, a second Intramural programme to implement the mental health strategy, 2011-2013 was adopted. These documents have several important prevention and promotion interventions.

Other policy documents that directly influence mental health are the alcohol control policy governed by the Alcohol Control Law and Alcohol and Tobacco Control

Programme 2012-2014, adopted by Government in 2011 (intramural action plan). This programme seeks to integrate issues of tobacco and illegal drug consumption following the reorganisation of different state services into unified Department for Drugs, Tobacco and Alcohol control last year. Currently functional is the *National drug control and drug abuse prevention programme for 2010-2016,* which was adopted in 2010, and the *National drug control and drug abuse prevention programme 2010-2016* implementation intramural action plan, 2011-2013.

The Alcohol Control Law, which came into effect 1st of January of 2012, prohibits the advertising of alcohol. Restrictions limiting access to alcohol and alcohol advertisements (combined with reduced income of the population) have achieved a reduction in alcohol consumption, reduced alcohol psychosis and the number of alcohol intoxicated children.

Mental health services

Organisation and functioning of mental health systems

Lithuania has a well-developed mental health system. Psychiatric care services are provided predominantly in out-patient services and psychiatric hospitals. Mental health specialists – psychiatrist, child and adolescent psychiatrist, psychologist, social workers are trained according to the international standards.

Inpatient care includes:

- 11 Specialized psychiatric hospitals, with 2,528 beds in 2011. This is almost half the number for 1991 (5,380 psychiatric beds, in psychiatric hospitals). The table below shows the number of beds within each of these hospitals:

Name of hospital	**Number of beds**
Republican Vilnius Psychiatric Hospital	598 (previously 949 beds in 2001)
Kaunas hospital's division Mariu hospital	315
Rokiskis Psychiatric Hospital	340
Republican Hospital of Kaunas Psychiatric Hospital	235
Republican Hospital of Klaipeda Psychiatric Hospital unit	210
Vilnius City Mental Health Centre	170
Siauliai Hospital Branch Psychiatric Hospital	200
Siauliai Hospital Branch Psychiatric Hospital of Saukenai	55

Name of hospital	Number of beds
Vilnius University Children's Hospital Branch "Child Development Centre"	22
The Social and Health Projects Azuolyno Clinic	26
Klaipeda Seamen's Hospital Department of Psychiatry	215

- 5 Drug and alcohol abuse treatment centres with 259 beds in 2011 (Klaipeda Centre for Addictive Disorders (76 beds), Vilnius Centre for Addictive Disorders (90 beds), Kaunas County Centre for Addictive Disorders (39 beds), Siauliai Centre for Addictive Disorders (28 beds), and Panevezys County Centre for Addictive Disorders (26 beds)).
- 13 Psychosomatic or psychiatric inpatient units in general hospitals in Siauliai, Kaunas and other districts.

Community mental health care includes:

- 104 Mental health centres (1 Jan 2012). In 2002, there were 61 mental health centres operating in the community and providing outpatient mental health services. Of these, 13 are registered as legal entities but the rest are units existing within primary health care centres (polyclinics) without legal or financial independence.
- 3 Segregated long-term care institutions for intellectually disabled children, with 644 residents (in 2009).
- 20 Social care institutions for adults with 4,500 residents.
- 10 Group homes for people with mental health problems, older people, or people with physical disability (212 residents).

Mental health care services and payment procedures are approved by the Minister of Health.

Access and usage

Mental health centres are available in all municipalities and include a multidisciplinary team of specialists (an adult psychiatrist, child psychiatrist, social workers, psychologist, and mental health nurses). The aim is to provide a: psychiatrist per 20,000 residents, social worker per 25,000 residents, psychologist per 40,000 residents, mental health nurse per 40,000 residents. Patients are hospitalized based on territorial principles or can choose any hospital.

The general practitioner's role includes a gate-keeping function for referral to mental health and other specialists. In 1997, Lithuanian residents were asked to choose and

register with a primary health care facility in their catchment area. Referrals from General practitioners' have risen since this registration process; previously other health workers were able to refer patients for secondary care.

Residents should be registered by a family physician (eligibility for insurance should be proved under the registration procedure). Municipal mental health centres are free-of-charge for those registered by a family physician. Access to mental health care specialists is free-of-charge for referred patients (as well as in a case of emergency).

For most private specialized mental health services (outpatient consultations, inpatient addictive disorders' treatment etc.) patients are charged in private clinics not contracted by The State Sick Fund. Privately owned mental health care facilities are contracted by the State Sick Fund for the provision of certain services for those insured.

In 2005, mental health centres in Lithuania recorded 92,466 people with mental disorders. Women accounted for 57% of those receiving treatment and 43% were men. This was a slight reduction from figures in 2004 when 92,858 people with mental disorders were recorded; and showed a shift in 2005 towards more men receiving treatment, with women being recorded at 61% and men 39% the year before.

The table below lists the average length of stay, bed numbers and usage for psychiatric hospitals:

Hospital data for 2011

Data from: / Indicators	Average length of stay in hospital (days)	Functioning of hospital beds (days)	Hospital bed turnover rate	Number of beds
Psychiatric hospitals	29.44	294.38	10.00	2,528
Psychiatric hospitals and psychosomatic or psychiatry inpatient units at the general hospitals	25.0	291.2	11.7	3,368

Variation and gaps

There is a general problem regarding the equal distribution of medical personnel, due to population size. There are no specific figures for the distribution of mental health workers, but the number of physicians, varies across the different regions by a factor of 3. No policy currently exists to deal with the imbalances of distribution of health workers.

Annually about 800 care professionals graduate from Lithuanian universities and more than 1,000 from colleges. Migration abroad of highly skilled health professionals remains a major problem.

Financing

Expenditure on mental health services is not available. Lithuanian mental health services (MHS) are part of the National Health System (NHS), financed through the mandatory health insurance mechanism by The State Sick Fund (SF). The population has direct access to MHS at primary level. This could be considered an intervention for early diagnosis and treatment of mental illness, increasing accessibility and reducing stigma, and provision of easily accessible specialist help for secondary and tertiary prevention.

There are 3 service levels: primary, secondary and tertiary. Primary mental health care is funded by capitation fee and delivered by family doctors (GPs), through municipal Primary Health Care Centres and municipal Mental Health Care Centres. About 1.7 million Euros was spent on Primary health care in 2012. Municipalities are responsible for organising and supervising all primary health care services and receive a capitation fee through the Sick Fund. Prevention and promotion funding is included in the capitation fee and not earmarked. The reimbursement system is well developed.

Workforce

The exact numbers of mental health specialists are difficult to obtain. Some relevant numbers include 530 members of the Lithuanian psychiatric association (virtually all are practicing psychiatrists and the majority are residents in psychiatry). In 2011, there were 553 (1.73 per 10,000 population) practicing psychiatrists.

Data for the municipal mental health care system which consists primarily of 97 municipal Mental Health Centres and the workforce for 2011 in outpatient mental health care include:

180	Psychiatrists
40	Child-adolescent psychiatrists
200	Mental Health Nurses
160	Social workers
105	Psychologists

Hospital workforce numbers are not readily available and have to be obtained by contacting each hospital separately and subject to changes. This is due to the integration of nearly all psychiatric hospitals into general hospitals over the past two years. However drawing on the World Health Organization (2008) report, Policies and Practices there were: 18 psychiatrists per 100,000 population (17.76 according to World Health Organization 2011 Mental Health Atlas); 39 nurses working in mental health per 100,000 population and 7 psychologists per 100,000 population.

Based on a similar population size for the 2011 census of 3,053,800 the number of psychiatrists is approximately 550; with 1,200 nurses working in mental health care and 120 psychologists.

The number of auxiliary staff and psychotherapists is difficult to determine. Psychotherapy as a specialized method can only be practiced by physicians; new legal acts are under preparation. No formal education and requirements for counsellors is necessary.

Responsibility and delivery of mental health promotion and prevention of mental illness

Prevention and promotion is delegated to primary health services with no specific designated budget and is given low priority. Responsibility for mental health prevention and promotion is generally part of health care, social security and education systems, as well with a wide range of NGOs. A large training programme over 2009-2013 aimed to develop and improve the skills of virtually all mental health specialists in the outpatient services, so that they can better implement health promotion and disease prevention. However, it is unclear whether this will be adequately funded and assessed.

Mental health status

Prevalence of mental health in the population

Prevalence of mental disorders for 2010 (based on mental health service data) is as follows:

Prevalence						
ICD-10	Total		Adults (from 18)		Children (0-17)	
	N	Per 100,000	N	Per 100,000	N	Per 100,000
Organic, including symptomatic, mental disorder	18,810	579.7	18,742	711.6	68	11.1
Schizophrenia, schizotypal and delusional disorder	24,010	740.0	23,939	908.9	71	11.6
Mood [affective] disorder	25,998	801.3	25,860	981.8	138	22.6
Neurotic, stress-related and somatoform disorders	6,329	195.1	6,127	232.6	202	33.1
Behavioural syndromes associated with physiological disturbances and physical factors	370	11.4	319	12.1	51	8.4
Disorders of adult personality and behaviour	1,933	59.6	1,915	72.7	18	2.9
Mental retardation	18,751	577.9	17,785	675.2	966	158.2
Disorders of psychological development	1,435	44.2	1,277	48.5	158	25.9
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	2,483	76.5	2,052	77.9	431	70.6
	100,119	**3,085.7**	**98,016**	**3,721.4**	**2,103**	**344.3**

Source: National health care system, State Mental Health centre data

Incidence

Incidence for mental disorders in Lithuania (2010) based on mental health service data is as follows:

Incidence						
	Total		**Adults (from 18)**		**Children (0-17)**	
	N	**Per 100,000**	**N**	**Per 100,000**	**N**	**Per 100,000**
Organic, including symptomatic, mental disorder	2,334	71.0	2,329	87.4	5	0.8
Schizophrenia, schizotypal and delusional disorder	870	26.5	849	31.9	21	3.4
Mood [affective] disorder	2,167	65.9	2,147	80.6	20	3.2
Neurotic, stress-related and somatoform disorders	356	10.8	328	12.3	28	4.5
Behavioural syndromes associated with physiological disturbances and physical factors	17	0.5	14	0.5	3	0.5
Disorders of adult personality and behaviour	49	1.5	48	1.8	1	0.2
Mental retardation	399	12.1	360	13.5	39	6.3
Disorders of psychological development	210	6.4	205	7.7	5	0.8
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	211	6.4	165	6.2	46	7.4
	6,613	**201.2**	**6,445**	**242.0**	**168**	**26.9**

Protective and risk factors

There is no monitoring of risk factors specifically related to mental illness. Some of the known risk factors include perinatal trauma, head injury, severe trauma, alcohol, tobacco and drug use, family history of mental illness and bullying. There are no distinct programmes where schools collaborate with mental health services. But the educational system has established pedagogical-psychological services at national, regional (municipalities), and local (psychologist in schools) levels.

Prevention and promotion programmes/activities

A number of programmes aiming to prevent and promote mental health have been implemented (e.g. National Drug Control and Drug Addiction Prevention Programme, 1999; National Alcohol Control Programme, 1999; National Suicide Prevention Programme, 2003-2005). Programmes that are currently being implemented are the National drug control and drug abuse prevention programme 2010-2016, Alcohol Control Law and Alcohol and tobacco Control Programme 2012-2014; and the Intramural programme for implementation of mental health strategy, 2011-2013.

A National Programme was devoted to the European Year 2010: fighting poverty and social exclusion. After the tender process two projects in Lithuania received funding of 416,900 LTL: Theatre- discussion programme - "Don't you lose it" and the "Poverty reduction formula": with a series of public events devoted to sharing stories of poverty and also ways to tackle this.

Programme name	Aim/approach	Stakeholders /target group	Duration, Cost of programme
Schools (Prevention)			
Olweus Programme	Aim: to reduce bullying. International anti-bullying programme adapted for Lithuania. Deemed highly effective by numerous international assessments.	Children, school staff.	Since 2008
Snowball Programme	Aim: to teach communication skills, pro-social values and health promotion. Focus on prevention of use of alcohol, tobacco and drugs among school children. Implemented in the Kaunas region.	School children	Not reported
Second Step Programme	Aim: to manage and reduce aggression. Aggression management for school children. Can be delivered by trained teachers. 434 representatives from 165 schools and kindergartens participated in 2009. Three day training course for teachers.	Children, teachers.	2009-2010. Government funded. Fee payable to join if funding not supplied to groups.
Schools (Promotion)			
Health Promoting Schools	Aim: to promote health, through education. Coordinated by Disease Prevention Centre. Promotes closer relationship between students, teachers and parents.	Children	Not reported
Recommendations on provision of	Aim: to improve access to health care advice. Includes the health promotion and	All children and schools	Not reported

Programme name	Aim/approach	Stakeholders /target group	Duration, Cost of programme
health care services in educational setting	prevention activities that should be covered by health specialists working in schools. Mandatory for schools.		
Zippy's Friends	Aim: to improve social and coping skills. An international programme in 47 regions of Lithuania, including 9.363 children and 559 teachers.	Children 5-7 years, teachers	Not reported
Workplace (Promotion)			
Pilot programme for Brain Awareness Week	Aim: to increase awareness and skills to control some of the risk factors, provide evidence based recommendations for mental health in the workplace and promote protective factors.	Employees, employers	One week programme of five lectures
Violence against women at work: let's talk, Programme	Aim: to increase awareness about violence in the work place as a risk factor for ill mental health; and create socially aware work places.	Active workplaces	Not reported
Friendliest Workplace competition	Aim: to increase awareness about violence at work place as a risk factor for ill mental health.	Active workplaces	Not reported
Good Mood Programme	Aim: to reduce stress. A stress reduction programme initiated in 2006/7. 600 medical doctors participated.	Medical doctors	15 seminars

Financial sources/responsibility for prevention and promotion

Very little funding is available for the promotion of social, personal and emotional health/wellbeing in schools. Most of the funding is provided to the Public Health Care network to fund staff in the Health Bureaus and other institutions involved in coordinating activities. Some funding is provided through a National programme for violence prevention. Most funding available is through EU programmes.

One of the largest investments was in a mental health personnel training programme focusing on team work and also preventive and promotional activities (until 2013) and will involve virtually all mental health specialists in inpatient and outpatient services.

The funding sources for major NGOs are from state budgets. Financial support is programme or project based. Grants are given through applications to the Ministry of Labour and Social Affairs, department for the Affairs of the Disabled, the Ministry of Health, international funds and organisations. On a local level NGOs compete for municipal funds to provide social services.

Investments into mental health - health, education, social development and economic growth

The material conditions of hospitals/psychiatric dispensaries and the quality of services has improved over the last 10 years due to better investments into them. There remains a lack of systematic investment into complex services in the community, development of prevention programmes and scientific research.

There has been an increase in the budget to fund renovations in Public health bureaus and training for public health professionals in municipalities (currently 32). Since April 2010, 20 projects to modernize the Bureaus have been signed, worth 11.5 million LTL.

Other large investment projects include:

Training for health professionals who contribute to reducing morbidity and mortality from the main non-infectious diseases (European Union funds – 59,931,449 LTL, over 10,000,000 LTL of these – for mental health professionals);

Establishment of psychiatric day care centres (EU – 50,500,000 LTL, national spending – 8,911,765 LTL);

Establishment of crisis intervention centres (EU – 8,500,000 LTL, national spending – 1,500,000 LTL);

Modernization of psychiatric hospitals (EU – 12,764,716 LTL, national spending – 2,170,284 LTL);

Development of public health care infrastructure in municipalities (EU – 11,933,312 LTL, national spending – 2,105,879 LTL);

Modernization of the mental health services monitoring security infrastructure (EU – 555,250 LTL, national spending – 97,985 LTL).

Initiatives to strengthen MH systems in relation to MHP and PMI

There are no proposals currently for any initiatives to strengthen or introduce mental health promotion or prevention of mental illness activities.

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4.18. Luxembourg

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Summary

- Mental health is an explicit Government priority, despite the slow progress of deinstitutionalisation starting in 1990 and implemented from 2005 onwards.
- Per capita investment in health spending is one of the highest in the world, where mental health is allocated 13.4% of total health expenditure.
- Primary care includes specific mental health services and is available throughout the country; hospital and rehabilitation facilities are available at regional and by subsidiarity at national level and free choice for patients exist.
- Better monitoring systems (e.g. a valid Health Information System) is needed to measure 'public health' activities, such as readmissions to hospital.
- In some domains there exists poor coordination, inadequate forms of contracting and the lack of consultation to enhance clarity of roles and efficiency of stewardship and of service delivery.
- Collaboration at various levels (e.g. between General Practitioners and secondary care specialists), better networking between services and clearer governance arrangements are urgently need to improve actions and outcomes of mental healthcare.
- Resources and workforce are overly dependent on recruitment from neighbouring countries.
- Recent economic circumstances are making new investments into mental health care more difficult.

Data for this country profile were gathered in the first instance by the project's country collaborator for Luxembourg. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Luxembourg. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	511,840
Population density Inhabitants per km^2 (2009)	192.5
Women per 100 men (2011)	101
GDP PPP (2010)	1.2
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	87.5
Standardised Suicide rate by 100,000 inhabitants	10.8
Gallup Wellbeing index (2010)*	
Thriving	45
Struggling	54

* Reprinted with Permission of Gallup, Inc.

Mental Health Legislation and Policy

Current update and reference to prevention and promotion

The main mental health legislation in Luxembourg is the 'Placement of Persons with Mental Disorders Act of 2009. The Act specifies the requirements for compulsory admission to hospital for people with a mental disorder without their consent if they present a danger to others and/or themselves. No other health legislation explicitly refers to mental health, although general health laws (e.g. the law on hospitals from 1998, especially the chapter on patient rights) apply to hospitalized patients in psychiatric services. The current draft law on preventive medicine may include prevention of mental illness and promotion of mental health.

Mental health policy and inclusion of prevention and promotion

In 1989, the national government declared its ambition to reform mental health policy and ordered an external audit by Prof. Haefner of OMS Centre Zentralinstitut für psychische Gesundheit Mannheim. The 1993 report, recommended a new model of psychiatric care. Although there was the political will, the reaction and acceptance by

professionals, who had perhaps not been sufficiently included, was ambiguous and the implementation of the reform was slow for several years. In the early 2000's an agreement on the terms and strategy of the reform was made with professional opinion leaders. Based on the proposals of the Haefner report changes included the following principles:

- Decentralisation of institutional psychiatry: *By devolving primary care, to treat acute problems in specialised services in hospitals assuring emergency service*
- Awareness of mental health (problems) and fight stigma: *Health is a state of full well-being, psychiatric problems are a widespread burden and have to be considered and treated on the same level as somatic problems*
- "State of art" approach and treatments, reintegration as soon as possible in a convenient, if possible the original, environment of the patients (*Early detection, early treatment, short hospital stays, rapid reintegration, if possible in ambulatory settings, otherwise, a specialised setting for stationary rehabilitation).*

In 2005 the Ministry of Health initiated an assessment of the reform (Rössler report 2005). This coincided with the creation of a national psychiatry platform, drawn from all stakeholders, to steer and implement the action plan based on the terms of the reform. The board initially focused on the decentralisation of mental health services, the development of community infrastructures. Eventually the focus included the development of mental health promotion and mental disorder prevention especially among young people. More specifically, a government statement for 1999-2013 indicated that attention would move to promoting mental health in young people by preventing unhealthy behaviours and early detection and treatment of psychopathology. Also, steps were to be taken to prevent and combat bullying and stress in adolescents.

Mental health has been an increasing public health priority in Luxembourg since the government's 1989 declaration. Mental health prevention and promotion policies includes areas such as: awareness raising of the importance of mental health in young people, in the workplaces, for older people, fighting stigma, early detection, depression and suicide prevention, fighting alcohol and drug abuse and anxiety disorders.

Mental health services

Organisation and functioning of mental health systems

Mental health reform has been on-going since 1992. Prior to this the institutional care system was highly centralised, with Luxembourg having the highest number of "psychiatric" beds in Europe in 1990 (Health in Transitions 1999; 852 beds for 384,400

population (2.2 per 1,000); virtually all located in the state-run neuro-psychiatric hospital at Ettelbrück, opened over a century ago.

Reform of mental health services ranged from deinstitutionalization to prevention. The principles of mental health reform were based on the Haefner (1993) and Pr. Rössler, (2005) recommendations. These included the decentralisation of psychiatric hospital services including emergency admission to general hospitals, the development of outpatient services at regional levels, the conversion of the "old" neuro-psychiatric hospital at Ettelbrück in a stationary national rehabilitation setting.

From 2005 on, acute patients and compulsory admissions are only admitted in psychiatric services of general hospitals and reintegrated as soon as possible into the community, regional outpatient service or rehabilitation. Patients with dementia who can no longer stay at home are directed to long term settings such as specialised nursing homes. Child and adolescent psychiatric departments were also created.

Those developments were financed by Health Insurance contributions (medical aspects) and State budget (mostly social aspects and infrastructures).

As a result between 2005 and 2009 the number of psychiatric beds in acute and rehabilitation settings was reduced from 110.1 to 87.5 per 100,000 inhabitants, respectively to 44.8 for acute psychiatric beds in acute hospitals (34.5). During the same period the average reduction in psychiatric beds for the EU Member States was from 48.3 to 44 per 100,000.

At present, mental health services cover all the Luxembourg's regions. Urgent specialised care is provided in the emergency service of the next regional hospital. There are 3 hospital regions (North, Centre, South), which are the same for the outpatient providers.

In each region a general hospital is on duty for emergencies having a specialised psychiatric service with: crises intervention, open and closed wards, ambulatory day clinic and relay antenna for home visits.

Most psychiatric services of the institutions voluntarily participate in international quality benchmark as IQIP or EFQM (accreditation and performance measurements), which several have already been awarded.

Access to primary care is provided by general practitioners and access to specialised primary care is through psychiatrists. There is a greater density of psychiatrist in urban regions and near hospital catchment areas with about half of psychiatrists being affiliated with hospitals. Psychiatrists and specialised psychiatrists for young and adolescents are also gate-keepers for scheduled admissions in acute hospitals, as in ambulatory or residual rehabilitation settings.

Patients are able to choose which hospital will provide pre-and post-hospital care, though all care providers must prioritise patients from their own region. Duration is unlimited in pre and post-hospital settings and concludes with therapeutic contracts with patients to avoid, for example, unplanned admissions. Compulsory admissions are within the region where the person resides.

Hospitals provide continuity of care by collaborating with regional out-patient facilities or the national stationary rehabilitation institute in Ettelbrück.

Progressive reintegration is done by hospital day care units (short stay), or if longer term care is needed -especially for more chronic patients- they are referred to the regional outpatient facilities. These services provide Consultation centres, Day-centres (with an out-of pocket free therapeutic, occupational and social offer), low level meeting places, supportive housing and sheltered therapeutic workplaces.

If reintegration needs medium to long in-patient treatment, patients are referred to the Centre Hospitalier Neuro-Psychiatrique (CHNP) (the converted "old psychiatric hospital"), which has specialised units for drug addiction (low level and withdrawal treatments), alcohol addiction, general psychiatry, forensic psychiatry, adolescents psychiatry and a supportive housing service (Service Psychiatrique de Soins à Domicile (SPAD).

The national Platform on psychiatry regularly meet with all those in charge of all these structures (at least 4 times/year) and guarantees coordination at a high level.

Regular independent assessment is part of the reform implementation. In 2005 Pr. Rössler performed a first assessment report, a second in 2009. An external assessment of the CRP- Santé has been requested by the Platform. The same expert conducted an assessment study on mental health in children and young people in 2010.

In 2012 mental health care is delivered by:

Primary care:	79.4 general practitioners per 100,000 population (liberal exercise, direct access) 18.2 psychiatrists per 100,000 population (liberal exercise, direct access)
Acute hospital care (general hospital)	5 hospitals (1 in South-, 3 in Center-, 1 in North- region) 200 adults inpatient beds per 510,000 population 43 child and adolescent inpatient beds per 510,000 population
Ambulatory Care	7 NGO's* providing 22 facilities: 6 in South-, 10 in Center-, 6 in North-region)

Stationary rehabilitation	1 specialized psychiatry hospital (CHNP): 237 beds/ 510,000 population
Other offers	NGO's * working in the domain of integration (strangers, homeless), in specific domains as depression and suicide-, alcohol or drug abuse - prevention, or early detection Psychology services in schools Different social services* e.g. prevention of Child abuse

*providers under contract with or financed by Directorate of Health or other authorities
Source: Ministry of Health 2012; data for workforce and resources 2009

Access and usage

Access to mental health care is relatively equitable and timely. Mental health care is part of the primary care system and treatment by psychiatrists. Treatment for severe mental disorders is available at primary care level. All general hospitals participate in the public hospital emergency service and have specialised psychiatric services closely linked to outpatient care facilities which are community-based and offer treatment at the primary care level.

The table below provides hospital admissions by diagnosis for 2009.

Diagnosis ICD 10	Total hospitalisations *2009*	Beds * occupied on average
Dementia F00-F03	435	26*/**
Organic, including symptomatic, mental disorders(F00-F09) Dementia F00-F09	524	34
Mental and behavioural disorders due to psychoactive substance use(F10-F19)	2691	180
Schizophrenia, schizotypal and delusional disorders(F20-F29)	782	113
Mood (affective disorders)F30-F39	1,508	75
Neurotic, stress-related and somatoform disorders(F40-F48)	434	13
Behavioural syndromes associated with physiological disturbances and physical factorsF50-F59	50	3
Disorders of adult personality and behaviour_ F60-F69	184	12
Mental retardation F70-F79	39	8
Disorders of psychological development (F80-F89)	24	2
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)	220	18
Unspecified mental disorder (F99-F99)	10	0.2

**all admissions for F00-F99 in acute and rehabilitation hospitals and beds*
*** (without beds occupied by dementia patients in long term settings*

Data: IGSS 2012 for Carte sanitaire 2012 (12)

Variation and gaps

The 2005 Rössler assessment highlighted concern that the reform of psychiatry, initially proposed in the 1990s, was being implemented slowly, especially in relation to the transition from the old psychiatric hospital. By 2009 Pr. Rössler reported that structural reform was progressing, although incomplete and further developments remained to be carried out.

Louazel et al. (2011) in a study on mental health in children and adolescents for 2010 showed that there is often poor coordination between the various services. Often services are accountable to different ministries, which brings a lack of clarity concerning roles and service delivery.

The detection of mental health problems in children (school problems, psychological, psychiatric, social and family) is sometimes hampered by long waiting periods. This process could be speeded up to avoid delayed action for the treatment of minor conditions. Better coordination and more efficient networking between the various services and sectors is needed.

Despite a relatively high number of psychiatrists for 2012 (not including psychotherapists), there is a slight uneven distribution of general practitioners and psychiatrists across regions. Psychiatrists are mostly concentrated in urban areas.

Direct access to specialised care (psychiatrists) is available and out-of pocket expenses are the lowest in OECD countries. Geographical access is also relatively good. However, collaboration and networking between general practitioners who prescribe 70% of psychotropic drugs, and psychiatrists could be improved.

The need for forensic psychiatry is growing and can only be met by creating new specific infrastructures.

Financing

According to the General Inspectorate of Social Security (IGSS) in 2005, 13.4% of total health budget was spent on mental health. More recent data was not available.

Financing for care and treatment (doctors' visits, prescriptions, hospitalisations etc.) is funded by the universal compulsory health Insurance (CNS), which also covers rehabilitation, the ambulatory sector and home visits essentially for patients with chronic illnesses.

Long-term care (e.g. for dementia) at home or in long term care settings is funded by the compulsory "dependency" assurance.

Preventive and social actions and services are mostly funded by the State budget.

Workforce

According to the World Health Organization Mental Health Atlas there were 21.15 psychiatrists per 100,000 (World Health Organization, 2011). Information on other professionals is unavailable. The Government is about to propose a law regulating the profession of "psychotherapists".

Responsibility and delivery of mental health promotion and prevention of mental illness

Although there is no specific legislation, the State is generally responsible for promotion and prevention. This responsibility lays between several government departments (Health, Family, Education, Labour, Justice vs. Health in All Policies) which contracts often with NGOs, to operationalize and implement actions in these areas.

Within the Ministry of Health, the Directorate of Health- Service Action-Socio-Thérapeutique is responsible for promoting, coordinating and supervising activities concerning mental illness, drug addiction and the integration of people who are homeless.

The Ministry of Family deals with nursing homes and the care of people with intellectual and physical disabilities.

The Ministry of Education, in collaboration with the Directorate of Health- Division for School Medicine, operates broad activities for health education in schools such as health promotion, mental health and healthy life styles in general: diet, alcohol, sex education, etc. In cooperation with the Directorate of Health- Division for Curative Medicine, it is also responsible for training professionals, such as nurses, in the health system.

Broad activities for health promotion and prevention at work are conducted by the Ministry of Labour in collaboration the Directorate of Health- Division for Occupational Health.

Except the "Omboudscomité" for the rights of children, or the "Centre d'Information et de Prévention" in the domain of suicide prevention, NGOs generally have executive roles. Some NGO's, such as the "Ligue Luxembourgeoise d'Hygiène Mentale", were initiators and champions for psychiatric reform.

Mental health status

Prevalence of mental health in the population

Existing data on mental health are too incomplete and unreliable to estimate the prevalence of mental illness in Luxembourg. There is some limited availability of administrative data from the Health assurance. More reliable data concern patient admission and length of stays in hospital. There are no coordinated data exist at present for use of outpatient services and facilities run by NGO's not bonded by contracts.

An agenda for e-health is on track.

Protective and risk factors

Not reported

Prevention and promotion programs/activities

Implementation of the National Psychiatric Reform produced several specific programmes and activities that attempted to raise awareness in mental health and tackle stigma and social exclusion. This was done in collaboration with public authorities, primary care health services, NGO's, medical doctors, nursing and social services, together with schools, employers, patient associations and other key stakeholders.

The following provides examples of activities:

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Primary prevention			
Phone helplines; Orientation –Information			
- 116 111 Kanner a Jugend Telefon (children) - SOS Détresse - Elterentelefon (parents) - Fraentelefon (women) - InfoMann (men) - Seniorentelefon (elder people) - Fro-No (info-drugs)	Aim: to prevent suicide. A (confidential) helpline (phone) for people who want anonymous listening, help; suicide prevention; gender- and/or age- specific help/orientation.	NGO sponsored by political authorities: Ministry of Family/People	Continuous, Cost-free
"Consultations Nourrissons"	Aim: to provide national wide and free post-natal primary care offers in the	Ligue medico sociale, private charity association, under conventional contract with	Continuous since the after war period,

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	communities, screening of the physical and psychological development of the child, identification of psychosocial needs, parent-hood capacity reinforcement.	the Ministry of Health and the Ministry of Family / babies and young children with their parents	reorganised 2007 / 2008 to amplify the psychosocial support of parents in need
Bébé +	Aim: to provide information, consultation, pre and post-natal care, parent-hood capacity reinforcement.	NGO Initiativ Liewensufank sponsored by City of Differdange/pregnant women, expecting parents, parents with young children	Since 4 years
12345 Kanner a Jugend Telefon	Aim: to provide (confidential) helpline (phone).	NGO sponsored by political authorities: Ministry of Family/ Children and young people	Continuous since 2009
SOS Détresse	Aim: to provide (confidential) helpline (phone).	NGO sponsored by political authorities: Ministry of Family/People who want anonymous listening, help; suicide prevention	Continuous
• Family first • Alupse Bébé Services Parentalité de • Jugend an Drogenhellef • Réseau Psy	Aim: to provide four different programmes aiming different subgroups of families with chronic or acute (mental health) problems; multidisciplinary social help and accompanying.	NGO's sponsored by political authorities: different sponsors essentially Ministries of Family and Health /Vulnerable families exposed to particular problems/risks - Drugs - Precariousness, (risk of) social exclusion, poverty - Psychiatric problems	Continuous
NGO's for social, occupational, cultural and leisure activities in the elderly e.g. Amiperas a.s.b.l. Uelzechtdall, Alzheimer association, Senior/third age academy/university	Aim: to provide "add life to years", quality of life for the elderly; social clubs for elderly/seniors at regional (suburban-) or local (urban) level. A network of regional and local clubs for seniors has been set up over the country, organised by municipalities and Ministry of Family.	NGO's sponsored by political authorities: local communities + Ministry of Family + minimal out of pocket /Retired, alone standing, interested seniors (of different age groups) in an active + cultural life after retirement	various, continuous

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Thematic, punctual activities e.g. National Day on suicide Prevention Journée de la Santé	Aim: to highlight and raise awareness of specific problems, such as preventing suicide, and initiate (public) debates on societal problems vs. mental health in general.	NGO's sponsored by different political authorities, Ministry of Health/ (mostly pre-)aware populations	Various
Schools (prevention)			
School medecine	Aim: to provide National medico social surveillance programme of all children and adolescents in primary and secondary schools School health programme consists of 2 action fields: 1. Medico psycho social screening programme every second year by school medical interdisciplinary teams 2. Health promotion programmes (mental health sexual health, drug abuse, violence…. The early identification of psychological distress, the support and the follow up of children and families in need, as the promotion of health promoting circumstances and environments are main objectives.	Division of School medicine, Directorate of Health/ responsible for the national coordination of the school medical services and for the realization of the school health programme in the secondary schools. In the primary schools the implementation services are : the Ligue medico social presented before, active in the majority of the municipalities, and local school medico social services in the greatest municipalities of the country Coverage: > 95% of all children and adolescents	The national school medical services were instituted since the beginning of the 1900s. With the law of 1987 reorganising the national school medicine, the consideration of the global health of the children, was highlighted. The recent ministerial regulation of October 2011 strengthened the consideration of the psychological needs of the children and the adolescents and the importance of coherent interdisciplinary approaches to best respond to their needs
SPOS (Service de psychologie et d'orientation scolaire	Aim: to provide wellbeing in school, problem solving, orientation and counseling	Ministry of National Education/ Pupils, students	Since decades in secondary level schools

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
SDIP (Service de détection et d'intervention précoce)	Aim: to provide early detection of mental health problems, referral by (SPOS), teachers, school medicine.	Ministry of National Education/ Pupils, students	Continuous since 2004
Workplace (prevention)			
Wellbeing at work Burnout prevention	Aim: to provide Increasing Corporate identity, work-climate, productivity, Prevention of illness /absenteeism/ chronic conditions /early retreat.	Different political authorities, different employers /Awareness of health-services at work, pilot programmes	Varies in duration, continuous
JOB-COACH	Aim: to provide Job-search and coaching during reintegration process, secondary prevention of stigma and isolation patients with (chronic) mental-health.	ATP-NGO, Ministry of Labour, Ministry of health, Fonds Social Européen/ stewardship of patients with (chronic) mental-health problems by (specialised) job-coachs	Continuous since 2008
Sheltered Work -Caritas - Home and Solidarity/ Workshop-Laundry -ATP-NGO/ different workshops: agriculture, different artisanries, restaurant-catering -Mathellef-NGO/ Workshop-horse stable, restaurant-catering	Aim: to provide Sheltered plants or workplaces approved as occupational therapy with the possibility of progressive reintegration. (285 places for GDL).	NGO's sponsored by different political authorities, mainly Ministry of Health, Ministry of Labour /The main purposes of sheltered work is to restore self-confidence and to allow participants a better level of competence in their abilities in order to enable them to find paid work on the "first labour market", otherwise give them a longer period of stabilisation in a process of paid work.	Continuous since the 1990s
Other programmes			
Ambulatory settings for patients with mental health problems and their families - CERMM-NGO - Réseau Psy-NGO - Liewen Dobaussen	These settings are places of reference, specialized in advising adults, families or other social partners facing the difficulties of mental illness. Each setting has a consulting-centre, day-centre (with therapeutic, occupational and social	NGO's sponsored by different political authorities, Ministry of Health, national assurance CNS/ people with psychological problems facing isolation, difficulties of autonomy, integration, etc. The offers may be solicited separately or in combination.	Continuous since the 1990s

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
- Ligue Luxembourgeoise d'hygiène mentale-NGO	facilities), low level meeting-place, sheltered housing with specialised home care.		
Patient Associations - Jo zu Mir - LASH - A.A - AMA	Self- aid groups allowing exchange of experience and counselling for prevention.	NGO's sponsored by different political authorities/ patients suffering from bi-polar, anxious, depressive troubles, addictions, etc.	Continuous since the 1990s

Financial responsibility for prevention and promotion

See above.

Investments into mental health –health, education, social development and economic growth

See under State budget, not available under this title.

Initiatives to strengthen mental health systems in relation to MHP and PMI

Not available

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4.19 Malta

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Summary

- A relatively large number of psychiatric inpatient beds continue to be provided by two main mental hospitals.
- Community mental health services are small in number but provide a number of day treatment centres, with an emphasis on offering psychological, interpersonal and practical living skills support.
- A lack of clear governance and leadership exists in the mental health sector. There is also a reported lack of synergy between social and health sectors. Some services tend to be duplicated by NGOs.
- Within the small population there are generally insufficient human resources from the Government to provide prevention and promotion activities. NGOs however, carry out a variety of prevention and promotion initiatives across the areas of schools/young people, the workplace and with the elderly.

Data for this country profile were gathered in the first instance by the project's country collaborator for Malta. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from Malta (also the country collaborator and author). This expert provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by the Governmental expert and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	417,617
Population density Inhabitants per km^2 (2009)	1,307.9
Women per 100 men (2011)	101.2
GDP PPP (2010)	0.7
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	155.9
Standardised Suicide rate by 100,000 inhabitants	7.9
Gallup Wellbeing index (2010)	
Thriving	40
Struggling	48

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

The current Mental Health Act was enacted in 1976 with various amendments since this time. This Act emphasises involuntary inpatient treatment based on a medical model determined solely by psychiatrists. A new Mental Health Act has been drafted and the first reading was unanimously approved by Parliament in July 2011. It is envisaged that the new law will come into force by the 4th quarter of 2012. The new Act promotes the bio-psycho-social model proffered by a multidisciplinary team, making some reference to mental health promotion and prevention. Clients and their carers are entitled to receive a seamless spectrum of services aimed at limiting the duration of the illness and any subsequent relapse. The vision of the new law is the provision of holistic care and aftercare to clients and their carers on a personalised basis. Clients are placed at the heart of mental health services and healthcare staff will be held accountable if effective and efficient treatment is not provided. Key points of the new Act include:

- A focus on the well-being of clients
- The protection and promotion of clients and their carers' rights
- Checks and balances to safeguard and protect such rights and to minimise abuse in this client group
- Promotes effective treatment in the shortest possible time so that all civil rights and liberties are restored
- The introduction of involuntary community treatment orders if certain stringent criteria are met
- Minimising the risk of institutionalisation

- The introduction of standards and management protocols to be enforced to ensure healthcare professionals provide diverse interventions, including promotion and prevention, for clients and carers
- A distinction between mental capacity and incapacitation/interdiction and mental capacity
- Promotion of social inclusion and anti-stigma and discrimination of this client group.

Mental health policy and inclusion of prevention and promotion

Since 1995, mental health has gained importance within the local political agenda and all successive governments have given a priority to this sector. There is no adhoc policy on mental health promotion and prevention. However, such modalities of service provision form part of the comprehensive mental health policy document, 'National Policy on Mental Health Services, published in 1995. The components of this policy are advocacy, promotion, prevention, treatment and rehabilitation. The policy strives to create healthy environments for families, schools, the workplace and in the community. It also aims to offer a range of appropriate services to empower people cope better with mental health issues, and so maximise their work and social lives.

The national health policy, 'Health Vision 2000', published in 1996 also identified mental health as one of the priority areas for resource allocation. This document lays various targets to be attained in a specific timeframe. The key priority areas concern local disease burden, health risk factors and health management issues. Inter-alia the document recommended the provision of complementary and diversified multi-sectoral mental health services to cater for the entire spectrum of psycho-social needs of the community, with an emphasis on promotion, prevention, early intervention and community support.

SEDQA, the government agency responsible for providing comprehensive services against substance abuse has formulated a number of national strategic documents to address the growing prevalence of substance abuse. Recent initiatives include the enhancement of educational attainment for adolescents. Government has increased substantially the financial allocation to the educational sector and opened new vocational institutes to create more job opportunities. Another new government initiative is aimed at increasing employees' skills, particularly those on a minimum wage, to enable them to progress into better jobs, increase their income and quality of life. Evening courses to improve job skills are organised by the Employment and Training Corporation and workers attending courses are paid a weekly grant of 25 Euros.

Mental health services

Organisation and functioning of mental health systems

The mental health sector includes both inpatient and community services, forming an integral part of the national health system. One management structure is responsible for all psychiatric services so as to ensure a seamless and consistent service. All services are provided by multidisciplinary teams.

Inpatient services: Inpatient facilities are mainly located in the psychiatric hospital (Mount Carmel Hospital) and a small unit on the sister island of Gozo. The total number of beds is 581 which includes psycho-geriatrics. There is a 15 bed short stay psychiatric unit in the general hospital. Inpatient services include both general psychiatry and specialised services such as child and adolescence, rehabilitation, dual diagnosis, old age, learning disability and forensic psychiatry. Liaison psychiatry is also provided in the general hospital and joint clinics such as Neuropsychiatry and Perinatal Psychiatric clinics are also provided.

The table below lists the number of inpatient facilities and available psychiatric beds.

	Total number of beds	% / 100,000 population
Number of psychiatric beds in general hospitals	15	0.003
Number of mental hospitals	2	
Number of beds in mental hospitals	581	0.140
Number of beds/places in community residential facilities	24	0.005

Figures for 2009

Outpatient services: Outpatient facilities are provided in the main general hospital and in the various primary healthcare centres. There are also a number of day centres around the island offering psychological, interpersonal and practical living skills group work. Outreach teams support individuals living in the community with severe and enduring mental illness, who are at higher risk of admission to hospital. A number of hostels and community homes are available that provide safe and secure housing for individuals who have experienced long term in-patient care and need support to live in the community. The Crisis Intervention Team operates on a 24/7 basis from the Casualty Department of the general hospital. The community mental health services also serve the wider community by increasing mental health awareness through the provision of information and education, to aid the cultivation of healthier environments within families, schools and the workplace.

Table below lists the type and number of outpatient facilities:

	Total number of facilities
Number of mental health outpatient facilities	2
Number of day treatment facilities	14
Number of community residential facilities	2

Other Services

Related services are provided by the Ministry of Education – school Psychosocial Development teachers (explained later on), psychologists, councillors and social workers.

The Malta Richmond Foundation, a non-governmental organisation (NGO), provides a number of services such as inpatient and outpatient rehabilitation schemes, home support service, sheltered employment and outreach services.

Mental health prevention and promotion is mainly provided by NGOs. The Health Promotion Department within the Ministry of Health lacks the human resources to provide such services.

Access and usage

Given Malta's geographical size, there is no evidence of inequality of access. Outpatient medication is provided free of charge on a means test or for those suffering from a chronic condition listed under the Social Security Act (e.g. schizophrenia). Table below provides the numbers and rates per 100,000 population for people accessing mental health services in 2009. Day treatment and outpatient facilities were the most frequently used services.

	Total number of patients	% / 100,000 population
Number of persons treated in mental health outpatient facilities [i.e. at least one contact in the year with the outpatient facility]	12,310	2.97
Number of persons treated in mental health day treatment facilities [i.e. at least one attendance per person in the year at the day-treatment facility]	14,010	3.38
Number of admissions to psychiatric beds in general hospitals	145	0.03
Number of persons staying in community residential facilities at the end of the year (i.e. December 31st).	24	0.005
Total number of admissions to mental hospitals	1,206	0.29
Total new admissions to mental hospital	398	0.09

Table below shows the number and rate per 100 000 population using long-term mental health care facilities in 2009.

Long term care in mental hospitals

	Number	**% / 100,000 population**
Number of persons staying less than 1 year	526	0.13
Number of persons staying more than 1 and less than 5 years	140	0.03
Number of persons staying more than 5 years	346	0.08

Variation and gaps

The main gaps in mental health services are:

- The provision of mental health prevention and promotion activities which are limited within the public sector
- The lack of collaboration between health and social care sectors which continue to operate in silos. No merger is anticipated. This is also the case with NGOs which has resulted in duplication of services provided to the same client group.

Financing

The health sector is financed through general taxation. Mental health expenditures by the government health department/ministry are 6.71% of the total health budget. Mental hospital expenditures are 96.82% of the total mental health budget (World Health Organization, 2011) (see table below). Despite the economic crisis, the level of expenditure in the health, social and educational sector has increased over the years. The financial statements indicate that the expenditure in the mental sector increased by 15.25% from 2009 to 2010. It is not envisaged that finances will be reduced; in fact government is committed to increasing the annual financial resources to further expand the community services on an incremental basis. However, the lack of financial resources for prevention and promotion in the mental sector needs to be addressed. Government expenditure in the educational sector that has a bearing on mental well-being is unavailable as no unit cost analysis is performed. The NGOs finance their activities mainly through government grants and voluntary contributions.

	Euro (millions)
Total Government Health Expenditure	328
Total Mental Health Expenditure	22
Total Mental Health Expenditure in the hospital sector	21.3
Total Mental Health Expenditure in the community sector	0.7

Workforce

The Tables below indicate mental health workforce data for 2009 (number and rate per 100,000 population).

Professions	Staff Working in hospital	Community Employees	Out Sourcing	Others
Psychiatrists	11	1		
Other Doctors	12	4		
Psychologists	8	5		
Psychologists Assistants	0	17		
Psychotherapists	0	0		
Nurses	222	41		1 Nursing Manager
Health Assist / Care Workers on Nursing Duties	7	5		
Social Workers	13	14	4	
Social Workers Assistants	0	0		
Occupational Therapists	14	5		
Occupational Therapists Assistant	0	0		
Physiotherapists	1 + 2 on rotation	0		
Pharmacists	3	0		
Pharmacy Assistant	0	0		

	Total professionals working in mental health sector / 100,000 population
Psychiatrists	3.14
Other medical doctors, not specialized in psychiatry	3.14
Nurses - (include both psychiatric nurses and general nurses working in mental health facilities).	66.24
Psychologists	4.35
Social workers	5.07
Occupational therapists	4.59

Responsibility and delivery of mental health promotion and prevention of mental illness

Mental health prevention and promotion is provided largely by NGOs. The Health Promotion Department within the Ministry of Health lacks the human and financial resources to provide such services.

Mental health status

Prevalence of mental health in the population

There is limited epidemiological data on incidence and prevalence of mental disorders since no funds are allocated by government to carry out such research. The figures quoted below are from European Health Interview Survey (HIS) 2008. The HIS was conducted on a representative sample taken from the National Statistics Office population register. The study population consisted of 5,500 Maltese persons aged 15 years and over. The response rate was 72%. Chronic depression: reported by 6.6% (lifetime prevalence) of this sample. Of these, 77.6% experienced symptoms in the previous 12 months, whilst 91.6% were diagnosed by a medical doctor. Chronic Anxiety: 7.8% reported this at some time in their life. Of these, 80.4% reported having symptoms in the previous 12 months whilst 73.9% had this condition diagnosed by a medical doctor. Prevalence of total mental health disorders (lifetime experience of chronic anxiety, depression, anorexia/bulimia and other mental illness): 15% reported having a mental disorder. Compared to OECD countries, Malta has one of the lowest self-reported lifetime and 12 month prevalence rates of total mental health disorders (Society at a glance, 2009, OECD). Suicide rate was 7.9/100,000 in 2009 (Eurobarometer, 2010). No

significant trends in mortality from suicide were observed between 1998 and 2009 (Department of Health Information & Research, 2010).

Protective and risk factors

Gender: Overall, women experience higher rates of lifetime experience of the selected mental disorders than men; 9.7% women reported having chronic anxiety compared to 5.6% males whilst the percentages for chronic depression are 7.7% for females and 5.4% for males. Age: The lifetime prevalence of chronic anxiety and depression increases across the age groups, up until the ages of 55 – 64 years. Marital Status: Widowed respondents, followed by those who are divorced or separated are more likely than single or married respondents to have had chronic anxiety or depression. Level of Education: Respondents with a primary educational level are twice as likely to report having had chronic anxiety and nine times more likely of having chronic depression during their lifetime than those with tertiary education. Employment: Respondents who are gainfully employed are less likely to report chronic anxiety or depression than those who are unemployed, retired or fulfill domestic tasks. Income: Those with the lowest income group are 3 times more likely to report chronic anxiety and depression than those within higher income groups. Social Networks: Rate of chronic anxiety and depression is influenced by the number of individuals living within the household. Respondents who had a number of people to rely on were less likely to have a lifetime experience of mental disorder than those who had none. Residence: 9.2% of respondents living in urban areas report having suffered from chronic anxiety at some point in their lives as compared to 6.6% living in sub-urban or rural areas.

Prevention and promotion programs/activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools (prevention)			
Tfal Favur Ambjetn Liberu (Children in favour of a free environment)	Aim: to promote three main topics, 'Mental Hygiene' 'Social relations' and 'Wise use of medicines'.	This is a comprehensive programme targeting children from kinder 2 through to year 6.	Not reported
BABES programme	Aim: to provide a primary prevention programme to enable children to learn and practice living/loving skills and make positive decisions about alcohol and other drugs.	Targeted at children aged 7 to 8 years.	Six one hour classroom sessions. The programme runs once weekly for 6 consecutive weeks.
Qed Nikber (Am	Aim: to develop decision	Target audience is	One day seminar.

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
growing up)	making skills, assertiveness and awareness about peer pressure. In classroom or as school day outings children are invited to take responsibility for their choices in life and understand the consequences of choices.	children in Year 6.	
Nikber Ahjar (Better Future)	Aim: to help children develop a resilient personality and give them prevention techniques related to addictions; build self-esteem, ability to express feelings, assertiveness through developing problem solving skills.	Children in residential homes	
Substance abuse Prevention Programmes	Aim: main goal to further build awareness on substance abuse and making healthy life choices. Age appropriate sessions and courses. Parental meetings also organised to complement the sessions.	Target audience is children aged 11 to 15 years. These sessions are also provided to parents. Teachers.	Not reported. Funding is through central government funds allocated in the yearly financial estimates. Formulated by Sedqa
Workplace or adults (prevention)			
Home Support Service	Aim: to empower working age persons experiencing mental health difficulties to manage their lives in their own environment. Provided by trained personnel in own home by the Malta Richmond Foundation, (NGO).	The target audience is adults aged 17-65 years.	Free for users, funded through a global government grant and voluntary contributions by the users and the public.
Wellness Programme	Aim: to help people who are on psychiatric treatment to engage in good health practices. Approach: to develop healthier eating habits and engage in regular	Target audience is anyone on psychiatric treatment between the ages of 18 to 50 years.	Weekly two hours sessions divided into two parts. Funding by global grant from government and through voluntary

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	physical activities. Provided by the Malta Richmond Foundation.		public contributions.
Substance Abuse-Free Employees Programme (SAFE)	Aim: to raise awareness on substance abuse in the workplace. Provided by government agency, Sedqa, responsible for dealing with substance abuse issues.	The target audience are the public and private sector.	Programme comprises four phases. Funded through the annual allocation by government to the agency.
Older people in long-term care facilities (prevention)			
Psychiatric service	Aim: to promote liaison between psychiatrists and geriatricians for the early detection and treatment of common mental health problems. Other services also detect visual and hearing problems as such disorders tend to cause social isolation.	Older persons.	Not reported.
Schools (promotion)			
Personal Social Development (PSD)	Aim: to enable students to gain skills required for everyday challenges and a positive attitude. Opportunity to discuss personal problems with specialists. Approach: Delivered by specialised teachers trained in Personal Social Development.	Kindergarten to secondary school level.	Level (11-15 years) children have minimum of one hour contact per week. Funded from the global annual allocation to the Ministry of Education, Social Policy and the Family.
Mental Health Promotion Programme	Aim: to raise awareness among school children and teachers on mental health issues, to promote mental health in a friendly and supportive environment, to reduce stigma. Programme provided by the Malta Mental Health Association, an NGO.	The target audience are school children aged 8 to 10 years.	Free. Publishing costs for the booklets sponsored by Vodafone Malta Ltd and EUFAMI.
Workplace (promotion)			
Employee Support	Aim: to promote the	Government	Programme will

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
programme for Public Employees	physical and psychological well-being of its employees. Programme delivers promotion and prevention initiatives. Designed to give information on mental and physical wellbeing, work related stress, mental health and emotional stress, marital and family concerns, bereavement and terminal illness, addictive behaviour and disability issues.	employees.	run for two years. The programme is partly financed with the assistance of EU funds under the European Social Fund Operational Programme II – Cohesion Policy 2007 – 2013.
Staff Organisation Support Programme (SOSP	Aim: to provide mental well-being at the workplace and helps organisations and their employees with support for managing stress.	The target is any organisation that wants to promote the psychological well-being of its employees.	Not reported. Funding by agreement between the organisation and Richmond Foundation.
Older people in long-term care facilities (promotion)			
Programm Anzjani (Programme for Elderly People)	Aim: to improve the mental and physical health of elderly people. Delivered by Sedqa, carried out in government's day centres and homes for the elderly. Delivered interactively by information sessions.	Elderly people.	Not reported. It is funded through central government funds.
Other Programmes			
21+ Club	Aim: to give psycho-social skills to young adults with emotional stress or loneliness. Clients are taught social skills to enable them to form fruitful relationships. Run by Caritas (Malta) a church organisation offering weekly meetings.	Young adults	Not reported. Funded by the local church through general revenue and voluntary donations.

Investments into mental health – health, education, social development and economic growth

No financial data available. Programme budgeting does not exist; allocated financial resources cannot be deduced for prevention/promotion programmes.

Initiatives to strengthen mental health systems in relation to MHP and PMI

A series of other initiatives have also been introduced:

- A Government initiative to promote a balance between work and family life through flexible working hours and tele-working. Parents of children under 5 years can take up to 5 years unpaid leave with social insurance contributions credited thus protecting pension rights.
- Kids in Development (KIDs) Programme to help children who have experienced severe emotional and behavioural difficulties. It is provided by the Malta Richmond Foundation, a non-governmental organisation. For children aged between 5 and 10 years with severe emotional and challenging behaviour.
- Bullying Programme: Psycho-social services are provided to both offenders and victims. Involvement from the family network.
- Counselling Services: Available to all school children experiencing psycho-social problems.
- Parenting skills courses are available in various settings. NGOs carry out such courses in schools to empower parents with the necessary skills to be better parents.
- Healthy Ageing Programme: Programmes provided by the state, church and NGOs to promote healthy ageing and prevent social exclusion
- Day centres for the elderly. University of Third Age, a life-long learning initiative. All local councils provide free training and computer facilities to the elderly to reduce the technological divide.
- National Strategy for Dementia 2012 –2020: Government has set-up a working group to finalise a National Strategy for Dementia. Aims to "*enhance the quality of life of patients with dementia and their families*. Currently in the final draft stages, due for formal launch in coming months.

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4.20 Netherlands

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Summary

- Mental health services are integrated between primary and secondary levels across 50 different mental health districts in the Netherlands. Three general psychiatric hospitals remain with the majority of services provided by integrated services, sheltered housing services, addiction clinics, child and adolescent services and others.
- A national infrastructure is in place which includes a network of health promoters, prevention workers and trained caregivers at local and district level. An emphasis is on encouraging people into healthy lifestyle choices.
- As municipalities are free to govern their own mental health services, this has lead to variations in practice. This is balanced out however, by the changes that implemented this service leading to a much more integrated supply system. Besides that, people with mental health problems are entitled to appropriate mental healthcare through their basic health insurance.
- With prevention and promotion firmly embedded in the goals of national policy and operating at local level, the amount and variety of activities in the Netherlands in impressive. An extremely extensive set of programmes is in existence for schools and young people, the workplace and the often-neglected domain of mental health promotion and prevention for older people.

Data for this country profile were gathered in the first instance by the project's country collaborator for the Netherlands. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from the Netherlands. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by the Governmental expert and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	16,655,799
Population density Inhabitants per km² (2009)	489.7
Women per 100 men (2011)	102
GDP PPP (2010)	1.1
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	139.6
Standardised Suicide rate by 100,000 inhabitants	8.5
Gallup Wellbeing index (2010)*	
Thriving	68
Struggling	32
Suffering	1

* Reprinted with Permission of Gallup, Inc.

Mental Health Legislation and Policy

Current update and reference to prevention and promotion

The 1994 Psychiatric Hospitals Act protects patients' rights where admitted to hospital on a compulsory basis. A new Act is being developed, which addresses the shortcomings of compulsory treatment under this current Act. Consultations with family and service user organisations highlighted the need for compulsory outpatient treatment. This new Act (Compulsory Mental Health Care Act) is currently discussed in the Parliament Other related legislation includes the Health insurance Act, Exceptional Medical Expenses Act, the Hospital Provision Act, the Social Support Act and the Health Care Charges Act.

Mental health policy and inclusion of prevention and promotion

National health policy in the Netherlands includes a strong public health component with prevention and promotion embedded within its goals to improve health through encouraging people to make health lifestyle choices. A national infrastructure has been developed to advance health promotion and prevention work – including a network of health promoters, prevention workers and trained caregivers at local and district level.

The Occupational Act requires employers to set up optimal working conditions so as to prevent work related health risks and to limit the possibility of accidents. The Public Health Act (Wet publieke gezondheidszorg, 2008) designates the municipality as primarily responsible for implementing health care for older people and includes the prevention specific disorders.

Mental health services

Organisation and functioning of mental health systems

The Netherlands is divided into approximately 50 mental health districts, each with a comprehensive system of inpatient and outpatient mental health services, including the provision of preventive services. Mental health services are integrated between primary and secondary services because of its importance in maximizing care and treatment.

Integrated mental health services provide both inpatient and ambulatory mental health care. The number and type and of mental health services are:

31	Integrated mental health services
3	General psychiatric hospital
7	RIAGG (organisations for ambulatory care)
20	Sheltered housing services
11	Clinics for addictions
9	Child and adolescent mental health services
7	Psychiatric hospitals (including forensic psychiatry)

Source: GGZ Nederland, 2009.

Access and usage

GPs act as the gateway into secondary care services when more specialist care is required. In 2007, GPs had 357 contacts per 1,000 registered patients for a psychological issue or diagnosis (NIVEL); the most common diagnoses were insomnia and depression.

In 2009, 858,975 people were treated in specialized mental health care services. Around 89% of them received ambulatory treatment; 1% attended day care or day hospitals; 6% were hospitalized; and about 4% lived in sheltered housing. The majority (approximately 71%) were adults aged between 18 and 64 years. Most prevalent diagnoses in this category were depressive disorders, anxiety disorders and other neurotic disorders. Eighteen percent were under the age of 18 years mainly with behavioural or emotional disorders, disorders in psychological development and relational problems such as child abuse or maltreatment. There were 9% of patients aged 65 years and above with dementia and depression being the most frequent diagnosis (GGZ Nederland, 2010).

Variation and gaps

Municipalities are largely free to organise public mental health services, which has led to variations in practice. However, since the 1990s changes to these services have resulted in a much more integrated system of supply. Large scale integrated institutions are the main feature of mental health care in the Netherlands, offering virtually an entire range

of services (Van Hoof et al., 2008). Since 2008 most mental health care is reimbursed by the basic benefit package under the Health insurance Act and financed by the health insurers. People with mental health problems are entitled to appropriate mental health care, regardless of where they live.

Workforce

In 2009, some 86,000 people were employed in mental health services. According to the World Health Organization Mental Health Atlas (2011) there were (per 100,000 population):

18.8	psychiatrists
132.3	nurses
15.05	psychologists
87.5	Other health workers

There is a recognised shortage of physicians in the mental health care sector which is likely to continue (HiT, 2010).

Financing

For 2009, the budget for mental health care was 11% of total health care expenditure in 2009 ("Zorg op waarde geschat update". Sectorrapport ggz 2010, Nov 2010).

Mental health care is financed through basic health insurance (under the Health Insurance Act) for up to a year, after which care is financed via the Exceptional Medical Expenses Act. Out of pocket payments by patients or families also exist. Municipalities are responsible for the financing of public mental health care.

Responsibility and delivery of mental health promotion and prevention of mental illness

Since the 1980s public health services provide health education and health promotion activities, including mental health. To fulfil tasks in public health, municipalities are obliged to set up a municipal health service (GGD), whose prevention work includes collecting information on the health of the population, contributing to prevention programmes, implementing youth health care and the control of infectious disease. Municipal health services also advise municipalities on matters of public health policy issues. However, these services are not uniform throughout the country.

Mental health status

Prevalence of mental health in the population

Mental health problems in the general population between the ages of 18 and 64 are shown below (GGZ Nederland, oktober 2010):

5.2% Depressive disorder
5.0% Specific phobia
3.8% Alcohol Abuse
3.8% Social phobia
2.1% ADHD
1.8% Generalized anxiety
disorder
1.2% Panic disorder
0.9% Drug Abuse
0.9% Dysthymia
0.8% Bipolar disorder
18.1% All diseases

For more serious mental disorders the prevalence and incidence rates are listed below (Volksgezondheid Toekomst Verkenning, 2010; NEMESIS-2 study, figures standardized to the population in 2007 (De Graaf et al., 2010)):

Dementia (F00-F03):	Prevalence: 50 000; 1,9 per 1000 men, 4,3 per 1000 women Incidence: 19 100 (2007, Source: VTV 2010)
Schizophrenia (F20):	Prevalence: 31 878; 2,3 per 1000 men, 1,7 per 1000 women Incidence: 2 401; 0,19 per 1000 men, 0,11 per 1000 women
ADHD:	Prevalence (1/2 year): 13 per 1.000 (for 13-17 years olds only)
Bipolar disorder:	Prevalence: 87 400; 6,9 per 1000 men, 9,7 per 1000 women
Any mood disorders:	Prevalence: 642 800; 49,1 per 1000 men, 74,3 per 1000 women

Incidence

See above.

Protective and risk factors

Risk factors include, having parents with a mental illness or alcohol use problems; experience of traumatic events in adolescence or neglect under 16 years; chronic illness; stressful life events (unemployment, death of a spouse, etc.); vulnerable personality (e.g. low self-esteem); low educational attainment and low income; being single and limited social support /isolation; asylum seeker.

Protective factors include: having above-average intelligence and social skills; well-developed adaptation (resilience); close relationship with at least one family member or parent; close relationship with someone outside the family (e.g. someone from the

church or a teacher); strong relationships with friends who do not show anti-social behaviour; successful in training/education; healthy self-esteem.

(Source: www.trimbosinstituut.nl)

Prevention and promotion programs/activities

Many prevention and promotion programmes in the Netherlands are evaluated to assess their effectiveness. There are several websites listing prevention and promotion programmes and courses for professionals in schools, workplace and the community (for example, Programmes of the Health Institute NIGZ and Loketgezondleven websites list over 400 different health prevention and promotion programs. The list below is a sample of programmes implemented in mental health and related areas.

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
Schools			
Prevention of smoking, drinking alcohol and drug use:			
Actie Tegengif (“Action Antidote”;	Aim: to prevent the onset of smoking.	young people 12-14 years	
'Alcoholmatiging Jeugd in de Achterhoek' (Moderation of alcohol use of youth in the Achterhoek)	Aim: a regional project to prevent alcohol abuse in young people	10-18 years old teenagers	
Op Tijd Voorbereid “Prepared in time	Aim: to prevent the onset of smoking and drinking. Approach: 8 primary schools, e-learning programme, info session for parents and group assignments in class.		
PAS-interventie (“Prevention Alcohol use) for Student	Aim: an intervention to delay alcohol use in young people.	Young people 12-16 years and their parents	
To prevent social/emotional problems and promote social competence:			
Kanjertraining (“Giant training”	Aim: to stimulate social competence and prevent or reduce social problems, 10 lessons).	students 4-16 years old	
Plezier op school (“Pleasure at school”	Aim: to increase social competence. Approach: Summer course for students going to secondary school who were bullied or had problems with peers.		
Programma Alternatieve Denkstrategieën	Aim: to promote social and emotional development children in primary and special education	4-12 years old students	

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
("Promoting Alternative Thinking Strategies";			
Taakspel ("Task game"; universal prevention programme	Aim: to reduce rule breaking and promote a game to learn to comply with rules in class and on the playground (group-oriented method), (target is) to improve task oriented behaviour, to diminish breaking rules and promote a positive educational climate, final goal is to reduce and change problem behaviour.	group 4-8 (7-12 years old), students	
VRIENDEN (FRIENDS; (individual or group)	Aim: to prevent anxiety disorders and complaints of depression. Approach: 10 meetings for students and 4 meetings for parents. The programme is also applicable as prevention programme in schools).	for 7-16 years old students and their parents	
Leefstijl ("Lifestyle"; primary (special)	Aim: Secondary education and pedagogical organisations, (target is) to promote constructive behaviour and positive social involvement. Approach: Skills transferred by educators and docents with education material, practices and training (method).	Secondary school students	
Levensvaardigheden ("Life skills"	Aim: Educational programme to support developing and maintaining social and emotional skills	Students in secondary schools (14-17 years)	
De gezonde school en genotmiddelen "The healthy school and drugs"	Aim: to prevent drug abuse and develop policy in schools	10-18 years teenagers	
Workplace			
Group training and workshops in 'Dealing with job stress'	Aim: to teach coping skills Approach: Through effective training to detect symptoms of stress and sources of stress, teach positive and realistic thinking, improve social skills, and do relaxation exercises.	Employees	
Projects to develop a thematic approach to work-related mental problems	Aim: to improve the existing services for employees in the field of mental health.		
Training supervisors and company doctors	Aim: to improve their skills via information, courses and workshops. Approach: Training is available on improving skills to detect work-related		

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
	mental problems and refer employees to the appropriate services.		
Mental health service prevention departments	Aim: to offer verbal or written information to the target group and to intermediaries. Approach: Written information may consist of folders, articles in magazines, and relevant links. Other activities focus on increasing the chances of a successful and permanent return to work.		
Training to improve the knowledge of intermediaries (e.g. supervisors)	Approach: Training on clinical syndromes, role limitations they may cause and how to deal with them		
Sterk op je werk ("Strong at work"):	Aim: to deal with stress at work and return to work. Approach: Online course on base of cognitive behavioural interventions for employees in mental health care; E-health module Return to Work embedded in collaborative occupational health care for depressive disorder;		On-going project.
Older people in long term care facilities			
"In de put, uit de put 55+"	Aim: to reduce and/or prevent (complaints of) depression in older adults, applicable in diverse settings. Approach: 10-12 group sessions to learn skills and techniques. (www.loketgezondleven.nl)	Those aged 55+ in various settings	
Preventie van depressie in verzorgingshuizen ("Prevention of depression in nursing homes")	Aim: to prevent or diminish complaints of depression, satisfaction about care, to promote quality of life, to promote social support, to diminish care consumption and medication. Approach: Meetings with personnel (and course), meetings for family	Residents with depression in nursing homes; Intermediate target group: personnel of nursing homes, family of residents	
Preventieproject Vroegsignalering ("Prevention project Early detection")	Aim: to recognise mental problems as early as possible to provide adequate care, support and/or treatment. Approach: Screening of residents (VSGO-GIP checklist), training of personnel. Scientific state: proven effective (in reduction of complaints of depression)	Residents of nursing homes. Intermediate target group; nurses, managers, prevention workers	
Other programmes			
Forty specialized	Aim: to prevent depression. Approach:	Adults and the	

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
mental health facilities engage in depression prevention. They help people who have a number of depressive symptoms or a history of depression.	Structured courses based on social learning theory, cognitive behavioural therapy, relaxation exercises, training in social skills and learning how to have more pleasurable activities. Special courses for people with chronic illnesses, students and young adults and members of ethnic minorities. Various regions have widow to- widow visiting services. Bibliotherapy – self-help, independent study has been effective in reduced incidence of depression. 'Structured life review' 'stories we live', for those in early stages of late life depression. Internet self -help interventions. Community approach is to improve the target group's neighbourhood cooperation on integrated depression prevention.	elderly	
Occupational rehabilitation projects in collaboration with the sociomedical sector and Labour Exchange for unemployed patients with chronic mental disorders.	Aim: to assist people with mental illness back to work. Also, aimed at people unemployed for a prolonged period due to mental illness.		
'Return to Work' courses	Aim: to help people who have been out of work for up to two years return to work.	Unemployed	
Family interventions	Aim: to support parents with mental illness. Approach: Counselling, social support, improving parenting skills) focus on parents with mental health problems and their children who may be at risk of depression and other disorders.	Parents with mental health problems and their children	

Financial responsibility for prevention and promotion

Activities aimed at health protection, prevention of sickness, and health promotion, including mental health are financed by Ministry of Health, Welfare and Sports. Funding comes from health insurance companies (the main source at 58%), municipalities, funds via the Exceptional Medical Expenses Act and other sources (grants and funds).

Investments into mental health – health, education, social development and economic growth

The total budget of prevention departments is higher in 2009 compared to previous years, mainly because of the numbers responding to requests for such information and merging of departments. Funding to prevent the exacerbation of chronic illness was in €14 million in 2011, in 2012 €11 million, €8.5 million for 2013 and €6 million for 2014 (note yearly reductions). Funding for the health lifestyle policy is €59 million for 2012, €53 million for 2013 and from 2014 €48 million, again a reduction in expenditure overtime.

The expected benefits of this integrated approach are to improve the quality of life for those with chronic physical disorders, reduce mortality, and the costs of health care.

Initiatives to strengthen MH systems in relation to MHP and PMI

See above.

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4.21 Norway

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Summary

- There is a lack of continuity of care and comprehensiveness of mental health services
- Outreach teams work throughout the country to create easier access to local based services. However there is a lack of mental health specialists (psychiatrists and psychologists).
- The Coordination Reform, initiated in 2012, has handed greater responsibility and obligation for prevention and promotion to the municipalities.
- There is a major focus on prevention and promotion for schools and young people. Strategic Government planning lists numerous interventions in this area along with a further focus on parents and improved collaboration between home and schools.

Data for this country profile were gathered in the first instance by the project's country collaborator for Norway. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Norway. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Indicator	Value
Population (1 January 2012)	4,920,305
Population density Inhabitants per km^2 (2012)	13.03
Women per 100 men (2011)	99.9
GDP PPP (2010)	11.7
Psychiatric care beds in hospitals per 100,000 inhabitants (2011)	90.1
(4,190 beds for adults + 310 for children/adolescents)	
Standardised Suicide rate by 100,000 inhabitants	11.5
Gallup Wellbeing index (2010)	
Not available	

Mental Health Legislation and Policy

Current update and reference to prevention and promotion

The main legislation for mental health services is: "Lov om etablering og gjennomføring av psykisk helsevern (psykisk helsevernloven)" (Mental Health Care Act) of 1999, which came into effect from January 2001. The Act aims to ensure that mental health care, during compulsory admission, is applied in an appropriate manner and based on the needs of the patient and respect for their human dignity.

In the last 10 years, the largest initiative in Norway was "The National Mental Health Program" (1999-2008). The programme sought to improve mental health services in Norway through a major expansion of primary care services provided by local councils and a restructuring of specialised services. Mental health promotion and health prevention was an important feature. In more recent years mental health promotion and prevention have become more focused issues in subsequent health policy reforms.

The most important ongoing initiative "The Coordination reform" includes changes in health legislation and health policy. The reform gives increased responsibility and financial support to municipalities for health promotion, prevention and treatment, including mental health and mental health services. The main principle is to establish services close to where people live and to strengthen targeted efforts and investments in health prevention and promotion. It involves legislation giving municipalities obligations and responsibility for preventing illnesses and promoting health. This reform demands better cooperation between hospitals and municipalities, with a long planning period, starting gradually from 2012.

The reform is supported by two new laws - one for public health, to promote health and reduce social inequalities in health, including mental health; the other, a new legislation for municipal health and social services. A white paper has been put forward to design health services over the next four years and to realize the Coordination reform and prepare future services. The new legislation came into force 1st January 2012.

Mental health policy and inclusion of prevention and promotion

Initiatives which affect mental health policy and prevention and promotion of mental health include the following:

The Government **action programme against poverty** was aimed at reducing the social causes that lead to health problems. This was followed up with a National strategy to reduce social inequalities in health which has been in place since 2007.

"The Coordination reform" as described above.

A **prevailing policy** was presented in the annual state budget on restructuring mental health services, decentralization and deinstitutionalization. This established Outreach teams in all of the 75 Mental Health District Centres.

National strategy for a healthier Norway from 2002: The White paper No. 16 (2002-2003) for a healthier Norway defines key target areas that focus on establishing health-promoting habits that prevent major public health diseases. The report emphasised the need to promote good health, well-being and prevent mental disorders. From a primary prevention perspective, there is a need to identify circumstances that significantly contribute to mental health and well-being. This strategy notes that the circumstances affecting population health lie outside the health sector's sphere of responsibility. For this reason, the report stressed the need to ensure that public health-related efforts are given a stronger political focus and made integral to ordinary planning and decision-making. One important strategy for achieving this is to promote a regional and local partnership model for public health. Great importance is attached to ensuring that the population's health is considered and incorporated more directly into community planning. This may be partly achieved by integrating the establishment of public health partnerships into relevant planning processes, and developing health profiles and health impact assessments for use as tools. There is also a need for research on the impact of these instruments and the conditions that must be present for these to succeed. If public health efforts are to be successful, the causal factors at the individual, social, cultural, structural and societal level, and the mutual effects of these factors, must be identified.

Alcohol and drug policy - White Paper no. 30 (2011 – 2012): A White paper on alcohol and drug policy was presented to the Norwegian Parliament in June 2012. The

consumption of alcohol and drugs is relatively low in Norway compared to other European countries, but there has been an increase in the consumption of alcohol and the number of drug-related deaths. Ensuring coordinated services as part of the Coordination Reform, is also an important challenge addressed in the White Paper. The Government therefore suggested prioritising action in the following areas:

- Prevention and early intervention
- Coordination – Services that work together
- Increased competence and quality
- Help to severe addicts – reduced number of drug related deaths
- Help to carers and children in families with alcohol and drug abuse

The White Paper confirms that the Coordination Reform also addresses alcohol and substance abuse. The financial mechanisms supporting the reform will also gradually include mental health, alcohol and substance abuse.

Inclusive working life (including mental health related problems)(2010-2013): Through an Agreement on a More Inclusive Working Life (IA agreement), the Government and its social partners are working for a more inclusive working life – for the benefit of the employees, the workplace and society. The IA Agreement is an instrument aimed at preventing sick leave, increasing focus on job presence and preventing "expulsion" and increasing the employment of people out of work. Through the agreement, focus has been placed on reducing sickness absence and the use of disability pensions, increasing the retirement age and ensuring the recruitment of people with impaired functioning capacity and other vulnerable groups into the employment market.

Strategy for mental health and work places 2007-2012 (to be extended): A strategy to support inclusion of people with mental disorders in labour market through individual support, collaboration with employers etc.

Establishing Centers for Healthy Lives: By 2012 there were approximately 150 such centres in Norway. Formal referral is not needed. The goal is to support people in establishing healthy lives, (e.g. through better diet, more exercise, not smoking, etc.).

Mental health services

Organisation and functioning of mental health systems

Various Governmental departments have responsibilities and tasks for organising mental health services and prevention and promotion tasks. These include:

- The Ministry of Health and Care Services have the overall responsibility for Government policy on health and care services in Norway.
- The Directorate of Health is a directorate and an administrative body under the Ministry of Health and Care Services.
- The National Institute of Public Health: The main tasks of the Institute of are related to health promotion and preventive medicine, including mental health.
- Other relevant ministries are: Ministry of Children, Equality and Social Inclusion and Ministry of Labour (including work life and social service benefits), Ministry of Education and Research.

The organization and types of mental health services include:

Municipal health and care services: These are responsible for providing high-quality health care and social services to everyone in need of them, regardless of age or diagnosis. The important services and professionals for mental health include: general practitioners (GP), psychologists, emergency services, mental health services and/or general care services (these services may be separated or incorporated), rehabilitation services and services related to health prevention and promotion in all areas, long term facilities for elderly (public and private homes), day centres for elderly or for people with mental health problems, and services for families, children and adolescence (health-sister, family centres, pedagogic psychological services, health services in the school, etc.). There are also initiatives to increase cooperation between health services and schools.

Specialist health care services are meant to support the work of municipalities and to provide treatment for more serious conditions. Specialist mental health services are based on three pillars:

- District Psychiatric Centres (DPCs) - provide specialised services on a decentralised level. 75 centres cover all municipalities.
- Psychiatrists and psychologists in private practice - provide services in co-operation with other mental health services.
- Hospital wards - provide highly specialised services (security psychiatry, closed acute wards, specialised functions)

Specialised services for children and adolescence in hospitals and outpatient clinics.

Social and employment services:

- NAV (Norwegian Labour and Welfare Administration): under the Ministry of Labour. Employment and national insurance services, such as sick pay, disability benefit, early retirement, rehabilitation services connected with work.

Municipal social services

Voluntary centres and user organisations which support general services and advocate for patients' rights.

Access and usage

General practitioners are gatekeepers into specialist mental health services. There has been a reduced threshold for referral and admission to mental health services and services have become more diversified. Most patients are now treated and cared for outside institutions, at outpatient clinics or in municipal services. This indicates a shift away from long-term care in hospitals, to outpatient clinics, outreach teams and support/treatment in smaller facilities in the community. Length of stay is considerably reduced to about 25 days, while at the same time the number of patients discharged/treated has increased continuously.

Variation and gaps

Each year, 3% of adults and 5% of children and adolescents are treated by specialist mental health services. The most serious gap appears to be in the continuity of care and comprehensiveness of services. The waiting times (if not an emergency) are on average between 60-70 days for mental health services and slightly more for drug misuse services (Norwegian Patient Register).

Financing

18% of the healthcare budget is spent on mental health (SAMDATA 2011). Spending on services outside hospitals has increased between 2006 and 2010. There was a large increase in mental health spending during the National Mental Health programme up to 2008. In 2011, the total budget for mental health specialized services for adults was 15 billion kroner (2 billion Euros), for children and adolescents 3.5 billion kroner (0.5 billion Euros) and for drug/alcohol services also 3.5 billion kroner (0.5 billion Euros).

Both municipal services and specialized services are funded by the state. There are some smaller out of pocket payments for seeing your GP and for outpatient clinics. Both municipalities and Regional Health Authorities are funded by block grants.

Workforce

In 2011 there were 20,470 staff working in mental health specialist services; 16,770 worked in adult services and 3,700 in children and adolescent services. No precise figures exist for municipal services as they are integrated in other sectors. It is assumed that the workforce comprises of between 12,000 and 15,000 per year (not including GPs).

The number of psychiatrists per 100,000 population was 28.1 (World Health Organization, 2011); for mental health nurses 170 per 100,000 population; and approximately 100 psychologists per 100,000 – 67 per 100,000 working within mental health services and the remainder working in municipalities and other sectors.

Responsibility and delivery of mental health promotion and prevention of mental illness

Mental Health prevention and promotion is by law a municipal responsibility, supported by the Directorate of Health and the National Institute for Public Health.

Mental health status

Prevalence of mental health in the population

For adults, research shows that between 20% and 50% of people have a mental health problem during their life time, depending on definitions and measures. Anxiety and depression are, together with drug addiction, the most common mental illnesses. Problematic alcohol abuse is estimated to vary from 66,500 to 377,000. Although the figures are uncertain, at any time it is presumed that one out of six adults has a mental illness in Norway. The prevalence for adolescents seems to be somewhat higher.

The suicide rate in Norway is 12-14 per 100,000 inhabitants and comparable with Iceland, Sweden and Denmark. The number of suicides has been relatively stable in recent decades with approximately 500-550 suicides registered per year. The number has varied between a peak of 583 in 1999 and a low of 494 in 2002. This corresponds to an average of 12.2 suicides per 100,000 inhabitants per year in the period between 1999-2008. There was an increase from the previous year for 2009. Approximately two to three times more men than women commit suicide. In 2009, there were 69 more men than women who took their own lives. Around half of all suicides occur in the under-50 age group. Suicide is also among the most common causes of death among young adults. Suicide among children under 15 years of age is rare.

Between 15 to 20% of children and adolescents in Norway have mental problems affecting their level of functioning. Approximately, 17% of those aged between 15-16 have mental problems, (25% girls and 9% boys). Annually about 8% of children / adolescents seem to be in need of support, with 5% require specialist services. Two out of three children aged between 6 and 12 years with a diagnosed mental illness are boys. The most common diagnoses are hyperactivity, concentration difficulties and behavioural disorders. During adolescence, more girls than boys suffer from anxiety and depression.

Incidence

Not reported.

Protective and risk factors

In Norway, cohabiting couples mostly have as good mental health as married couples, but are more likely to report alcohol dependence and previous major depression compared

with their married counterparts. A higher proportion of divorced cohabitants report having experienced a major depression compared to married people.

The risk that a child will develop mental disorders increases in periods when the parents have an increased symptom level (e.g. conflict-filled relationship or lacking parenting skills). The risk also increases if the family has substantial stress or negative life events and little social support, especially if the child has a temperament characterised by high levels of shyness and negative emotions. It is the interaction between risk and protective factors that determine whether a child develops symptoms of mental disorders.

Children and adolescents are most at risk of developing mental disorders in families where parents have lasting mental disorders, are drug addicts or violent, or where the family or children have arrived as refugees with traumatic experiences of war, torture, violence and loss of family and friends. Risk increases if a child is socially isolated or bullied at school. Children born with a biological vulnerability due to maternal abuse of alcohol, illicit drugs, medications and/or tobacco, or has been malnourished or exposed to environmental toxins during pregnancy are also at increased risk of mental illness.

Prevention and promotion programs/activities

The Government's strategy plan for the mental health of children and adolescents (2003) lists 100 interventions, including mental health prevention /promotion. Many interventions are targeted at parents; increasing collaboration between home and school; increasing knowledge and skills related to mental health and mental health problems in services, schools, parents and kindergarten. A new national strategy is currently under development and involved a wide range of Ministries. The main mental health promotion activities are integrated into ordinary municipal services, where special programmes are considered less important. However, a few examples of these include:

Program name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools and young people (Prevention)			
Offer of courses for secondary schools.	Aim: to increase knowledge and awareness of mental health. Teaching package on positive conditions for mental health knowledge, mental health problems and where to get help.	Pupils and teachers. Directorate of Health, Institute of Public health, Board of Education.	Began 2003 and continued
Health care and information about support services on internet.	Aim: to increase knowledge about mental health and services. Easily accessible low threshold service for young people. Klara-klok.no is the country's most popular	Young people. Directorate of Health, Youth information in Nordland county.	Continued.

Program name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	health site used for anonymous information and advice and is a first gateway to the local support system.		
Parental Guidance Programme.	Aim: to create meeting places where parents can exchange experiences and address issues about bringing up children. Supports parents to counteract negative behavior patterns and psychosocial problems in children and young people.	Parents, Ministry of Children, Equality and Social Inclusion. Municipalities.	Operating since 1995 and continuing.
Programme in schools.	Aim: to increase knowledge and guidance. Programme produces materials and videos for use in schools.	Parents and teachers, Ministry of Children, Equality and Social Inclusion in collaboration with other ministries.	Operating since 1995 and continued.
Preventing young people falling out of secondary education.	Aim: to prevent dropping out of secondary school. Offers training, work or other occupational activities to the target group.	All counties and young people, Board of Education.	2003-2005. Continued
Increased recruitment and strengthening of psychosocial competence in health care centers and school health services.	Aim: to increase recruitment and strengthening of psychosocial competence for target group.	Employees in health care centers and school health services. Directorate of Health.	2003-2006. Continued
Development of social skills and prevention and management of problem behavior.	Aim: to increase knowledge and guidance by providing comprehensive material about students with serious behavioral problems. Available in printed and electronic form. Also available on a website.	Children, Municipalities, counties and schools. Board of Education.	2003 onwards.
Preventive support measures for and with young people.	Aim: to increase young people's knowledge, insight and opportunity to master their life situation. Peers used as a preventive mental health care resource.	Schools and youth houses. User.	Implemented and evaluated in 2003. Continued

Program name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Increasing competence for school managers.	Aim: to increase knowledge and guidance.	School managers. Ministry of Education and Research.	2003 onwards.
Development and evaluation of models for comprehensive services for children and youth.	Aim: to increase prevention and strengthen services. Model for working with children and families in an interdisciplinary and coordinated way in family centers.	Families and employees in services. Directorate of Health in collaboration with the Board of Education and Ministry of Children, Equality and Social Inclusion.	2003-2004. Continued
Workplace (and adults of working age) (Prevention)			
'Faster Back' Programme.	Aim: to 1) shorten the time employees are on sick leave and 2) prevent employees from being sick.	Employees with somatic or mental disorders on, or at risk of being on sick leave. NAV is coordinating agent for the first group, while the regional health trusts for the second..	2007 onwards.
Prevention activities from The National strategy plan for work and physical health. Programmes. (Sorted into different categories as below):			2007-2012.
1) Cooperation and coordination.	Aim: Establishment of guides and follow-up pilots in the NAV-offices.	People with psychological impairments on their way into employment, and employees in danger of falling out of work. Collaboration between Work and Welfare Department, the municipalities and DPS and 'ordinary' work life.	2008-2012.
2) Client participation and self-help.	Aim: to use self-help methods and/or alternative treatment for people who need to strengthen their mental health.	Public sector. NAV and the National Health Department.	2008 onwards.
3) Measurements and services:	Aim: to tailor public services to peoples' needs. so people with mental impairments are included in working life	People with variable or reduced working capacity.	2008-2011.
4) Competence, network, information and attitude.	Aim: to prevent and strengthen the workplace using courses.	Working people in general. NAV, Department of Health and Social Services,	2008-2012.

Program name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
		and The Norwegian Labour Inspection Authority.	
Schools and young people (Promotion)			
Health Promotion in secondary and high school/youth colleges.	Aim: to achieve good health and healthy lifestyles for everyone at school.	Health Promotion Centre, University of Bergen, Directorate of Health and Board of Education.	2004-2006.
Development for strengthening of childhood environment.	Aim: to strengthen and further develop the local growing environments through a broad range of partnerships between public and volunteer organisations.	Children and families. Ministry of Children, Equality and Social Inclusion	1998-2004, extension to be considered.

Investments into mental health – health, education, social development and economic growth

Examples of investments with budgets are reported below in 'Establishing and testing of different models for psychological municipalities services' and 'Children of parents with mental disorders or substance abuse – a political challenge'.

Initiatives to strengthen mental health systems in relation to MHP and PMI

Governmental view and strategies towards mental health promotion and prevention:

Establishing and testing of different models for psychological municipalities services that shall contribute to early mental health promotion/prevention and treatment (adults, children/adolescents). Period 2010 – 2012. Financial support 15 million Norwegian Kr for 2011 to municipalities who wants to try to develop these services.

A new plan for services to people with dementia. The Care Plan 2015, which summarises the Norwegian Government's strategy for meeting current and future challenges. The Government recommends strengthening research related to care services and the elderly's health and living conditions, with special focus on dementia. The government has set as an objective that all municipalities shall have day services for people with dementia from 2015 (approx. 5,000 persons). This will be a legislative demand and the government will give financial support from 2012.

The strategic plan for children and young people's mental health (2003). Including both mental health services but also mental health promotion and prevention.

Children of parents with mental disorders or substance abuse According to the action plan against poverty, the Government has implemented measures to ensure that these children are identified in a more systematic way and followed-up when needed. It is important that our measures have a direct positive effect on the children concerned.

National Strategy for Work and Mental Health (2007-2012). The Norwegian authorities have embarked upon a wide-ranging programme to help more people suffering from mental health problems to join or rejoin the workforce. This includes The Job Coping Centre as one measures to achieve this. The use of cognitive behavioural techniques when counselling people with mild to moderate anxiety or depression shows promising results in helping them return to and cope with the workplace.

Report "Better safe than sorry..." Mental health: Health promotion and preventive measures and recommendations" has been prepared by the Norwegian Institute of Public Health on behalf of the Ministry of Health and Care Services . It recommends 50 different preventive measures to promote mental health.

Governmental policy for older people. Mental health services for older people, including those in long-term institutions, are underdeveloped, due to the frequency of mental health problems in this group and the lack of knowledge in this area. There will be increased initiatives to strengthen this area in the future by developing:

- Mental health services for elderly people living in long – term care facilities. This includes meaningful activities and cultural activities.
- A national strategy for specialized mental health services and care to elderly (in special wards in hospitals and DPS).

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4.22 Poland

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Summary

- Inpatient care facilities are mostly located in mental hospitals, although there are a significant number of psychiatric departments in general hospitals.

- There is a lack of diverse community mental health services in many regions. Despite an increase in the quantity of day treatment facilities during the last decade, there are still residents in large cities with no access to community mental health care.

- The concentration of beds in large psychiatric hospitals means that facilities are unevenly distributed. This sometimes leads to geographically long distances between patients' homes and hospital.

- Other problems include insufficient knowledge and skills among general practitioners and limited access to treatment for alcohol addiction.

- A number of prevention activities are to be found in schools. These are locally funded programmes however and tend not to be theoretically and empirically informed. Workplace activities are virtually non-existent as is work in mental health promotion and prevention with the older people.

Data for this country profile were gathered in the first instance by the project's country collaborator for Poland. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Poland. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	38,200,037
Population density Inhabitants per km² (2009)	122
Women per 100 men (2011)	107.1
GDP PPP (2010)	2.4
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	64.1
Standardised Suicide rate per 100,000 inhabitants	15.8
Gallup Wellbeing index (2010)*	
Thriving	28
Struggling	61
Suffering	10

* Reprinted with Permission of Gallup, Inc.

Mental Health Legislation and Policy

Current update and reference to prevention and promotion

In Poland the basic legislation that prioritises mental health promotion and prevention of mental illness (MHP and PMI) is The Mental Health Protection Act (1994, with later amendments), which endorses three main areas of activity:

- mental health promotion and prevention of mental illnesses,
- assurance of comprehensive and universal mental health care and other form of services indispensable for life in family and social environment,
- modelling adequate social attitudes, especially based on empathy, tolerance and kindness, toward mentally ill people and prevention of their discrimination.

Based on this Act, The Ordinance of the Council of Ministers was prepared to initiate the process of organising and providing mental health promotion and prevention of mental disorders (issued 1996). The Ordinance was an official governmental document that provided information on the types of public institutions were responsible for the implementation of mental health promotion and prevention of mental disorders, and the basic objectives in these two areas. A Committee for Mental Health Promotion was appointed (in 1997) by the Ordinance to develop national programmes on mental health promotion and prevention, to monitor their implementation on the national level, to initiate research projects in these areas, and to express opinions on official documents and governmental plans. The Committee, in 2001, prepared the draft project of the national programme which was finally accepted in December 2010.

There is also legislation regulating mental health activities in specific areas, including:

An Act on Upbringing in Sobriety and Counteracting Alcoholism (1982, later amendments), which give formal basis for The National Programme for Preventing and Resolving Alcohol-Related Problems. The current Programme, for the years 2011-2015, is a basic document of governmental administration providing for the significant objectives, strategies and methods of the State policy regarding alcohol-related problems and specific objectives for several ministers and district administration. The programme sets out seven objectives (e.g. reduce alcohol consumption by teenagers, to reduce health risks caused by alcohol abuse) and several strategies (e.g. constructing an effective legal and public control over harmful behaviour of people abusing alcohol, supporting activities of self-help groups).

The Act on Counteracting Drug Addiction (1997, with later amendments) and the National Programme for Counteracting Drug Addiction for the years 2011-2016 provides a basis for activities in the scope of drug prevention. The current programme prioritises prevention, treatment, supply reduction, issues of coordination, and flow of information.

National Programme of Social Maladjustment and Delinquency Prevention among Children and Adolescents (2003), outlines the framework and directions of activities undertaken by particular ministries, local self-government agencies, and NGOs. with the aim to prevent further increase in social maladjustment (including delinquency) among children and adolescents, and to reduce drastic manifestations of social maladjustment, particularly those involving threat to health and life of children and adolescents. Prevention of juvenile delinquency and social maladjustment in children and adolescents includes a system of integrated activities to eliminate risks to a correct development of the child, by providing children with: satisfactory living conditions, normal course of the process of education and upbringing, a sense of safety, acceptance, and subjectivity, as well as a possibility of their active participation in culture and spending their leisure time in an appropriate way. Moreover, children's rights should be observed.

Act on Social Assistance (2004) and Social Policy Strategy for years 2007-2013 deals with the issue of support for families in upbringing and educating children, care over older people, prevention of social exclusion and activation of disabled people. This is the most important Act concerning MHP and PMI for older people. It underline the need for development of community-based system to integrate older people

Act on Preventing Home Violence (2005), sets tasks aimed at counteracting domestic violence; the scope of assistance to victims of domestic violence; and the scope of sanctions on perpetrators of domestic violence.

Social Policy Strategy for years 2007-2013 (2005). One of the priorities declared in this document is "Creation of environment enhancing social integration in the aging population" which includes e.g.: developments of nursing system and specialist care for older people, elicitation and integration of older people within the local communities. In the frames of this Strategy, local governments design their policies regarding functioning of long-term care facilities for older people.

All, above mentioned, legislations are complimentary and congruent with EU and WHO regulations.

Mental health policy and inclusion of prevention and promotion

The National Programme on Mental Health Care was proposed in 2008 as an amendment to The Mental Health Protection Act. During the following two years this regulation was not implemented. Finally in December 2010 the National Programme was accepted by The Ordinance of the Council of Ministers and outlined for the implementation. This Programme defines strategy of interventions (activities) aimed at decreasing risk of mental health hazard, improving quality of life of individuals with mental health disorders and their relatives and providing access to health care services. The National Programme on Mental Health Care is designed to be implemented from 2011 to 2015. The main objectives of this Programme are to:

Promote mental health and prevent mental disorders

Provide individuals with mental disorders with comprehensive and common (widespread) health care service and other forms of care, which are essential for living in family and social environments.

Conduct research and develop information system in area of mental health.

The anticipated results of implementing this national mental health care programme are to:

- Share knowledge on mental health, to develop behaviours and life style advantageous for mental health, to develop skills needed to cope with situations dangerous for mental health
- Prevent mental disorders
- Enhance social integration of people with mental disorders
- Organise system of counselling and care during psychical crises
- Popularise community-based mental health services
- Implement various forms of care services and social support
- Encourage people with mental health disorders to job search
- Coordinate different forms of metal health care services
- Conduct cross sectional and long term epidemiological studies focusing on groups at risk for development of mental health disorders

- Promote and support research in the field of mental health
- Upgrade and extend the utilization of medical statistic systems
- Evaluate efficacy of the National Programme on Mental Health Care

The acceptance of the National Programme on Mental Health Care marked an important step forward, particularly after almost 10 years since the draft version was introduced. However, some of the solutions included in the programme appear insufficient, e.g. the Programme focuses on the prevention of mental disorders and underestimates the importance of mental health promotion. The planned budget (about €4 million per year) is not enough for implementing all of the programme's tasks. More importantly, even this limited budget in reality is not available (it remains a plan only).

Mental health services

Organisation and functioning of mental health systems

In 2009, the following types and number of mental health services available included:

Inpatient care facilities:

- mental health hospitals (n=289)
- general hospitals with psychiatric and/or alcohol/drug treatment departments (n=114)
- alcohol treatment/rehabilitation centres and drug treatment/rehabilitation centres (n=77)
- long-term care/treatment facilities (n=45).

The number of inpatient beds per 10,000 population includes:

- 4.5 beds for adults people with mental health disorders
- 1.9 beds for people with addictions
- 0.3 beds for children and adolescents
- 1.3 beds for long term care
- 0.3 bed for forensic psychiatry

Outpatient care facilities:

- psychiatric clinics for adults (n=1109)
- psychiatric clinics for children and adolescents (n=178)
- alcohol treatment clinics (n=471)
- drug treatment clinics (n=104)
- psychological counseling centres (n=262).

Intermediate/community care facilities:

- day treatment/ care units (n=259)
- mobile community teams/mental health centres (n=45)
- hostels (n=12).

These include home visits by mental professionals and crisis intervention services. Facilities outside the health sector providing care of children and adolescents at risk funded by the Ministry of Education include:

- Youth Centres of Socio-therapy (n=61) designed for adolescents with emotional problems, school failure and/or socialization problems. 68% of adolescents are referred by the family and juvenile courts, the other 32% – by parents or mental health care services.

- Youth Centres of Re-socialization (n=74) for adolescents who have serious conduct problems or committed a crime (with different delinquent behaviors). There is no available information about the financial resources allocated to them.

Children and adolescent services funded by local governments include:

- Day care rooms with socio-therapeutic programme (n=1,759) designed for children and adolescents from risk groups, e.g. parents at high risk of alcohol problems development. The main goal of this institution is to develop and to strengthen life skills of children and adolescents. In 2009, local governments spent about 38,500,000 PLN (about €9,600,000) for this kind of socio-therapy centres providing care for more than 68 thousands children/youth at risk (for more information see "Mental health prevention activities" section).

- Day care rooms with educational programme (n=5,750) designed for children and adolescents from low-income families, not sufficiently supervised by family members, with some school and/or socialization problems. In 2009, in all regions in Poland, this type of facility provided day care activities for more than 218 thousands children/youth. Local governments spent about 75,200,000 PLN (about €18,800,000) for this kind of places.

A comprehensive information system related to mental health promotion and prevention is not available. Some information exists on the different forms of treatment for people with mental health problems and alcohol / drug related disorders in the health sector.

Access and usage

Since 1991 general practitioners provide the gate-keeping function for referral into specialist mental health services. The number of people being treated by facilities for inpatient, outpatient, day treatment/ care units and mobile community teams are reported below. Figures are provided by primary diagnosis (2009):

Facility	Number of patients	Rate per 100 000 population
Inpatient	208,977	547.7
Outpatient	1,388,191	3,638.4
Day treatment/care units	24,037	63.0
Mobile community teams	6,157	Not reported

Variation and gaps

- There is a concentration of inpatient beds in large psychiatric hospitals. This has resulted in an uneven distribution of psychiatric facilities and geographical distance between the majority of large hospitals and patients' place of residence.
- Qualified staff are unevenly distributed across the country and between services.
- There is an enormous lack of diverse forms of community care in many regions of the country. Despite significant increase in number of day treatment care facilities in the past 10 years, citizens of many large cities often do not have access to this form of care. The work of Mobile community teams' is relatively small in scale.
- There is limited access to effective and comprehensive forms of treatments for alcohol addicted patients.
- There is a lack of knowledge and skills among general practitioners and other consultants concerning diagnosis of alcohol related problems, affective disorders, depressive, organic mental disorders, and running crisis intervention and short term interventions for patients, whose alcohol use is risky or harmful.
- Many chronic patients are hospitalized because of social and welfare issues.

Financing:

Mental health expenditures by the government health department/ministry are 5.08% of the total health budget (World Health Organization, 2011). Mental hospital expenditures are 72.97% of the total mental health budget. The primary source of funding for mental health services is via taxation expenditure (or public insurance), particularly for inpatient services. Institutions outside the health sector providing funding for care of children and adolescents at risk are the Ministry of Education and local governments.

In 2009, a total of 1,944,000,000 PLN (€486,000,000) or 3.4% of the overall budget was allocated to the National Health Fund (NFZ) for all forms of medical care. More specifically, financial resource allocations to health care services were:

inpatient care facilities - 1,436,400,000 PLN (74%)
outpatient care facilities – 368,900,000 PLN (19%)
intermediate care facilities – 138,800,000 PLN (7%)

No other funds are available for mental health promotion and for prevention of mental illnesses.

Workforce

Figures reported from Central Statistical Office, Institute Psychiatry and Neurology (2009) on the number of staff working within mental health services include:

Outpatient care facilities in 2009:

Psychiatrists	1,370
Psychiatric Nurses	958
Psychologists	1,494
Other Relevant Staff (e.g. psychotherapists, support staff, etc.)	954

Inpatient care facilities in 2009:

Psychiatrists (mental hospitals, alcohol/drug treatment departments, alcohol treatment/rehabilitation centres and drug treatment/rehabilitation centers)	835
Psychiatrists (general hospitals with psychiatric and/or alcohol/drug treatment departments)	934
Number of nurses (general hospitals with psychiatric and/or alcohol/drug treatment departments)	2,269

Estimated number of psychiatrists, psychiatric nurses, psychologists and other relevant staff based on information about full-time work in Inpatient care facilities in 2008, published by the Ministry of Health, 2011):

Psychiatrists	Circa. 1,000
Psychiatric Nurses	Approx. 5,500
Psychologists	Approx. 800
Other Relevant Staff (e.g. psychotherapists, support staff, etc.)	Approx. 800

Responsibility and delivery of mental health promotion and prevention of mental illness

Although there is no formal governmental policy for mental health promotion and prevention of mental illness, what investment that exists is carried out by local authorities.

Mental health status

Prevalence of mental health in the population

Figures for the prevalence of mental health in the population are not reported. The Institute of Psychiatry and Neurology (IPiN) and the Department of Health Services Organization collect and process data annually on incidence and prevalence mental health disorder registered in psychiatric facilities. Data from inpatient and outpatient facilities, day care units and mobile teams cannot be calculated given the likelihood of double counting patients receiving treatment by different services in the same year. Figures below for inpatients and outpatients only are based on the Mental Health Statistics yearbook which was published by IPiN in 2011 and contains data related to year 2009.

In 2009 inpatient care facilities provided treatment for 208,977 patients (547.7 per 100,000 population). The table below lists the number of people treated in inpatient services by psychiatric diagnosis according to ICD-10 codes.

Diagnosis	Number of patients	% of inpatients
Organic mental disorders (F00-F09, including dementia)	30,395	14.5%
Alcohol induced psychosis (F10.4. F10.5. F10.6)	9,647	4.6%
Other substance induced psychosis (F12.4-F.19.4. F12.5-F19.5. F12.6-F.19.6)	492	0.2%
Schizophrenia (F-20)	34,282	16.4%
Schizotypal and delusional disorders (F21-F29)	9,972	4.8%
Mood (affective) disorders (F30-F39)	17,913	8.7%
Neurotic, stress-related and somatoform disorders (F40 –F48)	15,338	7.3%
Conduct disorders (behavioural and emotional disorders with onset usually occurring in childhood and adolescents (F90-F98)	3,695	1.8%

Almost 1.4 million of people (1,388,191) received psychiatric treatment in outpatient mental health facilities (3,638.4 per 100,000 population). The following table lists the figures by diagnosis:

Diagnosis	Number of patients	% of inpatients
Organic mental disorders (F00-F09)	199,872	14.4%
Alcohol induced psychosis (F10.4. F10.5. F10.6)	2,939	0.2%
Other substance induced psychosis (F12.4-F.19.4. F12.5-F19.5. F12.6-F.19.6 – without F17)	679	0.04%
Schizophrenia (F20)	132,697	9.6%
Schizotypal and delusional disorders (F21-F29)	50,951	3.7%
Mood (affective) disorders (F30-F39)	253,895	18.3%
Neurotic, stress-s related and somatoform disorders (F40 –F48)	339,367	24.4%
Conduct disorders (behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)	52,724	3.8%

Incidence

Annual number of persons who receive treatment for the first time in their life is considered an indicator of registered incidence.

In 2009 among 208,977 of persons treated in inpatient care facilities, 86,233 (41%) were patients who received treatment first time in their life. The table below presents the figures according to diagnosis:

Diagnosis	Number of patients	% of inpatients
Organic mental disorders	11,926	39.2%
Alcohol induced psychosis	4,809	49.8%
Other substance induced psychosis	232	47.1%
Schizophrenia	5,409	15.8%
Schizotypal and delusional disorders	3,341	33.5%
Mood (affective) disorders	5,996	33.5%
Neurotic, stress related and somatoform disorders	9,475	61.8%
Conduct disorders (behavioural and emotional disorders with onset usually occurring in childhood and adolescence)	2,354	63.7%

In 2009, approximately 28% of all outpatient attendees (389,351) received treatment for the first time in these facilities. The figures by diagnosis are reported in the table below:

Diagnosis	Number of patients	% of inpatients
Organic mental disorders	43,262	21.6%
Alcohol induced psychosis	851	29%
Other substance induced psychosis	215	31.2%
Schizophrenia	15,825	11.9%
Schizotypal and delusional disorders	7,926	15.6%
Mood (affective) disorders	56,057	22.1%
Neurotic, stress related and somatoform disorders	110,916	32.7%
Conduct disorders	21,366	40.5%

Protective and risk factors

Youth Centres of Socio-therapy, Youth Centres of Re-socialization and Day Care Rooms offer the following protective initiatives:

Activities of Youth Centres of Socio-therapy reduce risk of poor adaptation of their students in public schools.

Activities of Youth Centres of Re-socialization reduce risk of their students being social maladjusted.

Activities of Day Care Rooms with Socio-therapeutic programme reduce risk of poor academic achievement and social skills.

According to data of the European Foundation for the Improvement of Living and Working Conditions, in comparison to older EU Member States (EU15) people in Poland are exposed to higher number of macro-stressors such as: poverty and unemployment (particularly among young people) and socio-economic stratification. Results of the Second European Quality of Life Survey (EQLS) conducted by the Foundation, showed that the level of subjective well-being measured by life satisfaction, happiness and fulfillment of life, is lower among Poles than among citizens of EU15, however, higher than among people living in other New Member States (NMS12). Research conducted by Public Opinion Research Centre among representative sample of 1,107 Polish adults showed that results of the EQLS are similar to respondents' perception. Study participants felt that the most threatening risk factors for

mental health problems are: unemployment, poverty, family crisis, substance abuse, uncertainty of the future, conflicts, bad terms with other people and hectic lifestyle.

For those with existing mental health problems other risk factors include:

- insufficient number and uneven distribution of modern outpatient and inpatient facilities,
- insufficient number of mental health professionals,
- insufficient financial resources – including limited access to the new pharmacotherapy,
- lack of social policy related to mental health,
- isolation and stigmatization of mentally ill people.

Prevention and promotion programs/activities

Prevention activities

Schools (children and young people)

A number of universal and selective prevention programs, especially in the area of alcohol and drug use, have been implemented in Poland over the last five years. Most programs, however, are not theoretically or empirically informed. Interventions implemented in schools and in communities are often based on personal or group ideologies (e.g. sobriety groups). The system of providing preventive activities in school is decentralized in Poland. Schools are responsible for choosing preventive activities based on its own needs assessment. Local authorities are the main source for funding school-based preventive activities.

Workplace

There are no systematic approaches to the prevention of mental disorders (or promotions) in the workplace. In the past five years there were only single cases of workplaces implementing a programme, mainly concerning coping with work-stress. There is also a project involving military and other "uniform" services (police, board guard, etc.) designed to solve alcohol related problems. Information on this is sensitive and therefore not publically available.

Prevention activities for older people in long-term care facilities

There are no special activities designed to prevent mental illness among older people. Only one example exists. In accordance with the National Programme of Domestic Violence Prevention, 2010 was proclaimed a year of violence prevention towards older and disabled people and a special campaign was implemented. As part of this campaign, guidelines for social and health care workers concerning prevention of violence and

supporting victims were elaborated, published and distributed in all Polish local communities.

Universal prevention

A 2010 survey by the State Agency for Prevention of Alcohol-Related problems (PARPA) indicated that the use of well informed and effective alcohol and drug prevention programmes in Poland is currently limited. The most popular prevention activities implemented for school-aged children and young people in 2009 with financial support of local authorities were:

- Outdoor events (e.g. picnics, family parties, local community events), about 780,000 participants
- Local programmes (invented or adapted by a teacher, school pedagogue or local NGO) implemented usually without any evaluation, about 720,000 participants
- Live professional theatre productions in schools, about 680,000 participants
- Traditional lectures, movies or presentations, about 430,000 participants
- Sport events, about 370,000 participants
- Contests for students, about 235,000 participants.

These kind of activities implemented as alcohol/drug/aggression (and other youth risky behaviours) dominate universal prevention in Poland. In 2009 local authorities invested 28,400,000 PLN (€7.1 million) to support them. No evaluation results are available except basic information on participants attendance.

The use of recommended prevention programmes (best practice programs) is again limited. Generally, these types of programmes are more challenging for schools, more expensive for local authorities, more time-consuming for teachers or other school staff. In 2009 about 200,000 children and young people participated in recommended prevention programmes (PARPA Survey, 2010). Local authorities invested 3,600,000 PLN (€0.9 million) for well-informed prevention activities. A prevention programme called **"Spojrz inaczej"** ("Have a second look") is a leading programme in Poland. It is estimated that a third of local community funds were spent on recommended programs.

Examples of Prevention activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Spojrz inaczej (Have a second look) programme	Aim: to support student's emotional and social development and adjustment. To strengthen student's life skills, and build health-oriented	Children in primary schools, middle schools, local authorities, school authorities, teachers, centres for youth at risk.	20-25 sessions in each grade of primary and middle education. Cost not reported.

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	behaviors and awareness.		
Selective/indicated prevention	Approach: Socio-therapy combining group therapy techniques, social support, life skills training and counselling.	Children, youth at risk of conduct problems, school failures. Families at risk, especially through alcohol problems.	Not reported
Workplace			
Mental Health Promotion in the Workplace Programme	Aim: to support employers to ensure secure and hygienic work environment, especially good psycho-social conditions. To reduce incidents of illnesses and costs of treatment related to work stress and burnout. Approach: Development of diagnostic instruments (stress inducing factors, stress level, current MHP /PMI activities, readiness for change, financial support for PMI/MHP activities), Training of MHP'PMI leaders in recruited (volunteering) workplaces.	At district level: National Centre for Health Promotion in Workplace, Bydgoszcz University, Regional (Torun) Centre for health Promotion in Workplace, workplaces from Kujawsko-Pomorskie district, media, local government At workplace level: Board of Directors, management, employees, occupational health service, trade unions.	2009-2011 app. 300 000 PLN (75 000 €), 2012 – 127 000 PLN (32 000 €) Duration not reported.

Promotion activities

Schools (children and young people)

No systematic mechanism to support the implementation of mental health promotion programmes in schools. The concept of mental health promotion is not well defined and hardly known by school authorities, school principals and teachers. One project, however, *Health Promoting Schools*, supports general health promotion (including mental health) in participating schools. Currently, more than 2000 schools from all sixteen regions in Poland joined this project. This is a part of the *Schools for Health in Europe Network*.

Most of the activities in this field are incidental. However, there are a few school-based programmes that are focused clearly on students' mental health promotion. Among them is a Polish adaptation of a British programme called "Zippy's Friends".

Workplace (adults of working age)

See prevention activities listed above.

Older people in long-term care facilities

None found. The Ministry of Work, only supports projects (conducted by various NGOs) designed to promote work activity of people aged 50+ (designed mainly for people of working age). There are Universities of the Third Age (U3A), usually affiliated within academic institutions which promote lifelong learning and development. Their long-term aim is the intellectual and social activation of older people. The students of U3A take part in lectures, workshops, additional classes and trips. Another initiative concerning lifelong learning is the Grundtvig Programme implemented in Poland since 2000. The project supports U3A, as well as, local initiatives and cultural institutions.

Another institution which may be considered as a "project or programme" supports seniors' mental health and helps them stay active are Community Clubs for Seniors. They are organised and financed mostly by local communities, Polish Red Cross or other NGOs (which in fact are sponsored by local communities). Community Clubs provide social activities and social support for individuals and families facing difficult situations.

Examples of promotion activities:

Schools			
Przyjaciele Zippiego (Zippy's Friends)	Aim: to promote children's emotional health by strengthening coping and social skills. Approach: Based on coping skills training. To build resilience in adolescent and adult life.	Children of 5-8 years in primary schools and kindergarten, teachers, parents.	Programme runs for 24 weeks, with one 45-minute session per week. Cost not reported.

Investments into mental health – health, education, social development and economic growth

In 2009 local communities, administrating approximately 99% of funds in Poland for alcohol and drug prevention spent about 345,000,000 PLN (€86,000,000) on activities for children and adolescents. No investment is reported for the workplace. For older people, the data is for the Grundtvig Programme (EC funds) with a 2011 investment of €3,123,000.

Initiatives to strengthen MH systems in relation to MHP and PMI

No initiatives to strengthen mental health systems in relation to prevention and promotion were identified.

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4.23 Portugal

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Summary

- There are five remaining psychiatric hospitals with plans for two further closures in the near future.

- Basic care is provided by local mental health services located in general hospitals.

- A range of community mental health services are available. Alcohol and drug abuse assistance is offered through separate agencies.

- The distribution of human resources across Portugal is highly uneven with a much higher concentration of mental health professionals located within the three major cities.

- Mental health prevention and promotion activities are scarce but future action is being considered across a wide range of areas including stigma, social exclusion, depression, suicide and alcohol and drug abuse. There is an increase in NGO involvement in mental health but has not included prevention and promotion activity.

Data for this country profile were gathered in the first instance by the project's country collaborator for Portugal. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Portugal. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	10636979
Population density Inhabitants per km² (2009)	115.5
Women per 100 men (2011)	106.7
GDP PPP (2010) 0.8	
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	58.6
Standardised Suicide rate by 100,000 inhabitants	7.8
Gallup Wellbeing index (2010)*	
Thriving	22
Struggling	61

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

The legal framework concerning mental health and currently being applied is the:

- Mental Health Act (Act nº 36/1998) - a national law approved by the Assembly of Portuguese Republic. This Act establishes general principles of mental health policy, patients' rights and duties and rules for compulsory detention of persons suffering from mental disorders. Article two refers to the protection and promotion of MH and recommends primary, secondary and tertiary activities for preventing mental illness (PMI), and those, which contribute to the promotion of populations' mental health (PMH). The Act has no specific measures for PMI and PMH just general principles.

Article three of this act is about general principles of MH policy:

- The provision of mental healthcare is primarily undertaken at the community level, to avoid the displacement of patients from their familiar environment and facilitate their rehabilitation and social integration;
- Mental healthcare is provided in the least restrictive environment possible;
- The treatment of mental patients on an inpatient basis, is usually in general hospitals;
- The care of patients who require psychosocial rehabilitation, is preferably undertaken in residential structures, day centres and training and professional rehabilitation units, that are part of the community and adapted to the patient's specific degree of autonomy. Article four sets the National Council of Mental Health as the Government's advisory body for MH policy, with the representation of entities interested in the functioning of the MH system, namely family and patient associations, health

subsystems, mental health professionals and government agencies with related fields of activity.

Legislative / legal order (49 / 2008, Ministers Council decision) approved the National Mental Health Plan (2007-2016) and the creation of the National Coordination Body for Mental Health in the High Commissariat for Health. In 2008 this Body was authorised to implement the National Mental Health Plan (NMHP 2007-2016). According to the new structure of the Ministry of Health (Legal Order 124/2011, 29 December 2011), on the 3rd January 2012 the coordination of the National Mental Health Plan became the responsibility of the "National Programme of Mental Health", a body integrated in the General Directorate of Health.

Mental Health (MH), including also the areas of promotion and prevention is a priority field in the National Health Plan in Portugal (2004 to 2010) approved by the Ministry of Health and the Council Ministers.

The Portuguese government, in 2005, at the Ministerial Conference of the countries that belong to the European Region of World Health Organization, held in Helsinki, endorsed the final declaration, "Facing the Challenges, Building Solutions" (Helsinki Mental Health Action Plan 2005). After, in the context of the European Commission was developed the Green Paper (EU 2005) "Improving the Mental Health Population. Towards a Strategy on Mental Health for the European Union ", which recommended a particular attention to MH problems and where the needs are important, to develop and implement MH national plans.

In 2006 the Portuguese Ministry of Health created a new National Commission for MH, to develop a new mental health policy and plan. This National Commission requested support from the World Health Organization and developed the National Mental Health Plan (NMHP, 2007 - 2016).

Mental health policy and inclusion of prevention and promotion

The NMHP (2007-2016) has been developed with the following objectives:

- Reduce the impact of mental disorders and contribute to the promotion of mental health of the population;
- Ensure equal access to quality care for everyone with mental disorders in the country, including those belonging to especially vulnerable groups;
- Promote and protect human rights of people with mental disorders;
- Promote the decentralization of mental health services, so as to enable care provision closer to people's homes and to facilitate greater participation by communities, people with mental disorders and their families;

- Promote the integration of mental healthcare into the general health system, at the primary care level and in general hospitals, so as to ensure continuity of care and facilitate access and reduce institutionalization.

Regarding PMI and PMH the NMHP (2007-2016) includes plans for the development of prevention and promotion activities (based on the document of the European Network for the Promotion of MH and the Prevention of Mental Disorders (EU, 2006) and the following strategies are encouraged (NMHP):

- Programmes for early childhood, including prenatal counseling, early intervention, parental training, prevention of domestic violence and infant abuse, family interventions and conflict resolution.
- Education programmes on mental health at school age, teacher awareness, prevention of youth violence, counseling for children and adolescents with specific problems, prevention of drug abuse, personal and social development programmes, prevention of suicide and eating disorders.
- Employment and mental health promotion policies in the workplace, reduction and management of work and unemployment related stress factors, reduction of absenteeism cause by psychiatric illness.
- Prevention programmes for depression, anxiety and suicide, telephone help lines for isolated people, restriction of access to means of suicide.
- Policies for fighting poverty and social exclusion, support measures for families at social risk or families with multiple problems and for the homeless, impact assessment of social policies in mental health and policies for the fight against stigma.
- Awareness and information in diverse sectors, such as primary care, schools, recreational centers, workplaces, television programmes, the Internet and the media.

Mental health services

Organisation and functioning of mental health systems

The organisation of MH services in Portugal is based on the following scheme (Portugal, World Health Organization Country Summary, 2009):

- The mental health services are organised by level (local, regional) and are connected with one another via the Hospital Referral Network, which also uses a “catchment area” model to ensure links with the primary health care centres (PHCC);
- The basic care-providers are the Local Mental Health Services. They are located in departments belonging to general NHS hospitals. They also incorporate specific teams to provide child and adolescent psychiatric care;

- There are currently five *psychiatric hospitals,* in which the number of places has been progressively falling. The latest psychiatric hospital closure was in 2011 with plans to close two more in the near future. These hospitals provide outpatient and inpatient care, and long-term care for people with severe and enduring mental illness;
- There are three *forensic units*, which are located in psychiatric hospitals and together contain a total of 135 beds;
- The area of drug addiction assistance is provided by a specific body, the Institute for Drug Dependence (IDT). It does not formally work in conjunction with MH services;
- Care in the alcohol-misuse field is provided by *alcohol-abuse intervention* units (local level), which operate in conjunction with the three *Regional Alcohol Abuse Centres,* also belonging to IDT, in the Northern, Central and Southern of Portugal.

Facilities and human resources (data available of 2005, before the approval of the NHMP (2007-2016) included the following:

- The majority of resources are concentrated in the three major Portuguese cities (Lisbon, Oporto and Coimbra) with much less allocation of resources in other parts of the country. The psychiatric hospitals still consumed in 2005 the majority of resources (83%), despite evidence indicating that community based services are more effective (Caldas de Almeida and Killaspy, 2011).
- Other data: (Portugal, World Health Organization Country Summary, 2008 with data from 2005):
- Long Stay Facilities: Six public psychiatric hospitals, in Porto, Lisbon and Coimbra, with a total of 1,713 beds available. Of these beds, 1,109 were for long-term inpatients and 604 were for acute patients. They are responsible for catchment areas with a total population of 2,222,618 (39,929 patients). The occupancy rate was 63% for acute patients and 79% for long-term patients. Of the total number of people receiving treatment and care (168,369 people - 1.7% of total population) only 24% attended facilities in psychiatric hospitals (first attendance rate: 9%).
- Psychiatric Services in General Hospitals: Portugal (mainland) had 30 Local Mental Health Services belonging to general hospitals (of these, 26 have inpatient units and 4 do not), with a total of 1,010 beds available. Of these beds 255 were for long-term inpatients and 755 were for acute. These services are responsible for catchment areas of a total population of 7,646,725 (118,838 patients).

Data from 2011 (Ministry of Health) show that significant changes took place since the beginning of the implementation of the National Mental Health Plan:

- One of the two Lisbon psychiatric hospitals (Miguel Bombarda) was closed down
- The number of beds in psychiatric hospitals reduced from 1,713 to 1,015

- The number of psychiatric services in general hospitals increased from 30 to 35

Despite the fact that there is no data available about treated prevalence, family doctors provide care to people with common mental health disorders several local mental health services belonging to general hospitals deliver outpatient care in the Primary Health Care Centres (PHCCs).

Informal Community Care / NGOs / Non statutory healthcare providers

Portugal has seen a major increase in the number of NGOs working in mental health since the 1990's. There are 62 organisations including consumers (3%), families (13%), mental health workers (30%) and mixed groups, involving each of the above mentioned groups (54%). The main activities of these NGOs are: involvement in policy making, advocacy for patient's rights, public awareness and psychoeducation, promoting cooperation and partnerships and also supported employment. The cooperation with the Portuguese Public Employment Services which began in the early 90's allowed NGOs to substantially invest in supported employment, which represents the most significant activity of the majority of these organisations. Supported employment includes professional training, help in seeking employment and support for employees. The government does not directly support NGOs but gives financial support to companies that employ people with mental health problems and also gives financial support for residential, social and occupational units. Other current important interventions by NGOs include social support, counselling, individualized support, family support, social skills training, leisure and occupational activities.

A recently established National Programme of Integrated Continuous Care 2011-2013 (a joint venture between Ministry of Labor, Social Solidarity and the Ministry of Health) aims to offer integrated services to all patients suffering from chronic illnesses and disability who have health and social needs.

Access and usage

The first point of contact is the general practitioner or family doctor situated in a primary care centre where the patient is registered. The GP acts as gatekeeper for referral on to specialist treatment. In order to shorten delays in obtaining a consultation however, it is theoretically possible to attend emergency departments though this would be for acute symptoms in general health.

The total adult outpatient attendances in 2005 were 350,935 and child and adolescent outpatient attendances were 34,266. The first attendances rate in Mental Health Services in General Hospitals was 12%.

Variation and gaps

The distribution of human resources is hugely unequal, with a high concentration of psychiatrists in the three major cities of Portugal and a discrepancy of distribution in

Mental Health Services within General Hospitals (1.1/25,000) compared to Psychiatric Hospitals (2.6/25,000). This situation is difficult to justify given that only 24% of the total number of patients were treated in psychiatric hospitals and 71% of consultations were carried out in general hospitals. This asymmetry also occurs with other professional groups but is more pronounced for psychiatrists.

Financing

The total mental health expenditure (2005) was calculated at €229,380,764. This is estimated to under 3.5% of the overall health budget (Portugal, World Health Organization Country Summary, 2009); and more recently 5.24% (World Health Organization, 2011). Public expenditure for general health care is mainly from taxation (over 90%). Private expenditure mainly includes out-of-pocket payments; these payments are estimated to be among the highest in Europe. There is no specific budget for mental health, there is some data on costs of mental health services.

Workforce:

Data for mental health professionals in Portugal is listed in the table below. More recent figures show that the number of psychiatrists in 2009 has increased to 10.2 per 100,000 population (OECD Health Data 2011).

Mental Health Workers	Number working in mental health services	Per 100,000 population
Psychiatrists	556	5.6
Child Psychiatrists	103	1.1
Neurosurgeons	Not reported	Not reported
Neurologists	Not reported	Not reported
Psychiatric Nurses	1,302	13.2
Psychologists	226	2.3
Occupational Therapists	59	0.6
Social Workers	108	1.1

Source: National Mental Health Report (2007)

Responsibility and delivery of mental health promotion and prevention of mental illness

Responsibility and delivery of mental health promotion and prevention are under the remit of the state. The state's mental health policy, formed in 1995 has components of advocacy, promotion, prevention, treatment and rehabilitation. Mental health and alcohol issues are dealt with by the same department at the Directorate General of Health which is part of the Ministry of Health.

Mental health status

Prevalence of mental health in the population

Prior to (2007-2016) there was no epidemiological study on mental illness and only estimate figures (Eurobarometer, 2003 and Eurobrain Council Report 2005) and some following the 2008/2009 study, as part of the "World Mental Health Survey Initiatives". Preliminary results are available from the Portuguese Mental Health Survey (presented at World Mental Health Consortium Annual Meeting in Lisbon, July 7-11, 2010) include:

An annual prevalence of mental illness in adult population: 22.9 %
A lifetime prevalence of mental illness in adult population: 42.7 %
Specific psychiatric disorders (Mental Health Survey preliminary findings, 2011) show:

DSM IV –R Diagnoses	Annual Prevalence (%)	Lifetime prevalence (%)
Anxiety disorders	16.5	28.5
Depressive disorders	7.9	19.3
Impulse control disorders	3.5	10.0
Alcohol use disorder and dependence	1.6	10.0

Portugal has one of the lowest suicide rates in Europe: 11.1/100,000 (Portuguese Suicidology Society -SPS, 2006). This rate doubled from 1998 to 2003 (it is not clear if this is due to a real increase or to better reporting). The highest rates occur in men and over the age of 75 (68.1/100,000, 2002). Where geographic distribution is concerned, there are significant regional variations in the suicide rate, which is highest in the Southern region of the country, Alentejo, (84.47/100,000). Possible determinants for this phenomenon include age (60%> 60 years old), gender (74% male), widowhood, social isolation, low social class and school level, serious somatic illness and a family history of suicide (Source: Portuguese Suicidology Society, 2006).

Incidence

Not reported

Protective and risk factors

An aging population, urbanisation, migration, poor economic growth, unemployment and the recent economic crisis are reported as risk factors by the World Health Organization country summary for Portugal. No other specific data are reported otherwise, except for the occasional study with limited results and in areas such as drug addiction prevention. Social and family support and improving family skills are sometimes mentioned as protective factors in some studies.

In the National Mental Health survey some socio-demographic factors were significantly associated with increased risk for mental illness; being female, aged between 18-24 years, separated, divorced or widowed and low educational attainment.

Prevention and promotion programs/activities

Programmes and activities for MH promotion (MHP) and prevention of mental illness (PMI) in Portugal are scarce as stated in the National Mental Health Plan (2007-2016) but in the plan there are also some points in this field due for implementation (see previous). In the NMHP, there are recommendations for specific programmes from these plans (as shown in the table below). In the list of "specific" activities and actions related to MHP and PMI, the NMHP (2007-2016) features future action regarding combating stigma, support for vulnerable groups, social exclusion, suicide and depression, alcohol and drug abuse, domestic violence and child abuse

There are few programmes and initiatives for mental health promotion and prevention of mental illness, with limited financial support in these areas. Despite these difficulties there are some good programmes but general take place within the context of research or as local projects. There are a number of professionals with the skills to implement such programmes but more extensive training would be useful.

Prevention and promotion programmes and activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of program
Schools and young people (Promotion)			
Evaluation of a programme for promotion of social and emotional skills in elementary school children	Aim: to evaluate outcomes on self-control, emotional differentiation, emotional regulation, social skills, and self-esteem. Approach: A research intervention by 12 Portuguese councils. The intervention is integrated in school curricular of activities.	Schools, children, local councils.	Four-year study
Health Education in schools	Aim: to teach health education in schools. Approach: Schools choose health education subjects (e.g. life styles, sleep, physical activities, eating, peers and the group, sexuality, violence, family and bullying). Students consult psychologists, teachers or health professionals. Programme implemented in 79% of	Students 1st to 12th grade, health professionals, teachers.	Not reported

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of program
	public schools.		
Social Adventure programme	Aim: to investigate actions in the field of health promotion and social behavior.	Adolescents and school-aged children.	Not reported
Schools and young people (Prevention)			
'WHY' programme	Aim: to improve the recognition, referral and provision of mental health care for depression and suicide risk. Approach: School-based experimental programme on depression and suicide prevention. Runs in three localities near Lisbon.	Adolescents, between 15 and 24 years.	Running since 2009, results expected 2012.
General population (Prevention)			
Optimized Suicide Prevention of suicide Programme	Aim: to provide EU members with evidence based prevention for suicidality. OSPI-Europe is a collaborative action and research project funded by the European Commission under the Seventh Framework Program. Approach: The Programme has five levels of intervention: general practitioner workshop, general public awareness campaign, community facilitator training, support for high-risk groups and their relatives and restricting access to lethal means.		Began 2008, currently running.
The following programmes are recommended for future implementation by the NMHP			
Programmes for early childhood.	Aim: to prevent mental illness. Approach: include prenatal counselling, early intervention, parental training, prevention of domestic violence and infant abuse, family intervention and conflict resolution.	Children, families	Not reported
Education programmes on mental health at school age:	Aim: to prevent drug abuse mental illness Approach: raising awareness among teachers, prevention of youth violence, counseling for	Children and adolescents, teachers.	Not reported

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of program
	children and adolescents with specific problems, prevention of drug abuse, personal and social development programmes, prevention of suicide and eating disorders.		
Programmes for prevention of depression, anxiety and suicide:	Aim: to prevent depression, anxiety and suicide:. Approach: telephone help lines for people living in isolation, and strategies involving restriction of access to common methods of suicide.	General public	Not reported

Financial sources/responsibility for prevention and promotion

Whilst prevention and promotion in mental health lies largely under the remit of the state there is a lack of financial investment in this area. Many programmes and projects that do exist have received international financial support, mostly from the EU and from collaborative cross-national studies. There are a few programmes implemented, that are unofficial, local, experimental, for research or in collaboration with international projects.

Investments into mental health – health, education, social development and economic growth

See above.

Initiatives to strengthen mental health systems in relation to MHP and PMI

The National Mental Health Plan (2007-2016) includes several initiatives for the development of prevention and promotion activities (see above).

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4.24 Romania

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Summary

- Psychiatric care has gradually improved in the past few years following new legislation to enhance access to mental health services and increase the number and access to community-based care.
- There have been steps towards an inter-sectorial approach for delivering mental health care services for people with autistic spectrum disorders and related mental health problems.
- There is an emphasis on pharmacological and a growing interest in psycho-social therapeutic treatment.
- Long-term facilities for older people are poorly represented within mental health infrastructures.
- Low budgeting is a problem along with insufficient psychiatric hospitals and qualified staff. There are additionally, inequalities in distribution of staff and psychiatric beds between different counties
- Promotion and prevention activities are somewhat sparse in Romania. Some activities in schools exist, organised at local level only and there are an indeterminate number of activities carried out by private companies in the workplace.

Data for this country profile were gathered in the first instance by the project's country collaborator for Latvia. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being from Latvia. This expert provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by the Governmental expert and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	21,431,298
Population density Inhabitants per km^2 (2009)	90.1
Women per 100 men (2011)	105.4
GDP PPP (2010)	2.1
Psychiatric care beds in hospitals per 100,000 inhabitants (2010)	77.14
(Urban: 93.89 and rural: 56.63: adults: 88.01 and children: 16.17)	
Standardised Suicide rate by 100,000 inhabitants (2010)	12.90
Gallup Wellbeing index (2010)*	
Thriving	21
Struggling	56

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Mental Health legislation was significantly changed in Romania in 2002 upon approval of the Mental Health and Protection of Persons with Mental Disorders Law - Law 487/2002. This law created a legal framework for actions in Mental Health. The law established that responsibility for promotion and prevention of mental health lies with the Ministry of Health and Family, Ministry of Education and Research, Intern Ministry, Ministry of Youth and Sport, Ministry of Labour and Social Solidarity, National Council of Audio-visual, non-governmental associations, professional associations and others. This law protects the rights of mental health service users and establishes the criteria for admission to a psychiatric unit, including the criteria for compulsory admission.

In 2004, Ministry of Health declared mental health a priority and issued "Measures for rehabilitation of the care system in Romania concerning Mental health" with objectives such as "measures for decreasing the morbidity of mental health disorders for all population."

The Ministry of Health proposed to develop accessible and good quality mental health services, with a less restrictive environment and programmes for promotion, prevention and education in mental health. For this objective, they proposed: Restructuring the mental health system to provide better primary, secondary and tertiary care and develop ambulatory psychiatric care, mental health centres, day hospitals at local level and mobile teams for crisis intervention during psychiatric emergency).

In 2005, the Mental Health Strategy ”The development of social cohesion in mental health community structures in Eastern Europe” was adopted by Order of the Ministry of Health 639/14.06.2005. The action plan for implementing this strategy was supported by a grant (RO-2003/005.551.03.03 Twinning Light – RO 03/IB/OT 09 and supported by Order of Ministry of Health 426/19.04.2006 in 2006.

The Romanian Governmental order 1424/18 November 2009 concerns the creation, organisation and functioning of the National Centre of Mental Health and Anti-Drug.

There is an annual National Programme of Mental Health coordinated methodologically by the Psychiatric Commission of the Ministry of Health and technically by the National Centre of Mental Health and Antidrug.

The National Programme of Mental Health has 2 sub-programs: one for psychiatric and psycho-social pathology and another for sub-programmes for prevention and treatment of drug dependence. The sub-programmes are delivered in psychiatric hospitals and psychiatric departments of the General Hospitals and Mental Health Centres. Since a major demand of the family associations with children with Autistic Spectrum Disorders was identified as being the early detection and therapeutic interventions the National Programme of Mental Health sustained in this 2 last years the training programme for the mental health professionals (a curricula was created and over 200 professionals trained). Among the activities coordinated from Sub-programmes for prophylaxis of psychiatric pathology is the elaboration of training curricula for mental health professionals in the domain of autistic spectrum disorders. The major activities, coordinated from the sub-programmes for prevention and treatment of drug dependence, are: substitution treatment with opioid agonists, testing the drugs metabolites in specialised units and treatment of intoxication with drugs. The objectives of this sub-programme are to increase social rehabilitation of the patients and the decrease the relapse rate of patients with drug dependence.

The Law 151/2010 concerning the integrative medical, education and social specialized services for persons with autistic spectrum disorders and related mental health problems was voted in January 2011.

A working group organised by Romanian Psychiatric Association and Romanian League for Mental Health had the purpose of elaborating a strategy to reform mental health. The strategy was adopted by Ministry of Health as official policy in Mental Health in 2006 though is no longer valid. This strategy proposed to assure mental health services were accessible, high quality and based on existent needs, and mental health programmes for prevention and education in mental health.

Mental health services

Organisation and functioning of mental health care systems

Psychiatric care in Romania has gradually improved in the last few years following new legislation which enhanced the accessibility of psychiatric services and openness toward the community, and availability of pharmacological and/or psychotherapeutic treatment.

Before 1989, psychiatrists were based in hospitals: the majority of hospitals had approximately 150-300 beds and two larger hospitals had 800 beds and 1,000. This is still the case where there is a low average number of psychiatric inpatient beds compared to other EU countries. The ambulatory settings were organised in connection with in-beds (hospital) departments. The accessibility to psychiatric services is improving following the increased collaboration with general practitioners and other specialists (Mihai et al., 2012).

The number and types of mental health services include:

Inpatient care: Psychiatric services in Romania are delivered in psychiatric hospitals: acute psychiatric departments in general hospitals (75), psychiatric hospitals (34 acute and chronic; reduced from 39 following the decentralization of hospital care).

	Urban	Rural	Child	University Hospital	Chronic	Day care	Total
Number of beds	11,413	5,420	1,184	1,947	5,280	143	16,833
Beds per 100,000 population (pop approx. 21.5 million)	50.72	24.08	5.26	8.65	23.46	0.63	74.81

Source: National Institute of Statistics and National Centre of Statistics and Informatics in Public Health (2010).

Other mental health services include:

20 Day care centres

52 Mental Health Centres (36 for adults and 29 for children). Almost all counties have at least one Mental Health Centre, a plan in accordance with the Mental Health in Europe Action Plan signed in 2005 at WHO Conference.

4 Specialist addiction units and forensic psychiatric hospitals

Over 150 Private ambulatory offices -

The biological medical model dominates, but interest in psychotherapeutic and socio-therapeutic models has increased in the last few years. Changing from a system of paternalistic type of care to a model of shared decision making involved also a change of approaches and new skills to create a therapeutic alliance. Many international experts consider the efficiency of combining psychotherapy and pharmacotherapy in psychiatric

care and that availability of pharmacotherapy depends on funds. Psychotherapy has developed from the interest of the professionals, being scarcely financed since June 2011 by the National Assurance Company.

In 2005, the project "Enhancing Social Cohesion through Strengthening Community Mental Health Services in South Eastern Europe", proposed:

- restructuring the mental health care system for a primary, secondary and tertiary prophylaxis
- development of ambulatory psychiatric care: mental health centres, mental health centres, psychiatric offices, mobile team for crisis intervention and psychiatry emergency units.

An action plan for implementing the mental health policy was supported by a PHARE programme (RO-2003/005.551.03.03 Twinning Light – RO 03/IB/OT 09)(7). One of the objectives of this plan was the sector distribution of psychiatric services. These sectors should be organised around the community mental health centres but as yet are still not developed.

In 2004 the number of people over 65 years old was almost 3.2 million. Long-term facilities for older people were poorly represented in the mental health structure. In 2011, the Ministry of Health proposed to change the purpose of some hospitals and transformed them into residential care facilities for older people. Primary schools in large towns and high schools usually have a general practitioner and a psychologist employed in the role of prevention and to detect mental illness early on.

Access and usage

Access to psychiatric care is either direct through emergency units or via the GP (Gater et al., 2005). The latter decides on referral to a psychiatrist, Mental Health Centre or Mental Health Hospital. Psychiatrists monitor treatment for patients with psychotic disorders or dementia. GPs only administer prescriptions of some antidepressants and tranquilisers for mild to moderate depressive episodes and under psychiatric supervision to patients with dementia.

Variation and gaps

Psychiatric services have some difficulties such as: low budget, insufficient ambulatory and day care centres, unequal distribution of psychiatric beds and units among different counties, particularly between urban and rural areas; insufficient qualified staff; unequal distribution of staff; lack of material support and financial resources; deficit in interdisciplinary collaboration and stigma upon psychiatric assistance. Some of these factors hamper progress towards community based mental health care.

Financing

Public expenditure for all healthcare has increased to 4% of GDP from 3.8% in 2012. The proportion of health expenditure allocated to mental health services is not available. Systems for financing healthcare include a combination of compulsory and voluntary contributions. The health insurance scheme implemented in 1999 significantly increased healthcare expenditure from 2.8% in 1998 to 3.4% of GDP in 1999. Despite this increase Romania still has the lowest proportion of GDP spent on health compared to other EU countries. There are limited data on private healthcare expenditure which is not regularly collected or calculated; growth in private healthcare expenditure therefore not known.

Workforce

According to the World Health Organization Mental Health Atlas (World Health Organization 2011) the number of psychiatrists per 100,000 population was 6.5 and 14.2 mental health nurses.

The number of psychologists and social workers is quite low with an average of one psychologist to every 50 hospital beds. During the past two years, an employment blockage has severely impaired numbers in the workforce of the public health system.

Responsibility and delivery of mental health promotion and prevention of mental illness

Mental health promotion as distinct activities has a low representation in Romania. Most frequently they are associated with prevention of mental disorder activities. All initiatives are carried locally or by region by non-governmental organisations (NGOs) or local authorities.

Mental health status

Prevalence of mental health in the population

No longitudinal or epidemiological studies on the prevalence of mental illness in the population have been conducted over the past 20 years. Nevertheless, a recently published study carried out in 2007 by the National School of Public Health and Management (Bucharest), estimates a lifetime prevalence of 13.4% for mental disorders. From these estimates, anxiety is more prevalent than depression, particularly in older people).

Incidence

Not reported.

Protective and risk factors

Not reported.

Prevention and promotion programmes/activities

As shown above, mental health promotion and prevention activities are sparse. There are some activities in schools organised at a local level and provided by NGOs and local authorities which promote psychological well-being. These school activities focus on the negative effects of alcohol and drug abuse. In the workplace, some companies organise programmes for increasing social and psychological well-being for employees. These however are delivered by individual companies and do not usually form part of a larger programme. For this reason it is difficult to know their frequency or report on their activities as this information is not in the public domain. The sole two activities reported are presented below:

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools (Prevention)			
School Children Mental Health in Europe research project	Aim: to elaborate instruments for evaluating and monitoring the mental health of children. Additional benefits anticipated are detection of major risk factors and a manifestation of the importance of psychiatric services. Study evaluated the prevalence of anxiety, depressive and conduct disorders and ADHD. Additonally, it evaluated the positive indicators of mental health. This project is in collaboration with eight other countries.	Students, teachers and parents.	2008-2011. Funded by EU.
General (Prevention)			
Competencies and performance in health	Aim: to provide courses in on themes such as management of stress in the workplace, efficient communication between doctor and patient and reconciliation of private and professional life. The National Centre for Mental health and the Romanian Mental Health League coordinate this national project.	Targeted at medical staff from psychiatric hospitals and community centres. Participants include doctors, nurses, social assistants and psychologists.	2009-2012. EU funded.

Financial sources/responsibility for prevention and promotion

The majority of funds are derived from EU programmes and occasionally from the state. However, no statistical data is available regarding funding. Most projects are planned to

run until 2013 currently, with potential future projects depending on EU competition for funding. Community mental health services received less financial funding, with higher levels of financing being afforded to social services in general.

Investments into mental health – health, education, social development and economic growth

See above.

Initiatives to strengthen mental health systems in relation to MHP and PMI

For prevention activities, the Ministry of Health have proposed a national programme for promoting health and education for health with a state financial contribution of 22,000 lei and National Assurance contribution of 8,138,000 lei (Ministry of Health, 2012).

In schools there are occasionally, initiatives on educational courses examining drug misuse and suicide prevention and courses are organised on these topics. Psychologists perform similar in high schools. They are not part of a national or regional structure, and depend on personal or local initiatives.

For older people the government approved the national programme called "Developing the network of long term care facilities for older people", initiated and supported financially by the Ministry of Health and Ministry of Work, The government established a list of 67 former hospitals which should be transformed into long term residential care facilities for older people. The initiative came with penalties for using the former hospitals for any other purpose. The local authorities were responsible for this programme until March 2011.

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4.25 Slovakia

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Summary

- Dedicated mental health legislation exists and was revised in 2009. Legal provisions for mental health are also featured in other laws (e.g. the Health Care Law, 2004).
- The Slovak health care system is currently being reformed and six new health laws have recently been approved.
- The 2004 National Mental Health Programme included goals for promotion, prevention and the destigmatisation of people with mental health problems, and further developments in mental health care. The National Programme for Health Promotion, however, makes no specific reference to mental health.
- Mental health care is provided in a wide range of settings in hospitals and the community, although there is a general shortage of nurses.
- A broad range of prevention of mental illness and mental health promotion initiatives exist for schools, the workplace and for older people. Many of these are funded by the Government.

Data for this country profile were gathered in the first instance by the project's country collaborator for Slovakia. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Slovakia. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated 2012/13.

Background information

Population (1 January 2011)	5,435,273
Population density Inhabitants per km^2 (2009)	110.5
Women per 100 men (2011)	105.7
GDP PPP (2010)	0.7
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	79.9
Standardised Suicide rate by 100,000 inhabitants	10.3
Gallup Wellbeing index (2010)*	
Thriving	21
Struggling	60

* Reprinted with Permission of Gallup, Inc.

Mental Health Legislation and Policy

Current update and reference to prevention and promotion

An officially approved mental health policy exists and was approved or most recently revised in 2006. Mental health is also specifically mentioned in the general health policy. In 2006 the Ministry of Health adopted the regulation of a Conception of psychiatric care which is based on the work of a large group of psychiatrists. This organises mental health care but does not include mental health promotion. A national mental health plan (2004) exists and was approved and revised in 2008 and later in 2012. The mental health plan components include:

- Timelines for the implementation of the mental health plan.
- Integration of mental health services into primary care.

Dedicated mental health legislation exists and was revised in 2009. Legal provisions concerning mental health are also covered in other laws - the Criminal law (2005), Health Care law (2004), Social welfare law (2008) and the Employment Services Act 5 (2004). These are continuously amended each year and the area of mental health is always discussed by expert groups, taking into account the current situation.

There are also publicly available guidelines:

- The regulation of the prevention of violence among patients hospitalized in psychiatric health care facilities (issued by the Ministry of Health of Slovak Republic, 2010),

- The regulation of the use of restriction means of patients in psychiatric health care facilities (issued by the Ministry of Health of Slovak Republic, 2009),
- The regulation of a physician practice to inform a parent or guardian of a child with disabilities and the importance of parent involvement in the educational, psychological and special pedagogical assistance and prevention, which provides special pedagogical centres (issued by the Ministry of Health of Slovak Republic, 2011)
- The guidelines created by Slovak Psychiatric Association -Methodological briefings .

In Slovakia several documents directly or indirectly regulate activities relating to mental health promotion and prevention of mental disorders in target groups. These include:

- National Mental Health Programme 2005 -2015
- National Programme for Health Promotion
- National Programme for the Fight against Drugs
- The National Action Plan for Tobacco Control for years 2012 - 2014
- National Action Plan for Alcohol Problems for the years 2006-2010
- The National Anti-Drug Strategy in the field of children and youth in the Slovak Republic 2020
- The National Action Plan for Alcohol Problems for years 2013-2020
- National Action Plan for Children
- National Action Plan to Prevent All Forms of Discrimination, Racism, Xenophobia, Anti-Semitism and Other Forms of Intolerance for the years 2009-2011
- National Action Plan for Prevention and Elimination of Violence against Women and families for the years 2009-2012
- National Programme of Care for Children and Adolescents in the Slovak Republic for the years 2008-2015
- National Health Promotion Programme for disadvantaged communities in Slovakia for the years 2009-2015

Such programmes are implemented through different, projects and activities undertaken at national and regional level. Implementation of individual activities and objectives is carried out by various agencies: Government, ministries, Public Health Authority of the Slovak Republic, Regional Public Health Authorities, Self-governing regions and Non-Governmental Organisations. At the end of an implementation period a report on the evaluation of the main objectives of the programme is published. Programmes are funded by an allocated budget, partially provided by the Ministries and partly by organisations responsible for its implementation.

In 2004, the Government adopted the National Mental Health Programme as a policy document with a chapter on promotion and prevention. According to this, mental health

issues must be included in the curricula of primary and secondary schools. The Programme has several goals for 2005–2015: destigmatization of people with mental disorders, development of psychiatric home care agencies, development of crisis intervention services and development of mental health programmes. The goals were set through a dialogue between EU Member States and the EC (the Green Paper on Mental Health consultation) and their future development is incorporated in several EU documents. The Ministry of Health adopted strategic documents concerning mental health care and drug addiction medicine in 2006. The programme has detailed multi-sectoral actions, with a time-frame for implementation.

Implementing drug prevention in Slovakia is the responsibility of the ministries of: Education, Health, Labour, Social Affairs and Family, and the Interior. Slovakia's National Programme for the Fight against Drugs (2004–2008) was adopted in June 2005. Its key objective is to prevent further deterioration in drug abuse and drug addiction, emphasising children and young people. In 2009 an Inter-ministerial Expert Working Group evaluated the 2004–2008 strategy and drafted a new strategy for 2009-2012 which covers the following fields: demand reduction; supply reduction; coordination and cooperation; international cooperation; information, research and evaluation.

The National Programme for Health Promotion does not mention any mental health issues except harm reduction caused by alcohol, drugs and tobacco products.

Modern elements of the integrated long-term care for dependent older persons were introduced by the Social Services Act that came into force in January 2009. It refers to providing nursing care in social care facilities (Article 22 of the social services Act), and providing social services in health care facilities (Article 70 of the Act on social services). Basic requirements concerning occupational safety and health and labour relations in Slovak republic are regulated by Act No. 124/2006 Coll. on Occupational Safety and Health Protection and on Amendments and Supplements to Certain Acts as amended by Act No. 309/2007 Coll. and Act No. 140/2008 Z. z. was amended by Act No. 132/2010. National Labour Inspectorate and regional labour inspectorates supervise the enforcement of laws on health and safety at work.

Mental health policy and inclusion of prevention and promotion

The Government Manifesto (2011) includes a section on Public healthcare and prevention. This declares an intention to strengthen and encourage health prevention practices, including supporting and financing existing nationwide programmes, including the National Mental Health Programme and the National Programme for Child and Adolescent Health, and to prepare other programmes focusing on senior citizens with no additional requirements for budgetary funds.

New Mental health plan was approved or most recently revised and adopted by the Government in 2012. This Mental health plan includes timelines for the implementation of a variety tasks including preventative programmes and activities. The Mental Health Board of the Ministry of Health which is responsible for the implementation of the National Mental Health Programme discussed this plan in 2012 and will do the first evaluation of activities in April 2013, next will be done in 2014.

The Slovak Republic has been actively engaged in mental health de-stigmatization efforts. Government and non-government organizations have collaborated on many projects to reduce stigma around mental illness and to support existing community services. The "Open the Doors, Open Your Hearts" anti-stigma programme has been engaged in an active media campaign allowing individuals with mental illness to document their struggles with mental illness on film and collaborating with local media stations for vocational training of individuals with mental illness. The primary focus of the destigmatization reforms is to bring together four stakeholders: mental health professionals, consumers, family members, and the community. The "Open the Doors, Open Your Heart" programme in combination with other community-based mental health programmes has been financially supported by the Government from the budget for Mental health plan activities in 2012 – 2013 as well.

Mental health services

Organisation and functioning of mental health systems

Mental health care is provided in outpatient and inpatient settings and covered by public health insurance. The organisation and performance of the public health system in Slovakia is provided by Act No. 355/2007 on Protection, Support and Development of Public Health. The executive public health bodies are:

- Ministry of Health of the Slovak Republic – defines priorities of state health policy in the sector of public health
- Public Health Authority of the Slovak Republic – manages, controls and coordinates the execution of state administration carried out by regional public health authorities
- Regional Public Health Authorities – 36 authorities covering 8 regions and 79 districts.
- Ministry of Defence of the Slovak Republic
- Ministry of Interior of the Slovak Republic
- Ministry of Transport, Construction and Regional Development of the Slovak Republic

- Slovak Information Service

Mental health services in Slovakia comprise:

- Mental health outpatient facilities
- General hospitals (psychiatric units/departments for adult patients, departments for children and adolescents, psychogeriatric units)
- Mental hospitals
- Centres for treatment of drug addiction
- Day treatment facilities

Figures for the number of statutory or public mental health facilities (where available) include:

	Total number of facilities/beds	Number of facilities/beds reserved for children and adolescents only	Number of facilities/beds reserved for older people only
Number of mental health outpatient facilities	376 Source: Annual report of the activity of psychiatric ambulatories A4-01/2011	35 Source: Annual report of the activity of psychiatric ambulatories A4-01/2011	5 Source: Annual report of the activity of psychiatric ambulatories A4-01/2011
Number of psychiatric beds in general hospitals (i.e. beds dedicated to mental health care in general hospital wards)	4148 1) The number of psychiatric beds in institutional medical facilities without spa treatment facilities: 1519 2) The number of psychiatric beds in institutional medical facilities to be included in a general hospital, Source: Annual Report P1-01 overview of hospital beds fund 2011	187 1) The number of psychiatric beds in institutional medical facilities without spa treatment facilities: 37 2) The number of psychiatric beds in institutional medical facilities to be included in a general hospital, Source: Annual Report P1-01 overview of hospital beds fund 2011	292 1) The number of psychiatric beds in institutional medical facilities without spa treatment facilities: 62 2) The number of psychiatric beds in institutional medical facilities to be included in a general hospital, Source: Annual Report P1-01 overview of hospital beds fund 2011
Number of mental hospitals	14 Including 10 (psychiatric hospitals and sanatoriums) +4 Source: Annual Report P1-01 overview of hospital beds fund 2011	1 (psychiatric hospital) Source: Annual Report P1-01 overview of hospital beds fund 2011	-

Note: Outpatient mental health facilities – ambulatories provide a comprehensive evaluation and treatment with therapy. (Number of days treatment facilities – (public, NGO, private – Total number of facilities – 18, Number of facilities reserved for children and adolescents only - 1. Payments for services are covered and paid from public funds / health insurance and private clients finance.

Figures for private mental health facilities include:

	Total number of facilities/beds	Number of facilities/beds reserved for children and adolescents only	Number of facilities/beds reserved for older people only
Number of mental hospitals	2 (NGO)	1	-
Number of beds in mental hospitals	260	80	-

Health care services provided within long-term care are mostly covered by the system of social health insurance (SHI) or through direct payments from clients.

Since 2008, all employers must offer an occupational health service for employees in high-risk environments. This consists of a professional counselling service for employers in occupational health protection. It includes professional health risk assessment and occupational health monitoring. It is provided by health professionals with special qualifications or external bodies that are authorized by public health authorities (PHA).

The implementation of drug treatment is the responsibility of the Ministry of Health. In Slovakia drug treatment is funded by public health insurance companies. The General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control was established in 1995 with expert committees on (1) prevention, (2) legal issues and law enforcement, (3) communication strategies, and (4) treatment and re-socialization. The National Monitoring Centre for Drugs, a part of the General Secretariat, focuses on monitoring and evaluating the drug situation in Slovakia, in connection with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon. The centre is a member of the REITOX network (European Information Network on Drugs and Drug Addictions), which monitors psychotropic substances and provides background information for political decisions at the national and European levels.

Access and usage

General practitioners act as a gate-keeping service in Slovakia. Admission to hospital generally requires referral from a GP or specialist. Psychiatric patients are however, exempt from needing referral.

Overall rates for first lifetime contact with psychiatric out-patient services (2009) are shown below.

Diagnosis according to ICD-10	**Number of males**	**Number of females**
F00 – F99	70,127	37,652
F00 – F03	5,262	3,504
F10 – F19	13,251	3,099

F20 – F29	6,301	3,370
F30 – F39	15,156	10,071
F40 – F41	9,374	6,449
F90 – F98	5,452	1,976

Source: Psychiatric care in the SR 2009

No figures were available for statistics for first lifetime inpatient admissions.

Variation and gaps

Health equality issues were included in the National Health Promotion Programme of the Slovak Republic, approved by Parliament and effective from June 2006. It had been accepted that standard psychiatric care should be delivered according to region, made generally accessible and diversified so it can be provided for the whole spectrum of patients with mental disorders within all age-categories.

A minimum network of providers is set by government regulation and is defined as the minimum number of capacities (providers and number of beds) in self-governing regions.

Financing

Financial allocations for mental health care are made from the overall health budget (in 2010 total health expenditure as % of GDP was 7.3); mental health care is financially integrated with other health care services.Mental health services are also part of social services and paid for by other sources.

Mental health care is provided in outpatient and inpatient settings and is covered by health care insurance (SHI).

Note: Under the existing legislative provisions and regulations health insurance companies have contracts with psychiatric clinics and constitutional psychiatric health care facilities.

Public health insurance covers services provided by constitutional psychiatric health care facilities by means of a treatment day. When there is a need of another hospital stay and the person´s health condition requires it, it is provided again. Based on the recommendations of a treating physician working in an ambulatory health facility, health insurance companies, if necessary also pay the constitutional hospital stay of psychiatric maintenance treatments.

Expenditures by the Government Health Department/Ministry

General government health expenditures refer to expenditures on health channelled through the Ministry or Department of Health:

1. Mental hospital expenditure (in local currency) year 2008€27.34 mil.
2. Mental health expenditure (in local currency) year 2008 €99.19 mil.

Note: The amount does not include any expenditure channelled through other ministries such as Welfare, Social Insurance, and security institutions.

According to the 2009 National report (2008 data) to the EMCDDA, the basic ensuring of the fulfilment of the anti-drug policy in the period 2005 to 2008 (as of June 30, 2008) came from public funds (relevant chapters of the State Budget and funds from the EU) together with funds of the relevant health insurance companies, overall €53,901.720 were spent. The resources from public funds (without health insurance companies) amounted to €41,739,459, which constitutes 77.40% of the relevant public funds.

Workforce

Health establishments in Slovakia are separated according to activity on establishments of outpatient type, establishments of institutional type, pharmaceutical care and emergency health service. Health establishments of outpatient type provide services to patients during doctor's surgery hours which are endorsed by particular municipality region. Health establishments of institutional type and emergency health service provide services to patients 24/7.

According to the Concept of Psychiatric Care, health workers in the specialised field of psychiatry are: physicians – psychiatrists; nurses, graduate nurses, nurses specialised in psychiatry; other health workers – physiotherapists, psychologists specialised in clinical psychology, pedagogic therapists, social workers; and volunteer healthcare workers.

Mental health professionals that fall into the following categories as defined by their primary employment setting.

Category	Number (Head Counts)	Number (Full-Time Equivalents)
Psychiatrists *	621 in year 2007 The Source: Register PZS	309 – number of physicians with working contracts in psychiatric care in institutional medical facilities without spa treatment facilities The Source: the Annual Report P1-01 of hospital beds fund in institutional

Category	Number (Head Counts)	Number (Full-Time Equivalents)
		medical facility 2011
Nurses in mental health settings *		1,261 – number of nurses with working contracts in psychiatric care in institutional medical facilities without spa treatment facilities The Source: the Annual Report P1-01 of hospital beds fund in institutional medical facility 2011

Number of psychologists: According to information gained from the Slovak Chamber of Psychologists, there are approximately 1,100 registered psychologists, considered as "other health care professionals". These psychologists are specialized in clinical (approx. 600), counselling and personnel psychology. This does not include school psychologists, who are not obliged to register in the Chamber, as they are in the Ministry of Education.

Number of psychiatrists: The figures below show the number of psychiatrists (child psychiatry, gerontopsychiatry and medicine of substance related addiction) with work contracts from 2000 to 2011 in institutional medical facilities without spa treatment facilities. These do not include those with contracts in mental health outpatient facilities.

Number of psychiatrists with work contracts between 2000-2011:

Category	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Psychiatrists	333	340	329	315	300	287	292	295	296	301	326	309

Source: Psychiatric care in the SR 2010

Mental health professionals graduated from training

Category	
Psychiatrists	22
Psychologists	90
Nurses in mental health settings	67
Neurologists	25
Other (specify)	*All data are from: The Annual Report of the Accreditation Board of Ministry of Health for continuing education of health professionals – year 2011

There is a shortage of nurses in Slovakia following the departure of health personnel and the low numbers of nurse graduates from medical schools. The decline in the number of nurse graduates is a result of the low salary in relation to the intensity of the work and changes in the system of training (provided either as vocational training or at a Bachelor's (Bc) level). Since these changes there has been a rise in the number of university graduates in nursing, but not the overall number of nurse graduates.

Responsibility and delivery of mental health promotion and prevention of mental illness

Several prevention programmes are implemented in schools, workplaces and facilities for seniors. These are mostly realized within responsibility of the Ministries of Health; Education; Culture; and Employment, Social Affairs and Family, and carried out by various governmental organisations and civil associations. They are financially supported from various sources, including budget chapters of the Ministries. Some programmes and projects are implemented at the initiative of NGOs, or as part of international projects.

Mental health status

Prevalence of mental health in the population

Two epidemiological studies have recently been conducted to assess the prevalence of depressive and anxiety disorders in Slovakia – the EPID (Heretik et al., 2003) and EPIA (Novotny et al., 2006) surveys. According to the EPID survey, the 6- month prevalence of major depression was 12.8%, and that of minor depression was 5.1%. Regional differences in the prevalence of depression were noted. Depression was associated with ethnicity, availability of mental health services, residence (urban), gender (female), occupation (unemployed, students, disabled), marital status (widowed), social support (living alone) and life events (family and health related). According to the EPIA survey, the 6-month prevalence of generalised anxiety disorder is 4%.

There were approximately 1,909 drug users in 2009 (a rate of 35.1 drug users per 100,000 population), with 1,525 men and 384 women receiving treatment. Total number of reported treated drug users is lower by 147 cases in the year 2009 in comparison with (2,056) cases in the year 2008.

609 cases of suicide and 795 cases of suicide attempts were reported in 2009 (20 suicides per 100,000 inhabitants for men, 17.6 for suicide attempts and less than 3 for women, 12 suicide attempts).

Since 2000, the NHIC produces an annual report on activity of psychiatric outpatient units. An increase in the number of psychiatric consultations has been observed for some time.

In 2009, 1,660,880 patients were diagnosed with a mental illness, almost 374,730 more than in 2000. The number of people with their first presentation to psychiatric outpatient units in 2009 was 70,127; an increase of 4,960 people compared to figures for 2000.

Protective and risk factors

Protective Factors:

In schools: Positive self-esteem; openness to the learning; suitable family environment and social support from parents; good social skills.

Workplace: higher level of education; working in the private sector.

Older people: effective coping (higher SOC); lifelong education.

Risk factors:

In schools: extroversion and negative self-esteem; various depressive and anxious states in adolescents; aggressiveness, low self-confidence and poor ability to socially interact; poor relations with parents; divorce of parents.

Workplace: stress at work.

Prevention and promotion programmes/activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools and young people (Prevention)			
Preventive programmes for optimizing personality development and prevention of risk behaviour in children and adolescents.	Aim: to provide professional psychological counselling and psychotherapy, early underpinning, re-education, counselling and psychotherapy correction of risk behaviour in personality development. Uses discussions and workshops.	Children and adolescents	2008-2010. Funded by Ministry of Education.
Path to Emotional Maturity	Aim: to contribute to gradual self-awareness and subsequently to group experience of the most significant features of emotional maturity through exercises and model situations Approach: A preventive-educational universal group programme.	12-15 age group. Ministry of Education; Research Institute for Child Psychology and Patho-psychology; Centres of educational and psychological counselling and prevention (CEPCP); teachers.	10 Modules. Operating since 1999.
'Why am I happy	Aim: to prevention and	Children and youth.	Since 1994.

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
in the world' programme.	eliminate addictions and implement cultural-educational activities to protect mental health. Approach: Nationwide contest of amateur photos, films, drama, exhibitions workshops, and concomitant educational activities.	National Cultural Centre (NCC) in Bratislava; Office of the National Council of the SR.	Funded by: Bureau of Government, Budget chapters of the Ministry of Culture, Ministry of Foreign Affairs of the SR.
Slovak Awareness Centre	Aim: to raise awareness in order to teach responsible behaviour when using new online technologies. Various activities and social events for children, promotional materials and phone line.	Children, youth, parents, teachers. eSlovensko (NGO); Ministry of Interior; Slovak Committee for UNICEF; Slovak Telekom and SK-NIC Slovakia; members of Internet industry in Slovakia; and Union of Cities and Towns of Slovakia.	Operating since 2008. Co-financed by the EU Safer Internet Programme.
'Mad? So what!?' Programme.	Aim: to prevent mental and behavioural disorders. Reducing youth prejudice against people with mental disabilities. Long-term goal is to provide a model of education of adolescents, teachers and educators in the field of mental health.	Students aged 15-to 20 years; and teachers. Civic Association Integra, o. z.; Ministry of Health; Slovak League for Mental health (LDZ); Civic Association "Open the Doors, Open Your Hearts" (ODOS); Slovak Chamber of Psychologists.	Operating since 2003. Funded by Ministry of Health and others.
Mental health in secondary schools	Aim: to prevent of suicidality in adolescents; destigmatization of mental disorders and psychiatry. Anti-stgma programme in three phases.	Secondary school students; professionals working in secondary schools; counselling psychologists. Slovak League for Mental health (LDZ); Ministry of Health	2007-2010. European Social Fund granted €263,892.64
Second Step: A Violence Prevention Curriculum	Aims: to prevent socio-pathological phenomena in schools, particularly aggression, bullying and intolerance.	Children and youth in kindergartens, primary and secondary schools; teachers, school psychologists, educational consultants. Civic Association PROFKREATIS; The Public Health Authority	Operating since 2011.
National Network	Aim: to provide information	Pupils, teachers, parents,	August 2007 –

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
for the Prevention of bullying and violence in schools	on bullying and violence To train Prevention coordinators in prevention at primary and secondary schools. To monitor bullying in schools.	wider public. Civic Association, Papilion.	December 2007
'Our Life' preventative peer programme.	Aim: to increase proportion of children and adolescents, applying a healthy lifestyle and positive social behaviour. Approach: Peer approach, programme themes are: prevention of substance misuse, prevention of STD's, prevention of eating disorders.	Pupils, students, peer-activists, teachers. Regional Public Health Authority, Trebisov.	Operating since 2005.
Additional textbooks approved by the Ministry of Education.	Aim: to prevent of socio-pathological phenomena at all school levels. Three programmes focusing on 1: drug addiction and prevention, education for healthy lifestyle. 2: of socio-pathological phenomena, and ways to prevent and resolve crisis. 3: combating violence, addiction, prejudice, racism and non-productive lifestyles. 4: Improving child–child and teacher–child interactions. Can be included in the curriculum of educational subjects.	Ministry of Education; schools and school facilities; Centres of educational and psychological counselling and prevention (CEPCP); Prevention Coordinators.	Duration according to the development of textbooks. Operating since 2001.
Workplace (Prevention)			
Reduction of health risks of employees from environmental and working conditions, and the way of work.	Aim: to enhance the professional level of evaluation of the working environment, working conditions and working patters in relation to health risks. To reduce mental workload in the workplace.	Employers and employees. Public Health Authority; Regional Public Health Authorities	Operating since 2008. Funded by Public Health Authority.
Preventive and educational programmes to protect and promote the health of	Aim: to create appropriate psychosocial working conditions at all levels of management; to improve conditions for employees in the prevention of occupational diseases and	Employees and employers. Public Health Authority; Regional Public Health Authorities.	Not reported

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
employees.	excessive mental workload. Information and educational activities and events.		
Guides for Risk Assessment in Small and Medium Enterprises	Aim: to prepare guides on different topics (e.g. Mental Workload, Chemical hazards, Basic information; Identification in the enterprise; Work organisation; Checklists and evaluation list. Information on conducting written anonymous surveys.	Employers and employees. National labour inspectorate, the Technical University in Kosice.	Not reported.
Schools and young people (Promotion)			
'Health in Schools' Programme.	Mostly implemented through educational projects health and healthy lifestyles promotion, peer programs, sports activities and competitions. Topics include: mental health promotion, prevention of substance abuse and bullying.	Pupils and students in primary and secondary schools; teachers and other staff working in schools and school facilities. Main responsibility of Ministry of Education.	Operating since 2005. Funded by Ministry of Education and others.
Programme of systematic health promotion in schools in Trebisov	Aim: to positively influence individual and group determinants of health and to create a health supporting environment at school. To reduce risky behaviour including drug use. To teach effective communication and assertive and empathic behaviour.	Pupils and students in primary and secondary schools; teachers and other school staff. Regional Public Health Authority in Trebisov.	Operating since 2009.
Workplace (Promotion)			
Strengthening human resources through education.	Aims: to increase the skills and expertise of staff in the field of mental health issues.	Targeted at professionals in secondary schools; school and counselling psychologists and civic association workers. Slovak League for Mental Health, Ministry of Health.	March-April, 2009. Funded by European Social Fund.
Healthy Workplaces Programme.	Aim: to reduce the negative impacts of working environment and lifestyle on	Employees and employers. Public Health Authority; The Regional	Operating since 2008.

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	the health of employees through corrective action and intervention programs. Repeated screening tests and preventive medical examinations Development of intervention programmes for healthy lifestyle.	Public Health Authorities.	
Continual education for pedagogical employees and professional employees	Aims: to create an efficient system of further education of teachers and professional staff of schools and school facilities, focusing on core competencies.	Employees and employers. Methodology and Pedagogy Centre; Ministry of Education.	Operating since 2009. Funded by Ministry of Education.
Older people in long-term care facilities (promotion)			
'I am 65+ and happy to live the healthy life' Programme.	Aim: to positively influence the lifestyle of older people through educational programmes in social environment, physical activity, nutrition, mental health and health information. National project preparing older people in care homes and day-care centres with the provision of social services for pensioners to act as 'teachers' in encouraging healthy lifestyles. Implemented through courses, workshops, interactive discussions.	People 65 years and over. Ministry of Health of the SR; The Public Health Authority of the SR; The Union of Seniors of the SR; Humanitarian Foundation of disabled	Operating since 2004. State funded.
Centre Memory	Aim: to solve problems of seniors, people suffering from Alzheimer and other forms of dementia and those who provide social care to these people. Educational materials are used. Materials for education and memory training are used, as well as educational programmes for social workers and specialists.	Target those with Alzheimer's and other forms of dementia and professionals that provide social care. Memory Foundation	Funded by a Memory fund that collects money especially for these services. Clients' contribution and sponsorship.
Portal: www.senior.sk	Aim: to create a portal as a multifunctional online platform for the elderly and as a partner within the European network 'senior	People aged 50 and over. The Civic Association Regions; The Union for Seniors.	Operating since 2006. Funded by: Slovak Ministry of Transport, Post-Office and

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	net'. To support beginners or less experienced internet users in searching and using the relevant information. To build social contacts, participate in education and receive specific information, as well as to express opinions and suggestions		Telecommunication (The budget has been available for one year – till December 2006); own budget of the organisation
Memory training for older people	Aim: to improve quality of life of older people and achieve healthy self-assurance and self-sufficiency. To increase motivation, to support social contacts and inclusion. Led by a qualified mentor and includes a theoretical part and series of practical exercises to improve short- and long-time memory.	Older people with dementia. Psychiatric hospital of S. Blum in Plešivec; Memory Foundation; Health insurance companies.	Operating since 2006. Funded by Psychiatric hospital of S. Blum in Plešivec.
'Successful Ageing' Programme	Aim: to educate and help people prepare psychologically for retirement.	Those approaching retirement /elderly. The Public Health Authority of the SR; the Regional Public Health Authorities	Operating since 2003. State funded.

Financial sources/responsibility for prevention and promotion

It was difficult to obtain information on the allocated funds for prevention and promotion programmes and projects. However, the Government has declared an intention to strengthen and encourage health prevention practices, by supporting and financing existing nationwide programmes, including the National Mental Health Programme and National Programme for Child and Adolescent Health, and introduce programmes for older people. No additional funds have been allocated for this.

Investments into mental health – health, education, social development and economic growth

See above.

Initiatives to strengthen mental health systems in relation to MHP and PMI

The programmes and projects within the context of the National Action Plans will continue to be implemented.

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4.26 Slovenia

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Summary

- Figures published in 2008, show a majority of psychiatric beds were located in mental hospitals and a remainder in psychiatric inpatient units in general hospitals in the community.
- Outpatient and community services provide non-mobile and continuing care. Over 300 services provide services including housing units, structured daily activities and community self-help groups.
- There are marked regional differences in provision and utilisation of mental health services. An example is in community based services where some regions have abundant and diverse services compared to others with very limited offerings.
- The country's draft of the Mental Health Programme has a clear emphasis on prevention and promotion in specific areas for different parts of the population.
  - promotion of mental health and prevention of mental illness
  - integrated and coordinated treatment, rehabilitation and recovery of mental illness in the community
  - prevention of suicidal behaviour
  - combating stigma and social exclusion
  - network of mental health services - upgrading and updating of existing network services (counselling for children and parents, extension of daily hospitals in regions without psychiatric hospitals, regional teams) and integration between departments, to work consistently, effectively and to be accessible.

Data for this country profile were gathered in the first instance by the project's country collaborator for Slovenia. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being and the country collaborator. Any suggested revisions were made by the lead researcher, checked by the Governmental expert and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	2,050,189
Population density Inhabitants per km^2 (2009)	101.3
Women per 100 men (2011)	102.1
GDP per capita (EUR, at current prices and current exchange rate) (2011)*	17620.4
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	65.9
Standardised Suicide rate by 100,000 inhabitants (2010)	20.3
Gallup Wellbeing index (2012)**	
Thriving	28
Struggling	57

* (Source: Statistical Office of the Republic of Slovenia)
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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Slovenia's first Mental Health Legislation was introduced in 2008 (Official Gazette, No. 77/2008) following a coordination period of 14 years. The Act specifies the system of health care and social assistance for mental health institutions, the rights of patients during treatment, procedures for admission to various forms of treatment, and defines the right to a representative where a patient's freedom of movement is restricted.

This system of representation complements and builds upon the right to a representative in accordance with the Act on Patients' Rights (Official Gazette RS, No. 15/08). The Mental Health Act establishes a legal basis for the treatment of people in their local environment, whether in hospital or in the community. The Act also introduces a new institute, supervised treatment coordinator, a coordinator in the community, and consideration of treatment in the community instead of in a psychiatric hospital.

Mental health policy and inclusion of prevention and promotion

The Mental Health Act establishes a legal basis for adopting a national mental health programme, which defines a strategy and five-year action plan for mental health. The

proposed Resolution National Mental Health Programme (NMPH) aims to improve services available to people with mental health problems and to improve the mental health of the population through better access, early identification and diagnosis of mental illness. This programme includes the goals, organisation, development and functions of staff, a network of programmes and services in order to implement the programme nationally and provide a basis for evaluation.

The draft of the Mental Health Programme has a clear emphasis on mental health promotion and prevention, highlighting particular concerns on key problems such as suicidal behaviour and the risks/harm associated with alcohol consumption (misuse?). There are proposed eight specific areas:

- promotion of mental health and prevention of mental illness in children and young people, active population and old population,
- integrated and coordinated treatment, rehabilitation and recovery of mental illness in the community,
- prevention of suicidal behaviour,
- combating stigma and social exclusion,
- network of mental health services - upgrading and updating of existing network services (counselling for children and parents, extension of daily hospitals in regions without psychiatric hospitals, regional teams) and integration between departments, to work consistently, effectively and to be accessible.

Although there is no national or integrated policy concerning promotion of mental health and prevention of mental illness there are related health, social and educational policies that initiate these activities. The Ministry of Health, Ministry of Labour, Family and Social Affairs and Ministry of Education and Sport therefore hold responsibility for the administration of and provision of services to raise awareness about mental health and prevent mental illness in various groups.

Expected benefits of prevention and mental health promotion

The targets set by the draft of the NMHP in terms of the benefits to be derived from it include:

- Reduction in the number of admissions to hospitals by 10% and a reduced length of stay by 3%
- Reduction in the number of days on sick leave due to mental health problems for 10% and the number of cases for 7%.
- Reduction of the number of suicides from 416 to 380 for the entire population, especially in older people and children.

Mental health services

Organisation and functioning of mental health systems

Mental health care in Slovenia is organised according to a three levels – primary, secondary and tertiary levels of care. Primary level includes General Practitioners. Secondary level includes outpatient's specialist health care and regional hospitals. Tertiary level includes teaching research and subspecialist care. NGO provides housing units, structured daily activities, counselling.

Psychiatric inpatient services include for 2011:

5 Psychiatric hospitals (Begunje, Ormož, Idrija, Ljubljana, Vojnik)
2 Departments in general hospitals (children only ward in UKC Ljubljana and Maribor)
7 Institutional-based facilities (special institutions for persons with mental health problems, intellectual disabilities and comorbidities).

The number of people in institutions:

Name of Institution	Number of people (males and females, aged 18-64 years)
Hrastovec	706
Lukavci	309
Dom Nine Pokorn Grmovje	240
Dutovlje	171
Impoljca Sevnica	292
Podbrdo	90
Dom Danice Vogrinec Maribor	195

Community-based mental health services for 2010 include:
47 Group homes for people with mental illness that are run by NGOs, with a total number of 260 people.
24 Day care centres, with a total number of 2205 people
14 Counselling offices, offering counselling-informative programmes for people with mental health problems and in 2010 provided these services to 1078 users and their relatives.

Access and use

Mental health services are accessed by doctors at the primary care level. Mental and behavioral disorders can be diagnosed by General Practitioners who also treat non-serious problems. More serious or persistent mental health problems are referred to outpatient specialists or to hospital. In 2009, there were 61,951 first visits to GPs due to mental and behavioural disorders; 23,485 men and 38,466 women.

Inpatient care: During 2009 there were 11,520 hospitalizations due to mental and behavioral disorders, of which 6,148 men and 5,372 women. The average duration of hospital stay for mental disorders was 36.5 days; 35.7 for men and 37.4 days for women.

Outpatient: Out-patient and community services provide non-mobile and continuing care. In the year 2009 the number of visits to outpatient facilities was 61,716.

Other community based services: In the 12 statistical regions there is a total number of 301 mental health services which provide: housing units; structured daily activities; ambulatory activity and activity in community; community groups (self-help groups, etc.); and public awareness and education services. Each service can offer one or more of these activities.

Variations and gaps in services

There are marked differences between regions in the patterns, provision and utilisation of mental health services. Some regions have a predominance of community based services and activities. The Central-Slovenian region, for example, offers the most diverse and abundant choice of services. By contrast there are very limited mental health services in the regions of Zasavska and Notranjsko-kraska. Day services and services offering structured activities, work or work related activities are lacking for the most part.

Financing

Not available

Workforce

In 2009 there were 210 psychiatrists. There is no valid information that could be obtained for the number of nurses working in psychiatry.

Responsibility and delivery of mental health promotion and prevention of mental illness

Dernovšek, M. and L. Šprah (2008) assessed the prevention and promotion activities conducted by 162 mental health services across Slovenia. For prevention activities the most frequent approaches were selective primary prevention in 27.9% and tertiary prevention in 28.2% of cases. Secondary prevention activities were less common by comparison at 14%. Most prevention activities were found in the Obalno-kraška, Osrednjeslovenska and Goriška regions. The lowest prevention activities were in Zasavska, Notranjsko-kraška and Gorenjska regions.

The table below details the number of promotional activities in mental health by region. The variations in activities across regions are wide with some regions carrying out relatively few activities with others having significantly more (for example, Notranjsko-kraška vs Osrednjeslovenska).

Table: Comparison of the number of services by region conducting promotional activities (per 100,000 inhabitants), 2008

The number of promotional activities (per 100 000 inhabitants)	Individual or group counselling by phone or in person	Media campaigns (TV, newspaper, radio)	Izdajanje pisnega gradiva (brošure, letaki)	Website - providing information, interactive participation	Lectures, workshops for users and relatives	Lectures, workshops for the general public	Number of all activities in the region
Pomurska	10	7	3	11	8	5	55
Podravska	7	6	6	11	8	7	144
Koroška	9	7	4	15	11	12	43
Savinjska	7	6	6	11	5	7	111
Zasavska	7	4	7	7	7	7	17
Spodnjeposavska	6	6	4	10	10	9	31
Jugovzhodna	9	7	5	11	7	7	66
Osrednjeslovenska	13	11	12	18	12	11	396
Gorenjska	8	6	7	8	8	6	89
Notranjsko-kraška	6	8	4	12	10	6	23
Goriška	7	12	8	14	12	6	73
Obalno-kraška	17	15	12	20	18	18	107

Mental health status

Prevalence and incidence of mental illness

No recent national epidemiological data were available. The figures presented here come from the Andlin-Sobocki et al.'s (2005) report and listed below:

Diagnosis	Total prevalence of disorders
Dementia	18,662
Mood disorders	104,839
Anxiety disorders	194,892
Psychotic disorders	10,753

The lifetime prevalence of diagnosed depression is 15% to 20%. The prevalence of depression is 5% of the population and the prevalence of anxiety and stress disorder is approximately 2% of the population.

The incidence for schizophrenia and bipolar disorder is 30 and 50 people per 100,000 population per year.

Risk factors for mental illness

Increased alcohol use and illegal drugs, unemployment, poverty, urbanization rate, violence and delinquency, poor education.

Prevention and promotion programmes/activities

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
Schools			
Free hands, clean lungs – smoking prevention	Aim: to provide a smoking cessation programme that focuses on social skills, stress management and alternative forms of leisure activity.	15 to 19 year old students who smoke	Not available
Smoking prevention	Aim: To promote healthy lifestyle habits at children to prevent the uptake of smoking. Teaches children to respond appropriately to social pressures leading them to start smoking by being assertive, able to resolve conflicts etc.	Children in elementary education	Not available
Programme Peers and I - Let's talk	Aim: to prevent school violence through peer education - peer mediation, which is also transferred to different areas of health (sex, drug use, diet, exercise, etc.).	Adolescents	2003/04, cost not available
"This is me"- promotion	Aim: A 10-workshop programme to teach skills to develop a positive self-image, good social skills and mental health – delivered by teachers. Online counselling services are included and provided by medical specialists, psychologists, social workers and other specialists.	Young people	2000 -
Slovenian Network Project of Healthy Schools (WHO initiative)	Aim: To develop a healthy way of life in terms of physical, mental, social and environmental health. Topics covered in quality use of leisure time, mental health	All children and young people in education	2005-

Programme name	Aim/approach	Stakeholders/ target group	Duration, Cost of programme
	promotion, stress management, diet and exercise and healthy lifestyle.		
Workplace			
'Fit for work' programme - health promotion (Ministry of Health and European Commission)	Aim: Seven training modules for lifelong learning on healthy work/ life balance, making positive health changes in the workplace, improving the work environment, and introducing a health promotion network at work. Includes a media campaign targeting managers and directors.	Employees and employers	2004-
WORK (Work in Tune with Life) project	Aim: To raise awareness among company members, stakeholders and the public of the needs and benefits of promoting mental health at work, create practical models and exchange experiences.	Employees, managers and the general public	1997-
"We are moving Europe. Europe Move"	Aim: A European initiative for health promotion in the workplace – focus on physical activity and active living, healthy eating, mental health and stress, and smoking cessation. Includes a media campaign sponsored by the Ministry of Health.	Employees, businesses and the general public	2007-2009
HIRES Plus European project	Aim: to increase awareness among stakeholders and evaluate the effects of restructuring on employees' health.	All relevant stakeholders including families of employees	2009-
Employee Assistance Programme in support of the 'Health and Efficiency at Work' project	Aim: to provide stress management, absenteeism and presenteeism management and turnover management support.	Employees, supervisors, trade union representatives and managers	2011-2012 pilot schemes
Older people in long-term facilities			
No programmes reported	The Resolution of the National Mental Health Programme 2011-2016 proposes to enhance this area.		

Financial responsibility for prevention and promotion activities

International programmes are founded by European funding. Other initiatives are funded by the Ministry of Health, Ministry of labor, family and social affairs and the Ministry of Education. Some programmes may also have been financed by municipal budgets, especially if they take place at the local level.

Investments into mental health – health, education, social development and economic growth

No information on national level was available on the financial investments allocated for mental health promotion or prevention programmes in Slovenia.

Initiatives to strengthen mental health systems in relation to prevention and promotion of mental health

Proposals to enhance this area are specified in the draft of the Resolution of the National Mental Health Programme.

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4.27 Spain

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Summary

- Spain has a decentralised mental health system which offers a wide range of community based facilities including psychiatric units in general hospitals, day hospitals and home care delivered by multidisciplinary teams. Other services include ‘labour insertion centres’ which assist those with mental health problems in finding work.
- There remains uneven distribution across Autonomous Communities of various services such as rehabilitation services, lack of mental health programmes for children, adolescents and other groups such as the elderly, immigrants and prisoners.
- Poor information systems prevail and more need for coordination between services is recorded.
- Many interventions in promotion and prevention in adult, and child populations and the workplace have been carried out in the majority of ACs but few have been evaluated.

Data for this country profile were gathered in the first instance by the project’s country collaborators for Spain. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by Governmental Experts in Mental Health and Well-Being from Spain. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)*	47,190,493
Population density Inhabitants per km^2 (2011)*	93.49
(Women: 23,907,306*; Men: 23,283,187*)	
GDP PPS 2011 Index (EU-27): 100 (EUROSTAT)	99
Psychiatric care beds in hospitals per 100,000 population (2010)	37.8
(Based on Eurostat 2012 population for 2010 - 45,989,016)	
Standardised Suicide rate by 100 000 inhabitants (2010)	6.3**
Gallup Wellbeing index (2010)***	
Thriving	36
Struggling	58

* INE (National Statistics Institute)
** Data from the Ministry of Health
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Mental health legislation and policy

Current update and reference to prevention and promotion

Spain reformed its compulsory admission to hospital legislation in 1983. According to Law 13/1983 compulsory admission to hospital can be ordered by a medical doctor but should be authorized by a judge. If treatment is urgent, admission may be carried out without initial judicial authorization but it must be obtained within a maximum time limit of 24 hours. Act No. 6/1984 allows a court to examine legality of the detention of individuals detained on a compulsory basis; the court may lift the confinement order if it is found to be unlawful.

Since 2001, Governance of the mental health care system has been mostly decentralised to 17 Autonomous Communities (ACs, regions), with some national coordination and agreement set by the Ministry of Health. Each region has primary jurisdiction for planning and organising its mental health system, subject only to the national framework prescribed by the Law of General Health Care (14/1986, 25 April, *Ley 14/1986, de 25 de abril, General de Sanidad*) and Law of Cohesion and Quality of the National Health System 15/2003, 28 May, (*Ley 16/2003, de 28 de mayo, de Cohesión y Calidad del Sistema Nacional de Salud*).

Other relevant legislation includes Law 39 on the Promotion of Personal Autonomy and Attention for People in a Situation of Dependency /2006, 14 December, *(Ley 39/2006, de 14 de diciembre, de Promoción de la Autonomía Personal y de la Atención a las Personas en Situación de Dependencia)* to implement the new National System for Autonomy and

Assistance for Situations of Dependency (SAAD). Article 2 of this Law defines its purpose to "support needs for personal autonomy", described as: "those (needs) that people with intellectual or mental disabilities require to achieve a satisfactory degree of personal autonomy within the community".

Mental health policy and inclusion of prevention and promotion

The 2006 Mental Health Strategy for the National Health System represents another important milestone (Ministry of Health and Consumer Affairs 2008). The Strategy acknowledges the achievements gained so far. For example:

- The establishment of community based mental health services
- An integrated mental health service within the health care network
- Decrease in the number of psychiatric beds in institutions
- Regulated training for mental health professionals
- All Autonomous Communities (ACs) have a mental health plan for their territory.

The Strategy goes on to state the following General Objectives:

- Promoting the mental health of the general population including specific groups.
- Preventing mental illness, suicide and addiction in the general population.
- Eradicating the stigma and discrimination associated with mental disorders.
- Improving the quality, equity and continuity of care for mental health problems.
- Implementing procedures to ensure obligatory use of good practices and respect for the rights and dignity of patients.
- Promoting cooperation and joint responsibility in all departments and agencies involved in improving mental health.
- Promoting the participation of people with mental disorders and their families and professionals in the public health system in their region.
- Promoting the training of professionals in the health system to adequately address the needs of the population in mental health.
- Promoting research in mental health.

The 2006 Mental Health Strategy was evaluated in 2009, many of the objectives had been started or were partially achieved including on the prevention and promotion of mental health (Ministry of Health and Social Policy 2009). The Strategy was updated in 2009, to cover the period between 2009-2013 (Ministry of Health and Social Policy 2011).

Mental health services

Organisation and functioning of mental health systems

The types of mental health services available across Autonomous Communities include hospital and community based facilities. The devolution of health care in Spain to the regions hampers the collection of mental health data for the whole country and its regions. Nevertheless, the principal sources of information on mental health facilities are from the Ministry of Health (Ministerio de Sanidad, Servicios Sociales e Igualdad), the National Statistics Institute, and the atlases developed by PSICOST Scientific Association in Andalucía (Garrido et al., 2006), Catalonia (2011), Madrid (2011) and Cantabria (Vázquez-Barquero et al., 2010) and a report on 8 Spanish regions for the Ministry of Health (2011).

Inpatient Care by type (2010)

Number of public sector mental health services in and places/beds in Spain 2010/2011

	A) Total number of facilities / beds	Number of facilities/beds reserved for children and adolescents	C) Number of facilities/beds reserved for older people only
3.2.1 Number of mental health outpatient facilities	169	NA	NA
3.2.2 Number of day treatment facilities	2,168	79	82
3.2.3 Number of Psychiatric beds in general hospitals (i/.e. beds dedicated to mental health care in general hospital wards)	4,837	23	281
3.2.4 Number of community residential facilities			
3.2.5 Number of beds / places in community residential facilities			
3.2.6 Number of mental hospitals	25	Na	Na
3.2.7 Number of beds in mental hospitals	4,326	Na	Na
3.2.8 Number of secure psychiatric beds			
3.2.9 Number of forensic beds	529		

Source: Spanish Ministry of Health (2010, 2011)

Number of private sector mental health services in and places/beds in Spain 2010/2011

	A) Total number of facilities / beds	Number of facilities/beds reserved for children and adolescents	C) Number of facilities/beds reserved for older people only
3.2.1 Number of mental health outpatient facilities	708	159	na
3.2.2 Number of day treatment facilities	666	0	58
3.2.3 Number of Psychiatric beds in general hospitals (i/.e. beds dedicated to mental health care in general hospital wards)			300
3.2.4 Number of community residential facilities			
3.2.5 Number of beds / places in community residential facilities			
3.2.6 Number of mental hospitals	60	Na	Na
3.2.7 Number of beds in mental hospitals	8,101	Na	Na
3.2.8 Number of secure psychiatric beds	Na	Na	Na
3.2.9 Number of forensic beds	0	0	0

Source: Spanish Ministry of Health (2010, 2011)

The table below provides details of the number of psychiatric beds in the public and private sectors broken down by Autonomus Communities (ACs) 2009.

Psychiatric hospital beds by Autonomous Communities in 2009

Autonomous Communities (number of inhabitants in ACs, 2006)	**Number of Psychiatric beds**
Andalusia (7,975,672)	1,163
Aragón (1,277,471)	843
Asturias (1,076,896)	48
Cantabria (568,091)	494
Castilla y León (2,523,020)	608
Castilla-La Mancha (1,932,261)	356
Catalonia (7,134,697)	4,736
Comunidad Valenciana (4,806,908)	617
Extremadura (1,086,373)	816
Galicia (2,767,524)	422
Balearic islands (1,001,062)	157
Canary islands (1,995,833)	128
La Rioja (306,377)	137
Madrid (6,008,183)	1,726
Murcia (1,370,306)	193
Navarre (601,874)	378
Basque country (2,133,684)	1,742
TOTAL (44,708,964)	14,564

Source: Ministry of Health 2009

Community-based mental health services

There are a wide range of community based facilities from day hospitals to home care services delivered by multidisciplinary teams. Other services include 'labour insertion centres' to assist people with mental health problems find employment. The number of mental health services and places/beds in Spain are listed in the table below based on data from the Mental Health Observatory of the Spanish Neuropsychiatric Association (NEA).

Community-based mental health services 2010

Type of services	**Number**	**Places/beds**
Psychosocial Rehabilitation Centres	72	-
Occupational centres	91	-
Adults Mental Health Centres	525	-
Child/Adolescent Mental Health Centres	207	-

Adult Short-Stay Hospital Units (General hospital)	141	3,020
Adult Short-Stay Hospital Units (Psychiatric hospital)	14	537
Adult Day Hospital	105	2,272
Child/Adolescent Day Hospital	52	1,061
Treatment and Rehabilitation Hospital Unit	117	3,510
Long-stay Units	71	5,489
Residential alternatives	-	5,327
Psycho geriatrics	65	3,417
Leisure and free time resources	167	5,363
Continuing care programmes and assertive treatment	89	-
Home care	9	-

Source: Mental Health Observatory of the Spanish Neuropsychiatric Association (AEN), 2010

Access and usage

Health care in Spain is universal in its coverage. Mental health care is provided at the Primary Care level in the first instance and when appropriate, general practitioners can refer patients to mental health centres where they can access specialized services (day care, rehabilitation, etc.). Patients have also access to specialized system through hospital emergency facilities. Under some circumstances, people can be referred by others agencies (welfare, justice, education, etc.).

Variation and gaps

The 2006 National Strategy on Mental Health highlighted a number of problems still to be addressed. This includes the uneven distribution of some services across ACs including rehabilitation facilities, the scarcity of specific mental health programmes for children, adolescents, older people, immigrants and prisoners, poor information systems, the need for more coordination and integration of services particularly between primary, social and specialised care, and the insufficient development of prevention and mental health promotion work in the community. The 2009 evaluation of the National Mental Health Strategy found that some of these problems had been resolved.

Financing

The main sources of funding for mental health services are tax expenditure, out of pocket and private insurance, but there are no official data on the financing of mental health services. PSICOSOT (2011) study, using the OECD methodology (OECD, 2000) noted that hospital expenditure on mental health and drug abuse was €764 million (€16 /inhab.) in 2009; 91% of this spending was public. This has increased by 20% since 2005. Expenditure on residential care for intellectual disability, mental health and addictions was €108 million (€2/inhab.) in 2009; the private sector accounted for 87% of the total costs for these services. The annual increase was higher in this case (57% more than in 2005).

Current expenditure on mental health varies among the regions and is estimated at between 3% and 8% of the total health budget which is approximately 5.5 million Euros for Spain.

Workforce

There is no official data on the mental health workforce. According to the Spanish Neuropsychiatric Association and PSICOSOT (2011) there are a total of (per 100 000): 7.1 psychiatrists, 8.1 nurses, 4.9 psychologists, 2.8 social workers, 1.1 occupational therapists and 11.1 infirmary assistants.

Number of mental health staff in the Spanish Autonomous Communities 2011 (Full time equivalents)

AC (Inhabitants 2010)	Psychiatrists	Psychologists	Nurses	Social workers	Occupational therapists	Infirmary assistant
Andalusia** (8,370,975)	489.5	259	613	121.5	55	751
Aragón**(1,347,095)	92	44	29.5	185.5	9	32
Asturias**(1,084,341)	99	41	168	16	4	140
Cantabria*(592,250)	40	26	27	4	3	
Castilla y León*(2,559,515)	174.5	101	268	35.5	20.5	318.5
Castilla-La Mancha*(2,098,373)	149	152	198	58	43	375
Catalonia*(7,512,381)	745	691	727	507	116	1011
Com Valenciana**(5,111,706)	308	154	295	53	26	500
Extremadura**(1,107,220)	71	66	100	17	11	289
Galicia (2,797,653)	-	-	-	-	-	-
Balearic islands**(1,106,049)	75	55.5	129	30	10.5	145
Canary islands**(2,118,519)	109.5	83	204	38.5	3.5	276
La Rioja*(322,415)	19	13	42	2	3	102
Madrid*(6,458,684)	562.5	422	487.5	145	149	497.5
Murcia**(1,461,979)	122	89	156	30.5	30	
Navarre**(636,924)	50.5	29	56	18	8	262
Basque country**(2,178,339)	229	94.5	309.5	68	30.3	502
TOTAL	**3335.5**	**2320**	**3809.5**	**1329.5**	**521.5**	**5201**

Does not include facilities for drug misuse services

Source: * Data from PSICOST (2011) ** Data from AEN (2011)

Responsibility and delivery of mental health promotion and prevention of mental illness

Responsibility mainly lies with the Ministry of Health. Delivery is coordinated by the Autonomous Communities.

Mental health status

Prevalence of mental health in the population

The 2006 Spanish National Health Survey (ENSE) (Ministry of Health, Social Policy and Equality, 2006) provides data on self-declared mental health problems diagnosed by a medical doctor in the last year. According to this report from a sample of 29,478 people 13.8% of the population over 16 years (8.2% males and 19.3% females), 20.9% of people over 65 (10.9% males and 28.3% females) and among 1.2% of children aged between 5 and 15 (1% boys and 1.3% girls) suffer from depression, anxiety or some other mental disorder.

Incidence

Not reported

Risk factors

Loss of a love one (death, separation and divorce), being an immigrant in a developing country, unemployment or on some form of work leave, a perceived lack of social support, suffering from chronic illness, sick or maternity leave, unemployment, suffering from a disability, alcohol dependence and being single (for men).

Protective factors

Married people or those cohabiting exhibit low prevalence of mental disorders. Higher educational level also corresponds with lower rates of mental illness.

Prevention and promotion programmes/activities

Related to promotion, from 2006 to 2008 most ACs reported having included interventions in their health plans. Some 46 programmes have been completed, 11 have been evaluated and 22 are in progress. This involves more than 34,000 completed interventions, over 2,000 evaluated interventions and 178 interventions in progress. Nevertheless, the number of evaluated interventions is low

Regarding prevention, all ACs had interventions of some sort (161 programs, Ministry of Health, 2009).

It is not easy to obtain information on health promotion activities in Spain, and to quantify the types of activities being carried out and in which target groups due to differences among the programs. Nevertheless, between 2006 and 2008 all ACs conducted a large number of interventions, as assessed by the National Strategy, although only a small percentage was evaluated.

Examples of programmes are listed below:

Prevention and promotion programmes/activities 1999 – 2011

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Mental Health-Sensitisation Programme. "Mentalízate" (Mental Preparation) Programme	Aim: to raise awareness among young people in terms of their knowledge about mental illness, inform them about the relationship between mental illness and risk behaviour, and improve their attitudes to people with mental illness and their families.	Young students with primary, secondary and university education (students approximately between 14 and 20 years), educators, teachers, and education system professionals in general	Financed and coordinated by FEAFES Confederación Española de Agrupaciones de Familiares y Personas con Enfermedad Mental-Spanish Federation of Family Groups and People with Mental Illness).
"My friends, my garden" (Health promotion and primary prevention)	Aim: to prevent drug addictions, from the general perspective of preventing mental health problems.	Children from 6 to 8 years old.	
"The Adventure of Life" (Health promotion and primary prevention)	Aim: to promote health. An educational intervention for children attending primary school, based on the idea of health as living autonomously, joyously and in solidarity. Course Started in 1999-2000, in 2007-2008 achieved a participation of 22123 children, 1316 parents and 1003 teachers and assistants.	Primary school children	1999-2000 and 2007-2008
"Pack Escoles" (Health promotion and primary prevention)	Aim: to set up workshops for children from the Secretariat of Youth, targeting issues such as self-esteem, body image, peer pressure, prevention of drug use and eating disorders.	Children	2007/2008
Workplace			
Health and Well-being of Health	Aim: to develop a guide to prevent burnout among health-professionals, directed at	Health care employees	2011

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Professionals in Workplace Settings	institutions, teams and professionals. Disseminated in 2011, planned to be translated into educational interventions.		
Other programs			
Prevention and independent life programme for people with mental illness	Aim: to encourage the development of strategies for preventing disability, promoting mental health and independent life for people with mental illness. Programmes can be developed in psycho-education, social support, empowerment and setting-up of mutual assistance networks, sensitisation activities and other actions designed to cover the needs of those with mental illness, promoting their leadership in the activities under consideration.	People with mental illness.	The programme has been carried out in Ceuta, and is awaiting implementation throughout Spain. It is financed by FEAFES (Confederación Española de Agrupaciones de Familiares y Personas con Enfermedad Mental- Spanish Federation of Family Groups and People with Mental Illness).
Prevention of Depression in Primary Care	Aims: to prevent major depression in adult patients in Primary Care Centres. To train health professionals for early identification and management of emotional illness through effective problem-solving strategies. General Practitioners identify patients at risk and referring them to the nurse, who administers the intervention.		
"Growing with you" (Mental health promotion and primary prevention)	Aim: to develop workshops for parents with children 0 to 36 months old, where they can share anxieties, fears, doubts and the gratification of parenthood, and improve their role in the educational process (especially the affective bond with children).	Parents of children under 3 years	
"Programme of care for the emerging psychotic disorder" (Secondary and tertiary prevention)	Aim: to promote the detection and early treatment of psychotic disorders in children and adolescents at higher risk, and inform the general population, primary care staff and other professionals that are in contact with adolescents and youngsters.	Adolescents at high risk of developing psychosis	Imminent

Investments into mental health – health, education, social development and economic growth

From 2008 to 2011, the Ministry of Health gave funds to the ACs amounting 11,350,000 Euros, and the Regions carried out 225 projects with them. There are no official data regarding investment by de ACs in these issues.

Initiatives to strengthen mental health systems in relation to MHP and PMI

Developments in mental health care and mental health strategy have underpinned the importance of implementing prevention and mental health promotion. Partial implementation of promotion and prevention activities has taken place, although there is still further work needed in this area.

The National Strategy includes objectives and indicators for the development of multiple promotion and prevention projects at different levels (family, school, women, work, elderly and depressed areas). The National Strategy also strengthens the community model and the evidence based practice.

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4.28 Sweden

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Summary

- Mental healthcare began a process of de-hospitalisation in the 1970s. In 1995 major reforms transferred some responsibilities from county council run medical care facilities to social service facilities run by the municipalities.
- Available community mental health services tend to vary due to the highly de-centralised system. There are a wide range of services however, with municipal services directed at disability caused through mental illness and county council services emphasising treatment of illness.
- A main criticism of mental health care in Sweden is that there is a lack of coordination between medical and social services. The Government appointed a National Coordinator of psychiatric services to address this in 2006.
- Regional variations exist in average treatment times and use of compulsory care.
- A small number of prevention and promotion activities are reported for Sweden in the areas of schools/young people and the workplace. The lines between health promotion and illness prevention tend to be indistinct.

Data for this country profile were gathered in the first instance by the project's country collaborator for Sweden. The research team used these data to prepare a draft country profile and supplemented this with published data where necessary. The draft profile was submitted for review by a Governmental Expert in Mental Health and Well-Being and the country collaborator from Sweden. Any suggested revisions were made by the lead researcher, checked by the Governmental expert and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	9,415,570
Population density Inhabitants per km² (2009)	22.7
Women per 100 men (2011)	100.7
GDP PPP (2010)	11.7
Psychiatric care beds in hospitals per 100,000 inhabitants (2010)	48.0
Standardised Suicide rate by 100,000 inhabitants	12.3
Gallup Wellbeing index (2010)*	
Thriving	68
Struggling	30

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Mental health issues are primarily regulated through three laws: The Health and Medical Services Act (1982) the Social Services Act (1982) and the Act concerning Support and Service for Persons with Certain Functional Impairments (1993). All these laws are called "frame laws" that provide a framework for medical and social services. They also stipulate rights to services for citizens. Health promotion/ illness prevention are included as general goals in these laws. There is no specific legislation for MHP/PMI (mental health promotion/prevention of mental illness) and no such legislation pending.

The Compulsory Psychiatric Care Act (1991) and The Forensic Psychiatric Care Act stipulate provisions regarding coercive interventions for the mentally ill. In 2008, compulsory community care was introduced as a "new form of care", with the purpose of facilitating the transfer of hospital patients to community life. To some extent, this legislation is PMI as it attempts to prevent relapses. (Sjöström et al., 2011).

In its proposal for public health policy in 2007/2008, the Government gave priority to six areas, of which two related to mental health: to support parenting and intensifying suicide prevention. Aside from these, no issues specifically related to mental health are included in the list of 11 target areas – although mental health may be indirectly relevant within several of these (e.g. health-promoting medical services).

Mental health policy and inclusion of prevention and promotion

The context of the Swedish Welfare State

Medical care and social services are highly decentralized in Sweden, which means that it is difficult to pinpoint policies on a national level. To a large extent, policy initiatives and decisions are primarily made at a regional (medical care) or municipal (social services) level. National policies are typically mediated through government agencies like the National Board of Health and Welfare (NBHW), the National Institute of Public Health, or the Swedish Association of Local Authorities and Regions (SALAR). Policies are often implemented through information, education and seeding money distributed from central to regional/municipal levels.

The design of the Swedish welfare state is founded on general principles, systems, benefits and interventions. This means that there are many factors in the systems that have a bearing on MHP/PMI (e.g. labour market or gender equality policies) but without being portrayed as such.

Legislation and Policy

There is no stand-alone mental health policy as such. However, in 2012, the Swedish government launched a roadmap for targeted interventions for mental health. This roadmap covers a five-year period (2012-16) and includes additional funding of 870.000.000 SEK per year, and aims both at preventative measures and improving treatment and support for those who are already affected by mental illness. Children and young people are specifically mentioned as a prioritized target group.

Previously, in the 2010 revision of the School Act the health promotion and prevention role of school health services was also reinforced.

In March 2011, the Riksdag adopted a general strategy regarding preventive alcohol, drugs, doping and tobacco policy.

In the Government's latest report on its policy for people with mental illness or disability derived from mental illness, four areas are given priority: services for children/youth; work and daily activities for people with disabilities; competence and evidence; long-term efforts towards development and increased quality in services.

In its strategy for disability policy 2011-2016, the Government states its ambitions to raise awareness of and change attitudes towards people with mental illness.

No proposals for legislation specifically addressing MHP/PMI are pending.

In 2008, The Government allotted 50 billion SEK (500 million Euro) as seed money for six municipalities to develop HP activities for children and youth.

Mental health services

Organisation and functioning of mental health systems

Due to its decentralized structure, there are considerable variations in the organisation of mental health care in Sweden. However, mental health services are basically organised into four types of organisations: Primary health care centres, “General” psychiatric hospital clinics, forensic psychiatric clinics, Child and youth psychiatric centres and outpatient units. There is an overlap between the latter and municipal social psychiatry services. The main difference is that municipal services are targeting disabilities deriving from mental illness, whereas county council services are oriented towards treatment of illness. Municipal social psychiatric facilities organise housing, everyday activities, support in everyday life and administer medication that is prescribed by County council doctors.

In 2010 there were 3,296 (3.5/10,000 inhabitants) beds in inpatient facilities, 1,113 (1.2/10,000 inhabitants) in inpatient forensic facilities and 157 (0.17/10,000 inhabitants)) in child/youth inpatient, totalling 4,566 inpatient beds (4.8/10,000 inhabitants): (SKL 2010). During 2008 1,583,704 inpatient days were produced (1,700/10,000 inhabitants). There is a considerable (> x 2 difference) between county councils. 68% of inpatient days in general inpatient facilities are voluntary, 29% are involuntary (“civil commitment”) and 2% forensic (of which 90% are male).

In 2006, most patients with psychiatric symptoms were treated in primary care – primarily those with minor problems. Unfortunately, there is no database over patients in primary care.

Access and usage

Typical initial health care contact in Sweden is with a general practitioner in a local health centre. Referral process varies county to county. In some counties GP’s have a gatekeeping role where normally they give referrals to specialists and other care.

88,401 treatment episodes were recorded in hospital clinics (93 episodes/10,000 inhabitants). Over the age of 25, men are in the majority. Particularly for women, there has been a distinct increase of patients in the age span 15-24. Numbers are decreasing for people older than 65. There is a considerable variation between different county councils (more than x2 difference). Data regarding inpatient care are thought to be relatively reliable. (NBHW 2008)

In county council outpatient facilities, 225,000 patients (237/10,000 inhabitants) had 690,000 doctor consultations (729/10,000 inhabitants). Statistics from SALAR indicate a higher number: 933,390 episodes (986/10,000 inhabitants). More women than men use

outpatient facilities. There is a tremendous variation between county councils – more than x30 difference. Data regarding outpatient care are thought to have quality problems. (NBHW 2008).

Effectiveness

In recent years, there is a strong policy emphasis on evidence-based practice. However, many treatments lacks a clear evidence-base, particularly so in the social service sector. It has been argued that due to the complexity of both problems and interventions, it is difficult to measure effects of interventions in this field. NBHW has produced National Guidelines for the Care of Depression and anxiety syndromes and Psychosocial interventions for schizophrenia.

Another trend is that interventions are increasingly assessed from a service user perspective, where service users more often find themselves in a role of being 'customers' – in theory, then, service users can choose better services if what they are offered is unsatisfactory.

Variation and gaps

Variation in Delivery:

The NHBW found that:

- People with mental illness risk lower health, lower life expectancy and lower quality of treatment for somatic disease;
- People with mental illness are increasingly treated in inpatient care for depression and anxiety-related illness. This increase is not limited to groups that with lower socioeconomic status. It is unclear whether this reflects a real increase or changes in detection patterns;
- People with schizophrenia, have a worse economic situation and have difficulties establishing themselves on the labour market (Socialstyrelsen, 2011);
- There is substantial regional variation in average treatment times for schizophrenia, psychosis and bipolar disease;
- There is substantial regional variation in the use of compulsory care.

Gaps in Care:

Mental health care was de-hospitalised starting in the 1970s. In 1995, a major mental health reform transferred some responsibilities from medical care facilities (county councils) to social service facilities (municipal). A common critique of mental health care since then has been insufficient coordination between medical and social services. In 2003, the Government appointed a National Coordinator of psychiatric services to address these issues. (Arvidsson 2009; Markström et al., 2004)

Financing

Costs for psychiatric care comprise 10.5% of total expenditure in health and medical services (Nationell psykiatrisamordning, 2006). More recent figures reveal a proportion of 10.0% (World Health Organization, 2011).

In terms of costs for inpatient care, the expenditure for general psychiatric facilities was 5.239 billion SEK (524 billion EUR), forensic inpatient facilities 1,805 billion SEK (180 billion EUR) and child and youth care 476 billion SEK (48 billion EUR). The average cost for one day at a general inpatient facility is 3,350 SEK (336 EUR), for a forensic facility 3,458 SEK (346 EUR) and a child/youth facility 6,310 SEK (631 EUR). Note that all treatment is almost free of charge for patients.

In 2006, about 20,000 individuals with disability deriving from severe mental illness were enlisted with municipal social services. Members in this group may be subject to e.g. social welfare payments, supervised housing, daily activities and case managers (Nationell psykiatrisamordning, 2006). 8,400 individuals (8.9/10,000 inhabitants) with psychiatric or physical disability received at least one kind of service according to the Act concerning Support and Service for Persons with Certain Functional Impairments (Socialstyrelsen, 2008).

Workforce

Professionals: (Statistics from the NBHW 2008)
Number of psychiatrists: 1611 (1.7/10,000 inhabitants)
Number of psychiatric nurses: 5266 5.7/10,000 inhabitants)
There are no national data on staffing, but a report from Örebro County Council provides an impression of the distribution of different professionals: 46 psychiatrists, 155 registered nurses (72 special qualifications in psychiatry), 187 mental health workers, 57 psychologists. Note that municipal services are excluded: those services primarily employ community care workers - doctors and psychologists are hardly ever employed.

Funding levels are not expected to change.

Responsibility and delivery of mental health promotion and prevention of mental illness

The Government is responsible for delivery of mental health promotion and prevention of mental illness with initiatives and decisions being mainly made at a regional or municipal level. National policies tend to be go through government agencies such as National Board of Health and Welfare (NBHW), the National Institute of Public Health, or the Swedish Association of Local Authorities and Regions (SALAR).

Mental health status

Prevalence of mental health in the population

There are no epidemiological data over the distribution of ICDD10-diagnoses in the Swedish population. The NBHW has a patient database from which the number of patients who have received inpatient treatment during a given year can be drawn (with ICD10-diagnoses). In 2010, 59,801 individuals received inpatient care for mental illness or behavioural disturbances (63/10,000 inhabitants). 7,706 individuals (8.3/10,000 inhabitants) were treated for Schizophrenia, schizotypical and delusional disorder. According to the same database, 1,138 individuals (1.2/10,000 inhabitants) died of suicide in 2009.

In its 2007/2008 proposal on public health policy, the Government identifies neuro-psychiatric illness as one of the three dominating illness groups that make up 60 % of the national illness burden in terms of Disability Adjusted Life Years (DALY).

According to Statistics Sweden (Government agency), 6% of men and 4% of women in 2005 reported that they suffer from long-term MI – the number is probably underestimated because of drop-outs. 13% of men and 23% of women reported anxiety problems. 30% of women aged 16-24 reported anxiety problem. Women with lower education more often report mental health problems. People with a background from another country – particularly men – report more mental health problems. Mental health problems are also more commonly reported in metropolitan areas.

Incidence

Not reported.

Protective and risk factors

Risk factors: Gender, socioeconomic factors, non-Swedish origin.

Protective factors: social network, employment, having a partner.

Prevention and promotion programmes/activities

It was reported that in Sweden there is sometimes a lack of distinction between health promotion and illness prevention - the concepts used in Sweden not translating directly into MHP and PMI. In reality, it was stated, most policies and programmes incorporate aspects of both MHP and PMI. The activities recorded however, are listed below:

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools (children and young people) (Prevention)			
WE-STAY	Aim: to study short- and long-term outcomes of underlying psychological and mental ill-health for adolescents who truant.	Children in high schools.	2010-2013. Funded by EU.
SUPREME	Aim: to produce an interactive website enhancing the mental health and well-being of European adolescents through developing, strengthening and sustaining Europe's scientific community.	Adolescents, NASP at Karolinska Institutet.	2010-2013
Workplace (adults of working age): (Prevention)			
Vision Zero Suicide Programme	Aim: to promote the idea that suicide is everyone's responsibility, and first-aid training to help suicidal persons should be provided for every citizen. Conveys a strong signal from the Government to the whole population that suicide is an important issue and must be addressed accordingly. Also intended to counteract stigma surrounding suicide.	General public, Government.	Operating since 2008.
Mental Health First Aid (pilot project)	Aim: to help provide initial support for people seeking help for mental health problems. A course to create a system for a long term preventive work throughout the country. If the pilot is successful, it will be funded by the government for 6 years.	General public	12-hour training course over 3 phases. 2010-2012.
Model project	Aim: to increase the quality in the early identification and care of suicidal people.	General public, NASP	Not reported.
'Hjärnkoll'	Aim: to combat stigma.	Employees,	Not reported.

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Programme	Nationwide anti-stigma programme, to reach a 5 % positive shift in public attitudes towards mental health problems, to involve 10,000 supporters into the programme, to involve 200 employers into the programme, and to increase media coverage of people with direct experience of mental illness.	employers. trade unions and occupational health services.	
Schools (children and young people) (Promotion)			
SEYLE	Aim: to lead adolescents to better health through decreased risk taking and suicidal behaviours, to evaluate outcomes of different preventive programmes and to recommend effective culturally adjusted models for promoting health of adolescents in different European countries.	Adolescents in schools.	Not reported.
Workplace (adults of working age): (Promotion)			
Action life-saving Programme	Aim: to improve the routines and quality of care, treatment and follow-up of the suicidal patients.	Suicidal patients., Stockholm South Psychiatric Unit and NASP	Not reported.

Investments into mental health – health, education, social development and economic growth

This was reported as almost impossible to estimate. Most investments in PMI/MHP are made by municipalities and there exists no national data. Specific PMI/MHP programmes are thought to be only a minor part of general policies and programmes.

Initiatives to strengthen mental health systems in relation to MHP and PMI

In schools:

In a national inventory of MHP/PMI activities in Swedish schools, the NBHW found:

- Schools apply a large number of programmes with a universal preventive purpose to counteract bullying and norm-breaking behaviour.
- Many schools also apply programmes for parental support and parental participation.
- A large majority of schools have written plans for what to do when it is observed that a child may suffer from MH problems.
- Most schools cooperated with other organisations (particularly social services and child/youth psychiatry) to identify, prevent or intervene when facing MH problems.

The NHBW concludes that there is a need to:

- clarify the role of schools in MHP/PMI;
- analyse which programmes to use, and
- improve the knowledge in schools in order to observe early symptoms' of MH problems.

The Government has assigned to the NBHW to disseminate knowledge about PMI targeting children and youth.

As part of a policy programme for gender equality in 2008, the Government has assigned the National Agency for Education to work with PMI and MHP in schools, specifically addressing gender equality.

In 2006, the National Agency for Education received funds for local development projects for improving collaboration between schools, the police, social services and child/youth psychiatry.

A 2010 report from the Swedish Council on Health Technology Assessment (SBU) evaluates PMI/MHP programmes for children and found that most activities were universal and not confined to school settings:

- The percentage of school nurses reported that they use manual-based programmes for parental support. The most commonly used programmes were EPDS, ICDP, COPE and KOMET.
- Programmes that were applied were Active parenting, ICDP, Coping with stress, SET (Social emotional training), KOMET, Second step, COPE, incredible years, Strengthening families, Children are people too; TeenAge Power Program; Beardslees family intervention.

In the Workplace (adults of working age):

Swedish labour market policy and legislation in general are designed in a way that in fact is health promoting (rules for sick-leave, employment security, safety regulations, strong influence of trade unions, etc.). There are very few specific programmes addressing MHP/PMI in the workplace.

A number of governmental agencies has co-authored a report about strategies to involve people with disabilities in working life. 15 distinct proposals were developed in three domains:

- developing interagency cooperation,
- reinforcing weak links in rehabilitation,
- disposing rules that hinder participation.

For mental disabilities, the report specifically points out the need to improve psychiatric care, especially counselling and speech therapies, that people with mental disability are given the right to daily activities according to the Act concerning Support and Service for Persons with Certain Functional Impairments. (LSS)

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4.29 United Kingdom

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Summary

- Psychiatric wards in general hospitals and psychiatric hospitals (some privately run) and separate purpose built units form the main core of inpatient provision. Since 1989, the number of psychiatric beds supplied by the National Health Service has dropped almost a half.

- Community based services are mainly provided by multidisciplinary mental health teams or primary mental healthcare services typically with mental health nurse practitioners and graduate primary care mental health workers. These services include crisis resolution/home treatment teams, early intervention teams and child and adolescent teams. NGOs play a significant role in delivering mental health services such as day care, advocacy and mental health prevention and promotion campaigns.

- There is a wide variation in the number of inpatient psychiatric beds. A significant variation in admission rates and total bed days and length of stay is also an issue.

- Current policy proposes improvements that include the furtherance of mental health promotion. Additionally, local government is viewed as having an important role in improving well-being. There are a large range of prevention and promotion activities and programmes listed many directed towards the general public, the workplace and for schools and young people respectively.

Data for this country profile were gathered in the first instance by the research team. The data were used to prepare a draft country profile which was submitted for review by Governmental Experts in Mental Health and Well-Being from Scotland and England. These experts provided additional up-to-date information and revisions. The country profile was then revised accordingly by the lead researcher, checked by Governmental experts and a final version validated by them. Completed and validated in 2012.

Background information

Population (1 January 2011)	62,435,709
Population density Inhabitants per km^2 (2008)	252.5
Women per 100 men (2011)	103.2
GDP PPP (2010)	0.9
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	60.8
Standardised Suicide rate by 100,000 inhabitants	6.6
Gallup Wellbeing index (2010)*	
Thriving	54
Struggling	44
Suffering	2

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

Mental health legislation in the UK consists of broadly parallel laws that cover England and Wales, Scotland and Northern Ireland. The legislation dates back to the 1983 Mental Health Act in England, the Mental Health (Scotland) Act 1984, and 1986 Mental Health Order Northern Ireland. These provided a legal framework for compulsory admission and the treatment of patients with a mental illness. Subsequent revisions to legislation have added human and legal rights of individuals to ensure that people with mental illness could be treated to prevent them harming themselves or others.

The Mental Capacity Act 2005 which came into force in England and Wales in 2007 enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

The latest Mental Health Act in Scotland was passed in 2003 and contains three types of compulsory powers – emergency detention, short term detention and Compulsory Treatment Order – and provides for compulsory treatment in the community as an alternative to detention. Scotland also has incapacity legislation and legislation to protect vulnerable adults

Mental health policy and inclusion of prevention and promotion

The introduction of the 10-year National Service Framework (NSF) in 1999 by the Department of Health brought significant changes to mental health services in England and Wales. The NSF, for working age adults, detailed seven standards for mental health: 1) Mental health promotion which services should promote for everyone; 2) and 3) Primary care and access to services should be available to anyone with a common mental health problem and offered treatment, including referral to specialist services if necessary; 4) and 5) Provision of effective services for people with a severe mental illness 6) Provision for carers of people with mental illness; and 7) Prevention of suicide.

In order to implement the NSF considerable expansion and improvements to existing community mental health services were needed. This was addressed in the NHS Plan (2000) which set targets to strengthen community mental health care by moving away from old acute wards. This led to the introduction of community mental health services (e.g. crisis resolution/home treatment, assertive outreach and early intervention teams) and primary care based talking therapy services (Improving Access to Psychological Therapies, IAPT). NSFs for older people and children and young peoples' mental health were launched separately. Recent mental health strategy includes 'No Health Without Mental Health' (February 2011) and its Implementation Framework published in July 2012. This mental health strategy's objectives include that 'more people will have good mental health' and 'more people with mental health problems will recover', and an emphasis on better mental health outcomes. The strategy takes a life course approach, recognising that the foundations of well-being start in early years and into adulthood and into a healthy old age.

Prior to the 2011 mental health strategy a public health White Paper, 'Healthy lives, healthy people' (2010), outlined a strategy in which local authorities are to adopt new responsibilities for public health, supported by new integrated Public health services. Since this time the coalition government has proposed to overhaul and modernise health and social care in England. The Health and Social Care Act, passed on 27 March 2012, aims to introduce clinically led commissioning supported by an independent NHS Commissioning Board; and enable various providers (NGO's, private sector and statutory services) to deliver innovative services; give patients a greater voice and enable them to choose services that best meet their needs. Local authorities will be obliged to establish a health and wellbeing board to act as a forum for local commissioners across the NHS, public health, social care and elected representatives on how to work together to achieve better health and wellbeing outcomes.

Preventing suicide in England: a cross-Government outcomes strategy to save lives was launched in September 2012. This strategy recognises the contributions that society can

make to prevent suicide. In particular it sets out to: Reduce the general suicide rate; and provide better support and information to those bereaved or affected by a suicide.

Mental health priorities for Scotland were set out in 'Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011' which includes sections on children and older people. All 22 commitments were delivered by early 2011. The Mental Health Strategy for Scotland: 2012-2015 (published August 2012) underlines a commitment to mental health and well-being consistent with NHS Scotland's Quality Strategy and its three Quality Ambitions that care and treatment should be Person Centred, Effective and Safe.

The NHS in Scotland is not subject to English reforms; Scottish Ministers have set out a commitment to a fully public NHS. The Mental Health Strategy includes commitments to faster access to mental health services for young people, better access to psychological therapies, crisis response, peer support, social prescribing and employment.
http://www.scotland.gov.uk/Publications/2012/08/9714

'Promoting mental health strategy and action plan 2003–2008' for Northern Ireland set out r mental health promotion and to prevent the incidence of emotional distress, mental illness and suicide in the population.

The new Welsh strategy for mental health and well-being and delivery plan for 2012 to 2016. The Welsh Assembly Government has produced strategies for both adult and child and adolescent mental health services. 'Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency' is a ten year plan to improve, modernise and develop mental health services in Wales. There is also the 'All Wales Mental Health Promotion Network'.

Mental health services

Organisation and functioning of mental health systems

England - Organisation and functioning of mental health systems

Providers of mental health care include the NHS, local authority (social care services), voluntary- and private-sectors. Ten strategic Health Authorities support regional and local health service delivery. Primary care trusts commission and occasionally supply mental health services for their local population. Some health and social care services are provided by local authorities in partnership with health services through various joint working arrangements. Mental health trusts, of which there are 58 in England, provide specialist services for people with mental illness. A relatively new type of NHS hospital includes Foundation trusts, introduced in 2004. These hospitals are run by local managers,

staff and members of the public. They aim to tailor services to local population needs and are given greater financial and operational freedom compared to other NHS trusts. There are currently 129 Foundation trusts in England and they represent the government's attempt at decentralising public services.

There is a broad range of available mental health services spanning from inpatient acute care to community-based provision in both primary and secondary care settings.

Inpatient care: Psychiatric wards in general hospitals, psychiatric hospitals (some private) and separate purpose built units (e.g. forensic secure care) form the main basis of inpatient care. In 2009, there were 51,035 psychiatric beds for working aged adults (60.8 per 100,000 in psychiatric beds in hospitals) (Mental health strategies 2010). Acute inpatient wards/units represented 20% of this total, 26% of beds were in supported housing facilities, 19% in registered residential care homes, 8% in nursing care homes for those with mental illness and over 6% in various secure units. Since 1989 the number of psychiatric beds provided directly by the NHS dropped by less than half from 59,300 to 25,560 beds by 2009/10.

Community based services: Much of mental health care in the community is provided by community mental health teams (with multidisciplinary staff) or primary mental health care services (with, for example, mental health nurse practitioners and graduate primary care mental health workers). The number of specialist community mental health services in 2009 was:

350	Crisis resolution/home treatment services (or 280 actual teams) (24/7 intensive short term home crisis support)
248	Assertive outreach teams (continuous intensive community support)
153	Early intervention teams (assessment and care for people with their first onset of psychosis)

Approximately 1,047 child and adolescent mental health teams existed in 2007, ranging from tier 2 (services in the community) to tier 4 (highly specialised services both inpatient and outpatient).

NGOs: A number of voluntary sector agencies, including prominent service user and carers organisations, play a significant role in delivering mental health services (such as day care, alternatives to hospital), advocacy, promotion, campaigning to improve mental health services and contributing to policy making decisions.

Wales Organisation and functioning of mental health systems

In Wales, the NHS and Social Services are the main governmental delivers of mental health services. The Welsh Assembly Government's policies and strategies include the Mental Health Strategy, the National Service Framework and the Carer's Strategy.

In 2009 the NHS in Wales reorganised authorities into 7 Local Health Boards and 22 Social Services authorities to streamline services and attempt to offer a more seamless provision. Both types of authorities have two chief functions: commissioning services i.e. planning, monitoring and reviewing and service deliver, in-house or by external provider.

The NHS delivers services through Local Health Boards at, Primary, Secondary and Tertiary Levels. In Primary Care, GPs take on the major role for mental health services. At Secondary Care level, specialist services undertake care for serious mental illnesses such as providing psychiatric hospitals and wards and coordinating services through Community Mental Health Teams. Tertiary Care is more specialised and is provided through regional and national hospitals and units. Some people needing tertiary care are referred to services in England. Typical services at this level might be for eating disorders, substance abuse, or needing intensive psychiatric care units and provision of medium secure and secure hospitals.

Community Mental Health Teams (CMHTs) are staffed and managed jointly by the NHS and Social Services. Some professionals working in teams include psychiatrists, psychiatric nurses, psychologists and social workers. People with serious mental illnesses whose care is managed through a CMHT have a 'care coordinator'. Duties of the CMHT include contributing to psychiatric diagnosis, acting as gatekeeper to specialist hospital or community care and coordinating treatment and care.

Social Services are part of the 22 Welsh Local Authorities but are increasingly being merged with other local authority departments. Amongst their responsibilities are planning and commissioning the full range of local mental health services, and delivering Community Care Services such as day services, home support and supported accommodation services. They also provide social workers to contribute towards CMHTs and Community Care Assessments.

Scotland - Organisation and functioning of mental health systems

Mental health services are delivered in Scotland through the NHS, local government and voluntary sector and through a combination of primary care services such as GPs and

specialist services such as community mental health teams or inpatient services. Most services are directly provided by NHS Boards which combine service provision and commissioning functions in Scotland.

The NHS in Scotland operates through 14 geographical boards and 8 specialist boards, including the State Hospital, NHS Health Scotland, NHS Health Improvement Scotland, NHS 24 and NHS Education Scotland all of which have mental health programmes and which work with geographical boards to create capability and in delivery.

Scottish Ministers have prioritised improvement in mental health services. Mental health targets form part of the overall framework for performance management of the NHS in Scotland with between 2 and 4 national targets being in place since 2007 (out of a total of between 24 and 16 targets). Targets and objectives for the Boards are agreed with stakeholders and service delivery organisations which ensures performance and improvement of services. Mental health has been regularly debated by the Scottish Parliament since its inception. Some high level examples of the work that has been taken forward and the improvements that have been made include:

Readmissions – The number of patients who had a psychiatric readmission within one year of a previous psychiatric admission decreased steadily from 4,576 for the year ending 31 December 2004 to 3,426 for the year ending 31 December 2009. Increased access to Intensive Home Treatment Teams has been evaluated as a significant service improvement by the Mental Welfare Commission. Data shows the introduction of compulsory treatment in the community has resulted in a reduction in those being detained for treatment.

Suicide – the number of suicides reduced by 13.8% between 2000-02 and 2008-10. We have also delivered the HEAT target to train at least 50% of all frontline staff in understanding suicide and being able to work safely with people at risk of suicide. Suicide has continued to fall since 2008, with the number of suicides in 2009 being the lowest since 1991 and the numbers for 2010 and 2011 also two of the lowest.

Dementia – NHS Boards in Scotland now have the highest level of diagnosis in the UK and are the most improved. The Alzheimer Society report 'Mapping the Dementia Gap: Progress on improving diagnosis of dementia 2010-2011' showed that NHS Scotland has nine of the top twelve performing health areas across the UK for dementia diagnosis[5].

Access to Psychological Therapies – There is a national target to deliver faster access to mental health services by ensuring access to a psychological therapy within 18 weeks by December 2014.

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[5] The report is available at http://alzheimers.org.uk/dementiamap with information at NHS Board or Trust level across the United Kingdom.

Child and Adolescent Mental Health Services –The HEAT target to ensure access to specialist Child and Adolescent Mental Health Services (CAMHS) treatment within 26 weeks by March 2013 and by 18 weeks by December 2014. Data suggests a reduction from over 1200 waits of over 26 weeks when this work began to around 250 currently. There has been a 34% increase in the size of the specialist CAMHS workforce between the end of 2008 and March 2012.

The Scottish Government prioritised the creation of good quality data on mental health services and has Board level data for community services, inpatient services and workforce (available at http://www.isdscotland.org/Health-Topics/Finance/National-Benchmarking-Project/)

Northern Ireland - Organisation and functioning of mental health systems

Northern Ireland has greater mental health service needs than other countries in the United Kingdom (Health and Social Care, 2011) with a mental health burden 20% higher than England or Scotland. Contributory factors include deprivation experienced in some communities and consequences of 'the troubles' conflict.

The rate of suicides has increased by 64% from 1999 to 2008, mostly amongst young males. In 2008, 77% of suicides were committed by males with 72% aged 15-34.

The Bamford Review (2007) laid out reforms to modernise law, policy and provision for people with mental health disorders and learning disabilities in Northern Ireland and set out a programme to transform services, however progress in achieving its modernisation and improvement aims has been slow.

Key areas for review are reducing stigma and raising awareness of mental health issues. For primary prevention, a 2006 suicide prevention strategy, Protect Life, was refreshed in 2011 and the new Mental Health and Wellbeing Strategy was developed to support the people of Northern Ireland's mental health needs. An early intervention system. The Stepped Care Model has been developed as a strategy for mild to moderate disorders but development has been hampered by lack of investment and doubts about levels of provision required by the model not being reached.

The Bamford Review had an action plan to map mental health services and provide information to services users but progress has been limited.

The Stepped Care Model, promoting greater care at home and in the community as opposed to in psychiatric hospitals is under adoption with each of the Health and Social Care Trusts (HSCs) of Northern Ireland developing Crisis Response and Home Treatment

models for the acutely ill, at home. However, these services are not being developed uniformly across the country in the way that they are accessed and the treatment offered, and more consistency is required. Yet to be developed are additional home treatment services for groups such as children and young people with learning disabilities and older people. Generally, a 60/40% split in favour of community care as opposed to hospital care is sought.

Great demand is being placed on the voluntary and community sector in providing support for the recovery model of care. Those sectors are encouraged to have greater involvement in local populations. The approach of Provision of Direct Payments is one strategy towards personalisation of care but there has been a proportionately lower uptake of this from those with mental health issues. Perceived bureaucracy and inconsistent promotion are seen as barriers.

With the aim of ending long-term residency of people in mental health and learning disability hospitals, by 2011, 181 long-stay patients had been discharged to the community with 150 needing to be resettled into the community. The strategy employs care in the home, or as near home as possible. It is said that greater impetus is needed in this area for a suggested complete resettlement of these people by 2012, according to Health and Social Care (2011).

Access and usage

Access to mental health service is free at the point of delivery. In England the number of detentions under the Mental Health Act (admissions and detentions of informal patients) amounted to 45,755 for 2009/10, an increase of 4% from the previous year (NHS Information Centre, 2010). The number of compulsory admissions, also higher than previous years, is around 28,000 detentions in 2009/10, including those readmitted to hospital. The high detention rate is likely to be linked to the reduction in hospital beds and increased availability of community-based care; people may be supported for longer in the community and admitted only when necessary, usually when severely unwell, and so less likely to agree to a voluntary admission (Care Quality Commission, 2011). These figures do not include people placed on Community Treatment Orders. Since their introduction in 2008 some 6,237 orders have been made; a much higher number than anticipated (NHS Information Centre, 2010). Between April and December 2011 there were 7,624 new cases of people with psychosis seen by Early Intervention Teams.

Variation and gaps

Variation across regional Strategic Health Authorities in England show the distribution of NHS inpatient psychiatric beds and the number of local authority supported residential facilities is considerable. In 2009 the number of adult beds per 100 000 population of working age was from 0.8 in the South East to 8.0 in London, with an average of 1.6 in

England. There is also a 6-fold variation in admission rates across NHS trusts, a 20-fold variation in total bed days and a 15-fold variation in the average length of stay (Audit Commission in 2010).

Financing

Mental health expenditure amounts to 13% of the health budget for 2012 or £14 billion a year. It has been calculated that mental illness accounts for 23% of the total burden of disease (CEP, 2012). The total healthcare expenditure as a proportion of GDP was 9.6% in 2010 (ONS, 2012).

Most mental health services are funded through the NHS or by local authorities (whose funding is from central government grants supplemented by local taxes). The total investment in mental health services for working age adults in 2010/11 was £6.550 billion or £195.8 per head of weighted working age population. This represented a 3.6% cash increase and a real increase of 0.7% from 2009/10. However, the NHS is expected to make £20bn efficiency savings by 2014/15 which is to be reinvested in front line services.

Growth in health expenditure has far outpaced the rise in both GDP and total public expenditure. Responsibility for health services is devolved to the Scottish, Welsh and Northern Irish administrations. Northern Ireland spends the most on health services (£2,106 per head in 2010/11) and England spends the least (£1,900 per head).

Workforce

In 2009 approximately there were 101,500 staff working in adult mental health services in England. This included some 36,000 nurses, 5,700 medical staff (19.4 psychiatrists per 100 000 population), over 6,000 social workers, 2,850 are psychologists and 5,200 therapists and other staff such as care support workers, support time recovery workers, gateway workers, graduate primary care workers, community development workers, day-care officers, employment and education advisors (Mental health strategies 2010).

Responsibility and delivery of mental health promotion and prevention of mental illness

The 1999 NSF put mental health services at the forefront of mental health promotion and suicide prevention activities. Current mental health policy and the Public Health White Paper (2010) proposes to widens arrangements for improving mental health to partner organisations, such as local authorities, user and care organisations, to deliver the main policy objectives, including mental health promotion. Local government is seen as having an important role in improving wellbeing in the population, rather than sole reliance on health practitioners to deliver such activities.

Mental health status

Prevalence of mental health in the population

Disorders in the general adult population (16-74 years). Common mental disorders 2007. Any CMD was 17.6% for England and Wales (ONS, Adult psychiatric survey 2007).

Diagnosis	Men %	Women %	Total %
Mixed anxiety and depressive disorder (past week)	7.6	11.8	9.7
Generalised anxiety Disorder (past week)	3.6	5.8	4.7
Depressive episode (past week)	2.2	3.0	2.6
Psychosis (past year)	0.3	0.5	0.4

Incidence

A study of 1,030,266 adults aged between 16-64 years (Kirkbride et al., 2006) had the following incidences of mental illness.

Diagnosis	Incidence cases per 100,000 person years
All psychotic disorders	34.8
Schizophrenia	12.8
Non-affective psychoses	10.4
Affective psychoses	9.8
Substance-induced psychosis	1.8

Risk factors

Based on the adult psychiatric survey 2007 the risk factors for common mental health problems, include poverty, unemployment, being female, work stress, social isolation, poor housing, negative life events, poor physical health, family history of depression, poor interpersonal and family relationships, problems with alcohol.

Prevention and promotion programmes/activities

Programme name	Aim/approach	Stakeholders / target group	Duration, Cost of programme
Schools			
UK Resilience Programme	Aim: to improve children's psychological well-being by building resilience and promoting accurate thinking. Delivered weekly or 2 weekly workshops to students aged 11 in 22 schools in Manchester, South Tyneside and Hertfordshire.	Children aged 11. High schools, Local authorities, Department for Education	Launched in 2007/8. A 3-year program
Emotional Health and Wellbeing in schools	Aim: a school based service that offers emotional support to young people and families. School Health Advisors are based at 2 high schools each week. Also offers a clinical psychologist to work on a one to one basis with families	Available in 9 schools in Manchester. Local councils	On-going
Wellbeing programmes for children	Aim: development of school based programme for mindfulness meditation in students at high school. Conducted by Cambridge University	Students in high school.	On-going
Workplace			
Royal Mail – Health and Wellbeing programme	Aim: to increase well-being. Occupational healthcare services Royal Mail Group runs a Health and Wellbeing programme includes health screenings; advice, nutrition and wellbeing; Men's and Women's Health Events; a confidential helpline; face to face counselling and online screening.	Employer, employees	Since 2002 -
British Gas	Aim: increase well-being. British Gas has prioritised staff health and wellbeing by organising events targeting mental health and musculoskeletal problems encouraging a four-month walking challenge for its 28,000 staff, give advice on nutrition and provide free healthy snacks	Employees, employers	Since 2010
Impact on Depression/Work place Training programme	Aim: Offers specialist training to organisations to build staff competencies and promote early intervention.Centre for Mental Health has been working with the Australian not-for-profit organisation, *beyondblue*: the national depression initiative, to adapt and make available in the UK their workplace mental	Employers, managers. Centre for Mental Health. Reached over 1,200 managers in 125 workplaces and many professions e.g. engineers, teachers, accountants, nurses administrators,	Since 2007 to the present

Programme name	Aim/approach	Stakeholders / target group	Duration, Cost of programme
	health programme.	librarians, journalists.	
Essex wellbeing programme for school staff	Aim: A programme to support work/life balance requirements for teachers and head-teachers. Available for all staff in Essex schools. Includes a half day training programme and telephone helpline for information, guidance and support.	Essex Local Authority, school teachers	Sept 2011
Early active rehabilitation programme (Bupa)	Aim: to provide private medical care for early intervention to assist those back to work following a period of illness or injury. Bupa programme that worked closely with a FTSE 100 private company with 38 000 employees in the UK.	Private sector employers, employees on sick leave.	2007-8
Driver and Vehicle Licensing Agency, Wales	Aim: to improve managers' capabilities; and set objectives on attendance.The DVLA developed a Strategy to move towards 'wellness' rather than 'sickness'. This included a more detailed management information to target 'hotspot' issues; review policies to support staff and managers; and introduce a new training course.	Public sector employees, Managers and employees with sickness absence. Public sector services	2005-2011
Pilot project to deal with sickness absence	Aim: to work in partnership with hospital managers and trade unions to help those back to work due to sickness. York Teaching Hospital NHS Foundation Trust invested in a multidisciplinary team, which included specialist nurses, clinical psychologists, counsellors. This reduced sickness absence by 3.8%.	Public sector employers, managers and employees	2008-2011. Investment of £160 000
Five Ways to Wellbeing with GPs and mental health teams	Aim: to increase well-being.An interactive educational 30 minute package to be delivered as in a lunchtime meeting (with free lunch). GPs and mental health practitioners are invited to review the evidence for the Five Ways to Wellbeing before doing a variety of activities that represent each of the Five Ways. Encouraged to think about their wellbeing and explore possible applications of the Five Ways to Wellbeing in healthcare settings.	GP practice staff, mental health staff, GP patients	2010-2011

Programme name	Aim/approach	Stakeholders / target group	Duration, Cost of programme
Health Promotion Agency (Northern Ireland)	Aim: to promote positive mental health at work: Guide for employers. Set out good practice principles for managers to support employees' mental health in the workplace.	Employers, employees	Published 2008
Older people in long term care facilities			
No relevant programmes found			
Other programmes			
Well-being Programme in England	Aim: to improve health and wellbeing in England. The Big Lottery Fund funded 17 portfolios across England to improve the health and well-being of people who live in deprived areas and experience poor mental and physical health.	Big Lottery Fund	Five year programme commencing 2007. £160m total funding for all portfolios
Lambeth Mental Health and Wellbeing Promotion Programme. And, Wellbeing and Happiness in Lambeth Programme 2009-2012.	Aim: to further Lambeth's Wellbeing and Happiness programme, including: wellbeing impact assessments on a mental-health day centre, a timebank, an advocacy service, development of a wellbeing indicator, commissioning budget for time banking, operated jointly by the PCT and council. A project to help schools develop a whole-school approach to emotional health and wellbeing. Implementation of council's strategy is mapped against four theme groups (health and wellbeing, economic development, children and young people, safer Lambeth) and local authority targets.	Local community residents, children in schools. Local council. Lambeth Primary care trust	Launched 2005 -Three year program. Updated in 2009
Liverpool City Council and Liverpool Primary Care Trust developed the 2010 Year of Health and Wellbeing programme (five ways to wellbeing program).	Aim: to help drive the programme forward through an interactive arts and cultural engagement process, which presented communities and local authority partners with an opportunity to shape the year - 13 work streams have been identified. Some activities planned or underway include: the country's first accredited workplace wellbeing charter, welcomed by public, private and voluntary sector employers.	Liverpool City Council and Primary Care Trust. Numerous organisations involved, including Mersey Fire and Mersey Dance. Local community residents	2010
Community action in rural Scotland	Aim: to strengthen local communities. The funding stream provides	Local community residents.	Each community

Programme name	Aim/approach	Stakeholders / target group	Duration, Cost of programme
(part of Five Ways to Wellbeing program)	investment to rural communities to support Development. E.g. organise community activities such as street barbecues, create volunteering resources, and identify community assets in general.		project has been given between £3,000 – £10,000
Changing Minds Centre 'Changing Minds Wellbeing Teams' in Northamptonshire	Aim: to provide two 'Wellbeing Teams' to guide individuals through information, resources and support people make positive lifestyle changes for better mental well-being. 'Peer Support Team' working across the county offering local people opportunity to talk about their feelings and support their recovery and wellbeing. And, 'Learn2B' project to enhance wellbeing through creative, social, recreational and therapeutic groups.	Local communities. Northamptonshire Primary Care Trust and County Council.	On-going service
'Live it Well' Strategy	Aim: to develop a joint strategy to improve mental health and wellbeing, reduce common mental health problems, ensure easy access to care in crisis, reduce numbers of suicide and improve care for mentally ill. Trains and motivate staff to address their own physical and mental health needs, but also key individuals and communities	Local communities. Health and social care professional. Mental health service users, carers and various voluntary organisations. Kent and Medway NHS and Social Care Partnership Trust	Launched Oct 2010
Wellbeing initiatives in Greenwich PCT in London	Aim: to address environmental, community development and physical health factors to improve mental well-being. Greenwich PCT and the council implemented initiatives 1) 'Feeling Good about Where you Live' 2) NHS Health Checks Plus 3) 'Supporting you to be well in Greenwich' website 4) Mental health awareness 5) Improving access to psychological therapies (IAPT)	Local community residents. to target patients less likely to attend appointments and refer them to positive mental health interventions	Commenced 2003 and on-going
Empowering communities and asset-based community development in south Ribble (Lancashire)	Aim: to harness community assets and strengthen interactions with the local population. Has 1) Appreciative Inquiry approach to community engagement to focus on community's positive attributes or assets rather than deficits or needs 2) Food growing 3) Family First	Local residents	

Programme name	Aim/approach	Stakeholders / target group	Duration, Cost of programme
	programme to increase school attendance, support families with debt issues, reduce alcohol and drug misuse.		
West Midlands initiative with Health Trainers and Psychological Therapy Practitioners	Aim: to provide health trainers and Psychological Therapy Practitioners services working with IAPT practitioners. HTs are a public health workforce that works with people from disadvantaged communities to help them create positive health behaviours and lifestyles. IAPT services meet clients with poor lifestyle and physical health problems. Both deliver Mental Health First Aid training; Mental Health Awareness.	Local councils staff, NHS staff	Running since 2004

Investments into mental health – health, education, social development and economic growth

In England considerable financial resource has been invested into expanding community mental health services over two decades, particularly in forensic mental health secure services. In 2011/12 the total invested in adult mental health services was £6.63 billion and £6.55 in 2010/11, representing a cash increase of 1.2%, but a real decrease of 1.0%. Investment in psychological therapies has increased significantly in real terms by 6.0%. However, investment in specialist community mental health services (Crisis Resolution, Early Intervention and Assertive Outreach) has decreased by £29.3 million overall, with only Early Intervention receiving increased investment (http://www.dh.gov.uk/health/2012/07/investment-mental-health/).

By comparison, relatively little has been invested in mental health promotion; in the same period (Mental health strategies, 2010). Spending on the prevention of mental disorder and promotion of mental health represents less than 0.001% of the annual NHS mental health budget (Department of Health, 2011).

Recent public sector spending cuts and job losses have impacted negatively on many of the gains made in mental health promotion and prevention work over the past few years (NHS Confederation, 2010).

Benefits to be expected

The main benefit expected from investments in mental health promotion and prevention of mental illness is psycho-social and material wellbeing of the local population and cost

savings to health and social care services. Action on wellbeing is perceived as having the potential to shield councils, their staff and their communities from the worst effects of the adverse economic context, and to build resilience for the future.

Initiatives to strengthen mental health systems in relation to MHP and PMI

Main recent initiative is the introduction of IAPT services based in primary care settings. These services were introduced in 2008.

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5. Analysis of country profiles and cross country comparisons of mental health systems and prevention and promotion of mental health

This chapter provides an analysis of the twenty nine country profiles presented in Chapter 4. Here we examine the existing mental health legislation/policies and strategies to promote mental health and prevent mental illness, and the types of facilities that deliver mental health care and use of services. An overview of the types of prevention and mental health promotion examples provided by our country collaborators is also presented. Where comparable national data have not been available, the profiles have been supplemented with data from published sources such as Eurostat, the WHO European Morbidity Database and Eurobarometer.

5.1 Mental Health policy framework and legislation

Table 5.1 lists the presence of mental health policies, strategies or plans for each participating country, together with information on whether these included mental health promotion and prevention and the main priorities for these. Only Estonia reported not having a mental health policy although their general health programme includes some reference to mental health. Slovenia has recently introduced a draft mental health policy, previously absent according to Semrau et al.'s (2011) overview of mental health policies in the European Region. Bulgaria and the Czech Republic appeared to be the only countries not to have encompassed any priorities for mental health promotion or prevention within their mental health policy. Estonia and Sweden are the countries without a stand-alone mental health policy.

What is striking about these recent key priorities for mental health promotion and prevention is their similarity across all participating countries. Improving the mental health and well-being of the population has become an important theme for around two thirds of all participating countries. In terms of priorities for prevention, suicide is, unsurprisingly, a common theme for countries with relatively high rates of suicide (for example, Belgium, Hungary, Latvia and Lithuania). Suicide prevention is, however, also a priority for other countries such as Ireland, Luxembourg, Portugal and the UK who have comparatively lower rates (see figure 5.1). Measures to reduce the rate of suicide sometimes coincide with policies on reducing drug and/or alcohol consumption (e.g. Lithuania). Other prevention priorities, particularly those relating to the reduction of mental illness, have focused on

specific age groups, notably children and adolescents (e.g. Croatia, France, Hungary, Italy and Slovakia).

Priorities for those at risk or those with existing mental health problems include early detection and early intervention. These are usually aimed at reducing the potential for prolonged/severe mental illness and the relapse of mental illness. Reducing social exclusion (e.g. through interventions to support those with mental illness into employment) and combating stigma also feature in several policies (see for example Greece, Norway, Poland, Portugal, Slovenia and Spain).

Table 5.1 Mental Health policies and prevention and promotion priorities

	MH policies, strategies or plans	Policies and strategies include MH promotion	Policies and strategies include prevention	Key priorities for prevention and promotion
Austria	yes	yes	yes	General mental health promotion and prevention; forthcoming suicide prevention programme
Belgium	yes	yes	yes	Suicide prevention; mental health promotion in the population
Bulgaria	yes	no	no	Health promotion and disease prevention a priority, but no reference to mental health
Croatia	yes	yes	yes	Mental health promotion for all, emphasis on employees; prevention themes for children and adolescents; and early intervention
Cyprus	yes	yes	yes	General mental health promotion and well-being in the population; prevention of mental illness and addiction
Czech Republic	yes	no	no	None
Denmark	yes	yes	yes	General citizen and patient-oriented disease prevention and health promotion; increase life expectancy and quality of life for those with mental illness
Estonia	no	yes	yes	General health plan to increase life expectancy and social cohesion; raise awareness of mental health issues, early identification; improve the well-being and quality of life of children and families.
Finland	yes	yes	yes	General health programme to improve public health; extend healthy life expectancy, social well-being and reduce health inequalities
France	yes	yes	yes	Suicide prevention; improve mental health of children and adolescents; improve mental health of employees and prevent stress; promote the mental health, well-being and social relations of older people

	MH policies, strategies or plans	Policies and strategies include MH promotion	Policies and strategies include prevention	Key priorities for prevention and promotion
Germany	yes	yes	yes	General mental health promotion; prevention of depression through early detection and treatment
Greece	yes	yes	yes	Improve mental health of the population; prevention of depression; early detection and diagnosis; increase social inclusion and combat stigma
Hungary	yes	yes	yes	Promotion of healthy lifestyles, increase life expectancy; reduce drug and alcohol use; strengthen mental health of children and adolescents in schools; suicide prevention
Ireland	yes	yes	yes	Promote positive mental health and well-being in the population; enhance capacity of the community to promote mental health; awareness raising; suicide prevention
Italy	yes	yes	yes	Promote public health and health equality; mental health promotion and prevention targeting infants and primary school children
Latvia	yes	yes	yes	General public health promotion; improve mental health; prevention measures including suicide prevention
Lithuania	yes	yes	yes	Reduce suicides, drug, tobacco and alcohol consumption; general mental health promotion and prevention
Luxembourg	yes	yes	yes	Mental health – a public health priority; awareness raising; combating stigma; early detection; depression and suicide prevention; reducing drug and alcohol misuse
Malta	yes	yes	yes	General mental health promotion, prevention and advocacy; prevention of drug misuse; early intervention
Netherlands	yes	yes	yes	Promotion of healthy lifestyles; strong prevention and promotion emphasis which includes mental health
Norway	yes	yes	yes	General health promotion and disease prevention through healthier living; promotion of well-being; reducing drug and alcohol consumption; promote inclusive work life
Poland	yes	yes	yes	General mental health promotion and prevention; social inclusion for mentally ill
Portugal	yes	yes	yes	Reduce impact of mental illness; promote mental health; prevention of problems in early childhood, in the workplace, of depression and suicide; combat poverty and social exclusion; awareness raising
Romania	yes	yes	yes	Prevention and treatment of drug dependence; early detection; decrease mental illness morbidity in the population

	MH policies, strategies or plans	Policies and strategies include MH promotion	Policies and strategies include prevention	Key priorities for prevention and promotion
Slovakia	yes	yes	yes	General health promotion; drug misuse prevention; mental health promotion and prevention in schools
Slovenia	yes (draft)	yes	yes	Promotion of mental health and prevention; suicide prevention; combat stigma and social exclusion
Spain	yes	yes	yes	Promote mental health of the general population; prevent mental illness, suicide and addiction; combat stigma
Sweden	no[6]	yes	yes	Suicide prevention; and supporting parenting; drug, tobacco and alcohol use prevention
UK	yes	yes	yes	Improve mental health and well-being in the population; faster access to mental health services, particularly talking therapies; prevention of suicide and emotional distress

There appeared to be no consensus in the distinction between promotion and prevention. Some countries saw prevention as removing negative risk factors, whereas promotion was seen as encouraging or having an inoculating effect on factors that lead to positive mental health. There is however some overlap between removing negative factors and encouraging positive ones; and across all the participating countries there remains a question of how closely these two concepts are related and the extent to which mental health promotion is being conflated with wellbeing and illness prevention.

Mental Health legislation

All twenty nine participating countries reported having some form of mental health legislation, with the majority having guidelines on compulsory admissions to hospital. Table 5.2 details the relevant legislation and the areas covered. A few Member States have no stand-alone mental health legislation but instead list procedures for compulsory admission to hospital within their general health or other legislation. Austria, for example, incorporates within its Federal Constitutional Act (1990, amended in 2011) the legal rights of patients regarding involuntary admission. Bulgaria, the Czech Republic and Latvia have their rules for compulsory admission contained within their general health legislation. Hungary include mental health within their Fundamental Law (Constitution) adopted in 2011. The remaining twenty five countries have specific mental health legislation that seeks to protect those detained in hospital on an involuntary basis.

[6] There is no stand-alone mental health policy in Sweden. National policies are typically mediated through government agencies such as the National Board of Health and Welfare (NBHW), the National Institute of Public Health, or the Swedish Association of Local Authorities and Regions (SALAR).

In countries such as Italy and Luxembourg, legislation covering mental health was closely aligned with programmes of psychiatric reform, notably the closure of mental institutions (or long-stay hospitals) and the decentralisation of psychiatric services across their regions. The Italian Mental Health Law (180/1978) sought to introduce a major transformation of psychiatric services, with a keen focus on the phasing out mental institutions and replacing these solely with units in general hospitals.

Table 5.2 Mental health legislation across participating EU countries

	Act name and year	Areas covered by legislation
Austria	Federal Constitutional Act. Law for compulsory admission to mental hospitals (1990) amended in 2011. Austrian Health Promotion Act BGBl. (No. 51/1998)	Mental health and structure of provision and responsibilities of the different health care system stakeholders. Specifies patients' legal rights when admitted to hospital on a compulsory basis and amended 1990 Law aimed to avoid a cumulative increase in length of stay. Federal law-enacted measures and initiatives to promote health and provide health education and information.
Belgium	Mental health legislation (enacted 2000) and a new legislation adopted in 2007.	Fixes a maximum number of psychiatric beds within mental health services. The new legislation concerns the detention of people with a mental disorder.
Bulgaria	Public Health Act (1973) and subsequent Health Act (2004)	Both Health Acts specifies rules for the treatment of involuntary patients. No standalone Mental Health Act.
Croatia	Law on the Protection of Persons with Mental Disorders (1997 revised 2002) and Health Care Act (2008 and revised 2012)	Involuntary admission to hospital for people with mental illness.
Cyprus	Mental Health Law (1997), plus several amendments. Proposed new legislation on Community Mental Healthcare	Protects the rights of those detained in hospital and sets out minimum standards during their hospital stay.
Czech Rep	Act No. 99/1963 Civil Procedure Code and Health Care Services Act (372/2011)	Mental health care is incorporated within general health care legislation rather than a separate Mental Health Act. Procedures for involuntary admission are provided in Act No. 99/1963 Civil Procedure Code.
Denmark	Mental Health legislation (1938) and revised in 1989.	Involuntary civil commitment, detainment and use of coercive measures.
Estonia	Psychiatric Care Act (1997)	Regulates psychiatric care in Estonia. Compulsory psychiatric treatment issued by courts according to the Penal Code and administered in psychiatric hospitals in a ward for compulsory psychiatric treatment and placed under supervision.
Finland	Mental Health Act (1116/1990) & Health Care Act (1326/2010)	Treatment of mental disorders and includes some details on promotion of mental well-being and prevention and alleviation of mental illness.
France	Mental Health Law (1990) (French Law No. 90-527) Rights and protection of individuals hospitalised because of mental disorders	Governance on the rights and protection of people who require compulsory admission to hospital due to mental illness. Upholds a person's civil liberties and safeguarding rights during involuntary hospitalisation.
Germany	National Mental Health Act (enacted 1999)	Federal States are responsible for their mental health policy. Provisions include involuntary admission hospital and treatment.
Greece	Mental Health Act (Law 2716/1999) and supplemented by Act 2005 (article 28) Code of Medical Ethics	Terms for diagnosing and providing psychiatric support, treatment and hospitalisation with or without patient consent. Action plan for reform and de-stigmatisation. Code of medical ethics (Act 2005) outlines the requirements of psychiatrists and their behaviour towards those with mental illness.

Hungary	Fundamental Law (Constitution), current version adopted April 2011.	Specifies the 'right to the highest possible level of physical and mental health'.
Ireland	Health Act 2004 and Mental Health Act (2001)	Involuntary detention of prisoners with mental disorders and mechanism for assurance of standards of mental health care.
Italy	Mental Health Law 180 (1978) and Health	Phasing out of mental hospitals, establishing general hospital units, guidance on compulsory admissions and setting up of community mental health services.
Latvia	Medical Treatment Law (adopted and implemented 1997)	Law emphasises the importance of good cooperation between mental health and other sectors; and mental and physical health being crucial to the nation and state.
Lithuania	Law on Mental Health Care (1995)	Regulates the provision of psychiatric services assures civil rights to the mentally ill and plans for the establishment of new local facilities providing outpatients mental health services , known as municipality mental health centres.
Luxembourg	Placement of Persons with Mental Disorders Act (2009)	Requirements for compulsory admission to hospital for people with a mental disorder without consent, if they present a danger to themselves or to others.
Malta	Mental Health Act (1976). A newly drafted Mental Health Act was approved in 2011 and due to be enforced 2012	Governs rules for involuntary inpatient treatment based on the medical model determined by psychiatrists. The new 2012 Mental Health Act promotes a bio-psycho-social model delivered by a multidisciplinary team.
Netherlands	Psychiatric Hospitals Act (1994). A proposed new Compulsory Mental Health Care Act is under discussion	Protects patients' rights where admitted to hospital on a compulsory basis. The new Act aims to highlight compulsory outpatient treatment.
Norway	Mental Health Care Act (1999, implemented 2001) with amendments in 2006 (Act No. 62)	Purpose of the Act is to ensure mental health care is applied and implemented appropriately and in accordance with the needs of the patient and respect for human dignity during compulsory
Poland	Mental Health Protection Act (1994) with later amendments	Sets out comprehensive and universal mental health care and services. Based on empathy, tolerance, kindness towards mentally ill people and preventing discrimination.
Portugal	Mental Health Act (Act nº 36/1998)	Establishes principles of mental health policy, patient's rights and duties and rules for compulsory detention of people with a mental disorder. Article 2 of the law refers to protection and promotion of MH and recommends primary, secondary and tertiary activities for preventing mental illness (PMI) and promoting a populations mental health (PMH).
Romania	Mental health and protection of persons with psychiatric disorders (Law 487/2002)	Protects rights of mental health service users and establishes criteria for admittance to psychiatric unit, including compulsory admission. Law establishes responsibility for promotion and prevention of mental illness with government ministries, Health, Family, Education and Research, Youth and Sport, Labour and Social Solidarity, NGO's professional associations and others.
Slovakia	Health Care Law (2004)	Law is part of the health reforms which have been in progress since 2004.
Slovenia	Mental Health Act (2008)	Specifies the systems of health care and social assistance in relation to mental health facilities, the rights of patients during treatment, procedures for admission to treatment and defines right to representation where

		freedom of movement is restricted. The law of patient's rights establishes a legal basis for treatment for people in local environment, hospital or community. The Act introduces a supervised treatment co-ordinator in the community and consideration of treatment in the community instead of psychiatric hospital.
Spain	Mental Health Law 13/1983 and Act No. 6/1984	Law on compulsory admission to hospital. Compulsory admission to hospital can be ordered by a medical doctor but should be authorised by a judge. Act No. 6/1984 allows a court to examine the legality of an involuntary admission.
Sweden	Compulsory Psychiatric Care Act (1991)	Compulsory Psychiatric Care Act (1991) and the Forensic Psychiatric Care Act set out special provisions regarding coercive interventions for the mentally ill. Also, compulsory community care introduced in 2008 as a "new form of care".
UK	Mental Health Act 1983 (amended 1995 & 2007) and the Mental Capacity Act (2005) for England and Wales in 2007. Mental Health Act in Scotland (2003)	The Mental Health Act stipulates procedures for admission to hospital for treatment with or without consent. the Mental Capacity Act aims to protect people, including those with mental illness, who are unable to make a decision for themselves at a particular time.

5.2 Mental health services

Inpatient care

Many participating countries, around two thirds, have endeavoured to move away from long-stay hospital care towards psychiatric services based in the community. Psychiatric inpatient services for these countries are in psychiatric hospitals based in the community (see Table 5.3). Italy and Sweden have gone a step further; their inpatient care is provided solely by psychiatric units in general hospitals. It is encouraging to see that psychiatric inpatient units based in general hospitals were available, to some degree, in almost all participating countries. This process of deinstitutionalisation has been an important step towards promoting the social inclusion of people with mental health problems (Mental Health Europe, 2008).

Table 5.3 Types of inpatient psychiatric services

Country	Long-stay hospital care	Psychiatric hospitals	Psychiatric units in general hospitals
Austria		yes	yes
Belgium		yes	yes
Bulgaria	yes	yes	yes
Croatia	yes	yes	yes
Cyprus	n/k	yes	yes
Czech Republic	yes	yes	yes
Denmark		yes	yes
Estonia		yes	yes
Finland		yes	yes
France		yes	yes
Germany		yes	yes
Greece	yes	yes	yes
Hungary	yes	yes	yes
Ireland		yes	yes
Italy		no	yes
Latvia	yes	yes	yes
Lithuania	yes	yes	yes
Luxembourg		yes	yes
Malta	yes	yes	yes
Netherlands		yes	yes
Norway		yes	n/k
Poland		yes	yes
Portugal	yes	yes	yes
Romania	yes	yes	yes
Slovakia	n/k	yes	yes
Slovenia	yes	yes	yes
Spain		yes	yes
Sweden		no	yes
UK		yes	yes

Source: Country profiles and WHO Mental Health Atlas (2011)

Long-stay hospital care (see definition below) was still present in at least a third of countries, however. A number of participating countries have a strategy or programme of deinstitutionalisation in social care (Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Slovakia, Romania and Ireland) However, four of these countries (Croatia, Hungary, the Czech Republic and Slovakia) have excluded institutions for people with mental health problems from these reforms or have less favourable arrangements for them (Mental Health Europe, 2012).

The process of moving away from this form of hospital care for these countries continues to be a difficult one. In Bulgaria, for example, establishing agreement and cross-sector collaboration between the Ministries of Health and Labour and Social Policy, important to ensuring the successful transfer from long-stay hospital care to community based mental health services, has been problematic. On a practical level, there are relatively weak partnerships between the health and social care sectors at municipal level – the services responsible for organising community based services – which has further hampered developments in the transfer process. In Croatia, EU structural funding is being sought in an attempt to improve the poor conditions of long-stay hospitals and the quality of life of patients, even whilst trying to develop community mental health services; this is proving difficult to resource, both financially and in terms of ensuring sufficient staffing.

Definition of long-stay hospital care

A working definition based on the descriptions of inpatient services provided by our country profiles (and Governmental experts who contributed to profiles) is used for the purposes of this report. This included descriptions in the collaborators template such as 'psychiatric asylums' (Czech Republic), 'special psychiatric hospitals' (Croatia), 'psychiatric hospitals providing long term care for people with severe and enduring mental illness' (Portugal), and 'psychiatric hospitals' with large numbers of beds (Malta) that are distinct from psychiatric units in general hospitals or psychiatric hospitals based in the community.

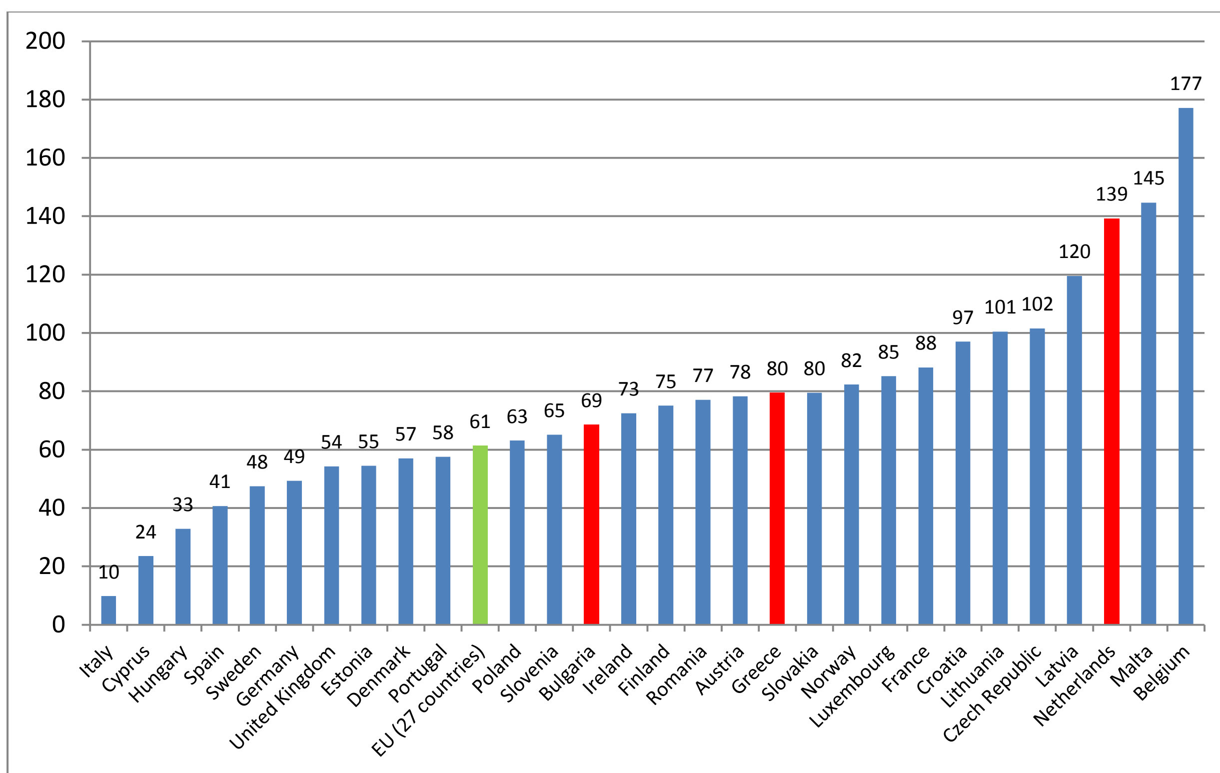
Despite the progress achieved by many EU countries in making the transition away from long-stay hospital care, more recent debates have considered the balance between community and hospital-based mental health services. Thornicroft & Tansella (2004) examined this and other questions through a review of the evidence and concluded a balance of both is necessary, regardless of the resources available. Although the ‘relative mixture of service components needed depends very much on specific local circumstances, and where the blend is likely to change over time’ (Thornicroft & Tansella, 2013, pg. 248).

Total number of psychiatric inpatient beds

The total number of psychiatric inpatient beds across participating countries has been declining slowly over the past decade or so. In 2001, there were 73.6 psychiatric beds per 100 000 population and by 2010 this had fallen to 61.4 per 100 000 population (Eurostat 2013).

The number of psychiatric inpatient beds between participating countries varies enormously and provides some indication of the reliance of some EU countries on hospital based care. Recent figures from Eurostat (2013) for the total number of psychiatric care beds across participating countries (including those in psychiatric hospitals and general hospital psychiatric units) are shown in Figure 5.1. Countries with relatively high bed numbers include Belgium (177.1 per 100 000 population), Malta (144.7 per 100 000 population) and the Netherlands (139.6). The average number for EU 27 Member States is 61.4 (per 100 000 population). Countries with the lowest number of psychiatric beds (per 100 000 population) are Italy (9.8), Hungary (32.9) and Spain (40.7).

Figure 5.1 Total number of psychiatric beds per 100 000 population for 2010 (includes psychiatric beds in psychiatric hospitals and general hospital units)



Source: Eurostat 2013 (red bars – 2009 data)

Beds in psychiatric hospitals

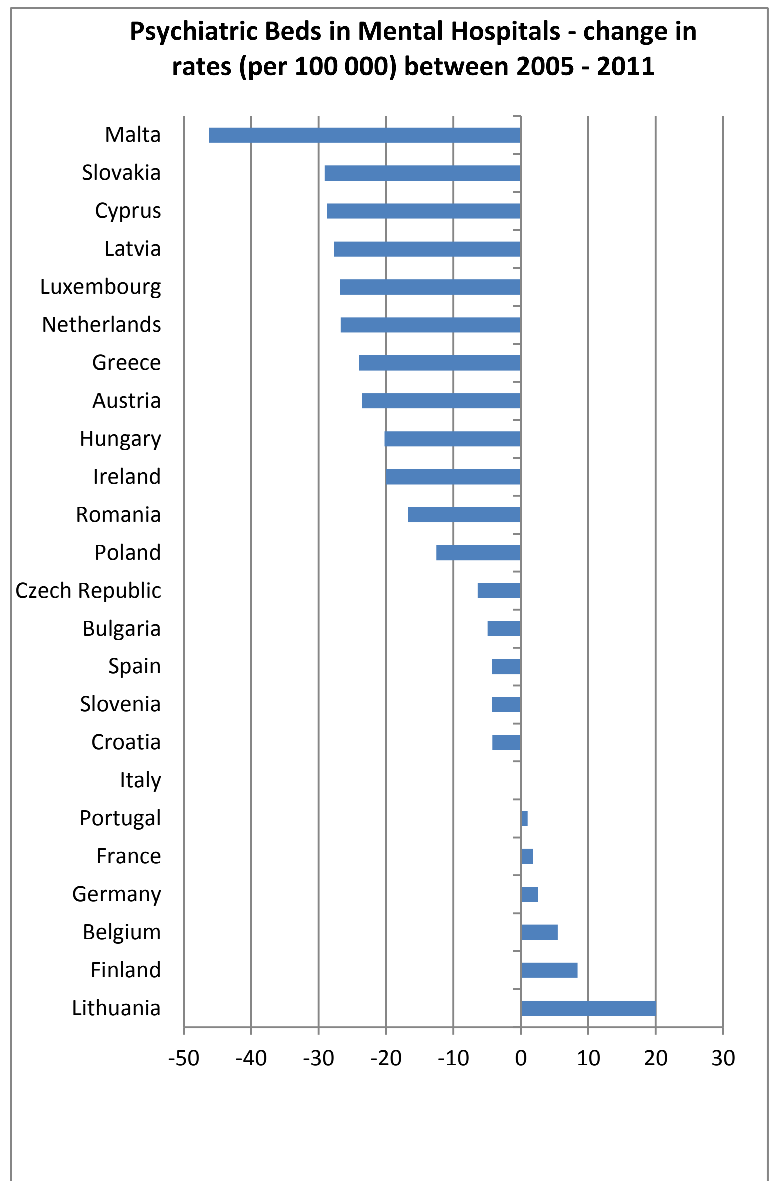
The number of psychiatric beds located in psychiatric hospitals (excluding those based in general hospital psychiatric units) has decreased over time. Figures for 2005 and 2011 gathered by the WHO (2011, 2005) show a decline in these types of psychiatric beds for the majority of participating countries (see Table 5.4). Dramatic bed reductions are found for countries such as Malta, Slovakia, Cyprus and Latvia in an attempt to move away from long-stay hospital care, but also to increase the level of community-based services as in Austria, Luxembourg, Netherlands and Greece (see Figure 5.2). A few countries, however, have not followed this trend and have instead increased the number of beds in their psychiatric hospitals, most notably Lithuania, Finland and Belgium.

Table 5.4 Psychiatric beds in mental hospitals (rate per 100 000)

Country	2011	2005
Austria	21.4	45.0
Belgium	134.5	129.0
Bulgaria	36.1	41.0
Croatia	76.0	80.2
Cyprus	16.3	45.0
Czech Republic	91.6	98.0
Denmark	n/k	n/k
Estonia	n/k	80.0
Finland	8.4	0
France	71.8	70.0
Germany	47.6	45.0
Greece	19.0	43.0
Hungary	2.8	23.0
Ireland	54.5	74.5
Italy	0	0
Latvia	107.3	135.0
Lithuania	106.1	86.0
Luxembourg	48.2	75.0
Malta	141.71	188.0
Netherlands	127.3	154.0
Norway	89.1	n/k
Poland	39.5	52.0
Portugal	16.0	15.0
Romania	38.3	55.0
Slovakia	30.9	60.0
Slovenia	67.7	72.0
Spain	32.7	37.0
Sweden	n/a	n/k
UK	n/k	n/k

Source: WHO Mental Health Atlas (2011; 2005)

Figure 5.2



Caution needs to be applied when interpreting these WHO Atlas data on psychiatric beds between 2005 and 2011 as they are not entirely comparable. However, they provide some indication of the reductions and increases in psychiatric bed numbers.

Beds in general hospital psychiatric units

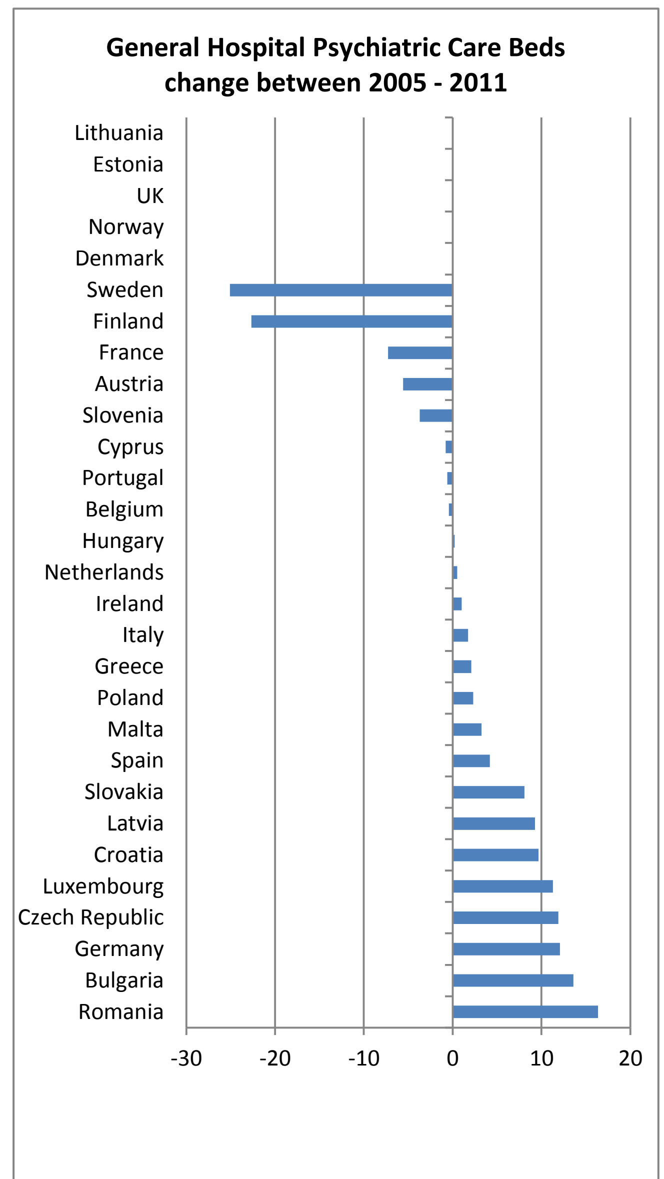
Psychiatric beds based in general hospital units have risen markedly for a number of countries over the period between 2005 and 2011. Table 5.5 and Figure 5.3 reveal that Sweden, Finland, France and Austria have reduced their psychiatric beds in general hospitals, while other countries have significantly increased beds in these units (Romania, Bulgaria, Germany, Czech Republic and several others).

Table 5.5 Psychiatric beds in general hospital psychiatric units (rate per 100 000)

Country	2011	2005
Austria	14.43	20.0
Belgium	25.58	26.0
Bulgaria	32.61	19.0
Croatia	19.48	9.8
Cyprus	5.23	6.0
Czech Republic	13.41	1.5
Denmark	53.91	n/k
Estonia	n/k	21.0
Finland	67.34	90.0
France	22.72	30.0
Germany	41.08	29.0
Greece	5.1	3.0
Hungary	72.21	72.0
Ireland	19.61	18.6
Italy	10.95	9.2
Latvia	12.28	3.0
Lithuania	n/k	11.0
Luxembourg	41.28	30.0
Malta	3.66	0.4
Netherlands	10.51	10.0
Norway	n/k	n/k
Poland	14.3	12.0
Portugal	9.41	10.0
Romania	36.38	20.0
Slovakia	38.1	30.0
Slovenia	8.89	12.6
Spain	10.19	6.0
Sweden	34.91	60.0
UK	n/k	n/k

Source: WHO Mental Health Atlas (2011; 2005)

Figure 5.3



Hospital Admission rates

Comparable data on the use of services was not available for all country profiles, so comparisons were drawn using international databases to gain an understanding of the patterns of hospital admission between participating countries. Table 5.6 shows data for inpatient and day case admission for schizophrenia, schizotypal disorders and delusional disorders from the WHO European Hospital Morbidity Database (2012). This shows that the highest number of admissions per capita were in Lithuania, Finland, Norway and Latvia at approximately three inpatients per 1000 population. In contrast the rates of admission were up to ten times lower in Denmark, Ireland and the Netherlands, with France, Belgium, Portugal and the UK following closely with less than 1 admission per 1000 population.

Table 5.6 Hospital inpatient admission rates, average length of stay and day cases for schizophrenia schizotypal and delusional disorders

Country	Number of inpatients (per 1000 population)	Average length of stay (days)
Denmark	0.03	11.86
Ireland	0.06	35.27
Netherlands	0.13	28.64
France	0.19	3.91
Belgium	0.23	12.34
Portugal	0.40	23.60
UK	0.47	110.89
Malta	0.48	55.65
Cyprus	0.63	31.56
Spain	0.88	20.42
Czech Rep	1.06	72.12
Luxembourg	1.27	20.88
Slovenia	1.44	52.36

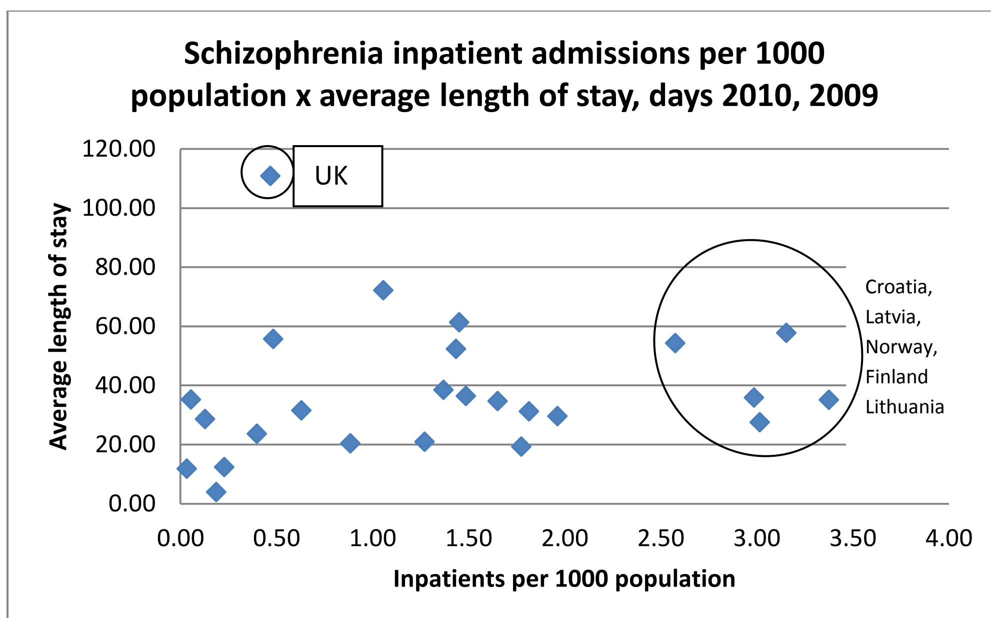
Country	Number of inpatients (per 1000 population)	Average length of stay (days)
Poland	1.45	61.37
Slovakia	1.49	36.37
Germany	1.65	34.64
Italy	1.78	19.33
Austria	1.82	31.22
Hungary	1.96	29.57
Croatia	2.58	54.26
Latvia	2.99	35.87
Norway	3.02	27.57
Finland	3.16	57.78
Lithuania	3.38	35.12
EU mean	**1.37**	**38.50**

Source: WHO European Hospital Morbidity Database (2012)

Average length of stay ranges from 11 days in Denmark to 110 days in the UK; the EU mean is 38.52 days. The UK rate is an outlier in this analysis. The UK had one of the lowest rates of admission but also had the highest average length of admission at almost four months. The next highest rate of admission is the Czech Republic at 72 days was also at the lower end of the admissions per 1000 population. This is in contrast with France, Denmark, Belgium, Italy and Spain where average length of stay is between 3 and 20 days.

When the two data sources are plotted together, the patterns in length of stay and admission rates that emerge can be used to group countries together. One group with less than 0.5 inpatients per 1000 population and under 40 days length of stay includes Denmark, Ireland, the Netherlands, France, Belgium and Portugal. Malta is close to this group having 55 days average length of stay and less than 0.5 inpatients per 1000 population. The UK is an outlier also with under 0.5 inpatients per 1000 population but an average length of stay of 100 days. The main grouping includes, Cyprus, Spain, Czech Republic, Luxembourg, Slovenia, Poland, Slovakia, Germany, Italy, Austria and Hungary which have similar patterns of admission and length of stay (see Figure 5.4).

Figure 5.4 Schizophrenia inpatient admissions by average length of stay



Source: WHO European Hospital Morbidity Database (2012)

The pattern that emerges from this chart arises from the relationship between length of stay and number of admissions. Some countries such as Finland and Croatia have relatively high numbers of admissions and lengths of stay. Another group which includes the UK and to a lesser degree Malta and the Czech Republic have a relatively low number of people admitted but for longer periods of time. By contrast, countries such as France, Denmark, Belgium and Portugal have relatively low rates of admission and low lengths of stay.

Community mental health services

All participating countries had some form of community-based mental health care, and offer more than one type. The type and range of community services also varied between countries, however (see Table 5.7 below). Often this appeared to be related to the available resources and commitment towards the provision of community-based services. High income countries, for example, offer a comprehensive range of community services, including specialist community mental health services such as early intervention for psychosis and/or assertive outreach care providing intensive support to those who would not otherwise engage with services. Around a third of countries offer such specialist services (Austria, Belgium, Denmark, Ireland, Italy, Spain and the UK).

The availability of community mental health services in all participating countries supports the trend towards these and the decline of institutional care (WHO, 2008).

Gaps in community based services

Despite all participating countries providing some degree of community-based mental health care, a few reported that these were limited. Croatia, Latvia and Malta had limited day centre/hospital care facilities and even inadequate outpatient services (Latvia). There were gaps in the provision of domiciliary care or home visits, with twelve countries not specifying the availability of this service (for example, Austria, Bulgaria, Cyprus, Estonia, Finland, Lithuania, Netherlands, Norway, Portugal, Romania, Slovenia and Sweden).

Bulgaria reported a significant lack of community-based mental health services, which was compounded by an uneven distribution of all psychiatric services nationally. In Croatia, the development of community services is still at a relatively early stage and are scarce, despite the presence of what appears to be a range of different services (e.g. day centres, home visits, etc.). This is also the case for the Czech Republic where the number of community services has remained unchanged over the past 10 years despite the closure of many beds in long-stay psychiatric hospitals.

Table 5.7 Types of community-based mental health services by country

	Primary MH care*	Day centres/ hospitals	Outpatient services	Mental health centres	Domiciliary care/ Home visits	Residential care/ Sheltered homes	Mental health/ vocational rehabilitation	Specialist community MH services (e.g. assertive outreach)
Austria	yes	yes	yes			yes		yes
Belgium	yes	yes	yes	yes	yes	yes	yes	yes
Bulgaria	yes	yes	yes	yes		yes		
Croatia	yes	limited	yes	yes	limited	limited		
Cyprus		yes	yes	yes			yes	yes
Czech Republic	yes	yes	yes		limited		yes	
Denmark	yes	yes	yes	yes	yes	yes	yes	yes
Estonia	yes	yes	yes				yes	
Finland	yes	yes	yes	yes		yes		
France	yes	yes	yes	yes	yes			
Germany	yes	yes	yes		yes	yes	yes	
Greece	yes	yes	yes	yes	yes	yes	yes	
Hungary	yes		yes	yes	yes	yes	yes	
Ireland	yes	yes	yes	yes	yes	yes	yes	yes
Italy	yes	yes	yes	yes	yes	yes	yes	yes
Latvia	yes	limited	limited		limited	yes		
Lithuania	yes		yes	yes		yes		
Luxembourg	yes	yes	yes	yes	yes	yes	yes	
Malta	yes	limited	yes		yes	yes	yes	
Netherlands	yes	yes	yes					
Norway	yes	yes	yes	yes			yes	
Poland	yes	yes	yes	yes	yes		yes	
Portugal	yes	yes	yes			yes	yes	
Romania	yes	yes	yes	yes		yes		
Slovakia	yes	yes	yes	yes	yes	yes	yes	
Slovenia	yes	yes	yes	yes		yes	yes	

	Primary MH care*	Day centres/ hospitals	Outpatient services	Mental health centres	Domiciliary care/ Home visits	Residential care/ Sheltered homes	Mental health/ vocational rehabilitation	Specialist community MH services (e.g. assertive outreach)
Spain	yes	yes	yes	yes	yes	yes	yes	yes
Sweden	yes		yes	yes			yes	
UK	yes	yes	yes	yes	yes	yes	yes	yes

Source: Country profiles and WHO Mental Health Atlas (2011) * For common mental health problems

5.3 Mental health workforce

Country profiles provide an indication of the numbers of professionals employed to deliver mental health care. However, the data are not comparable and so figures published by the WHO (2011) are used instead which are also the most up-to-date.

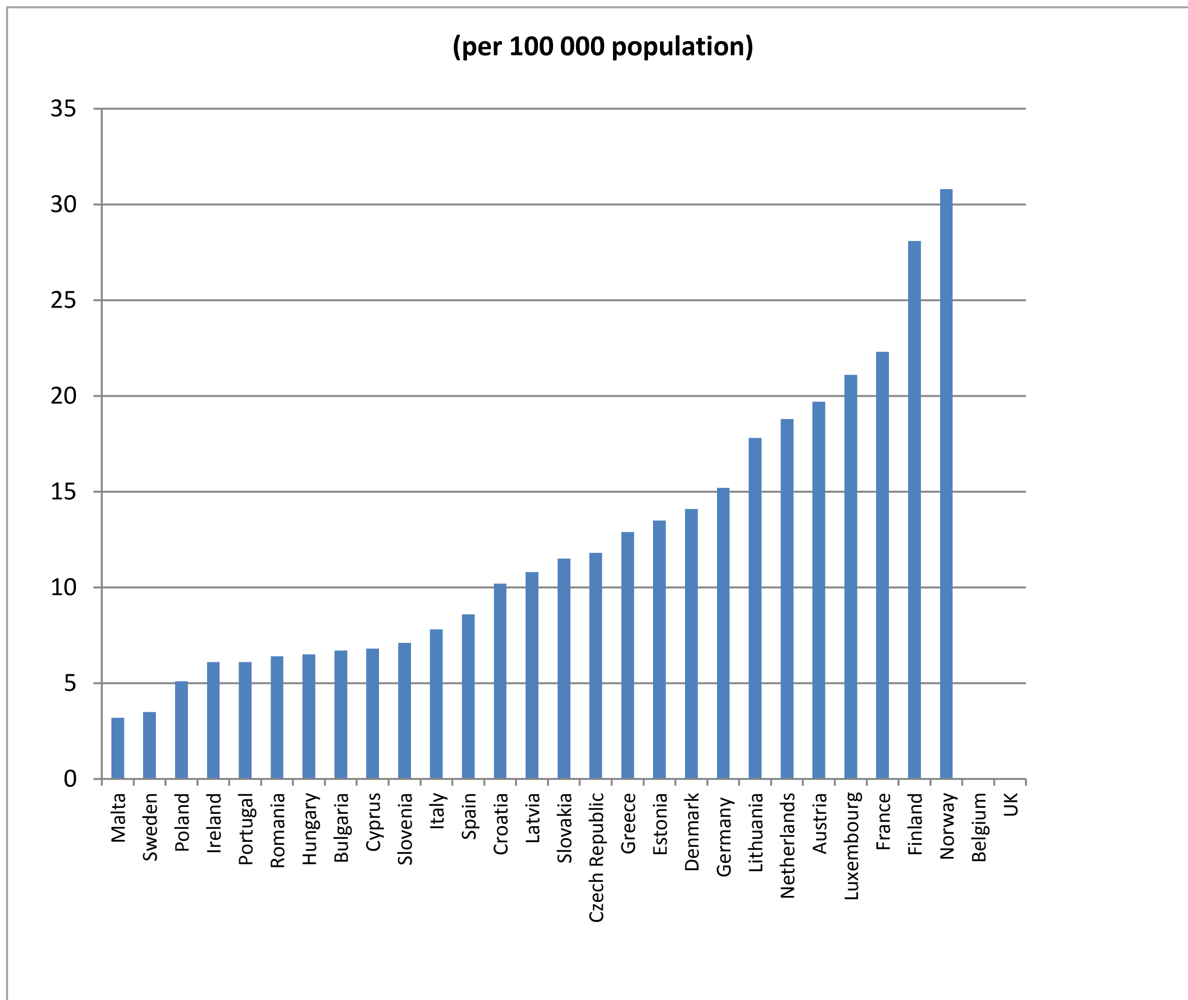
Table 5.8 Numbers of professionals working in mental health services by country for 2011 (rate per 100 000)

	Psychiatrists	Nurses	Psychologists	Social workers	Occupational therapists
Austria	19.7		79.9		
Belgium		0.04	1.3	0.9	0.03
Bulgaria	6.7	431.0	0.9	0.5	
Croatia	10.2	35.6	2.9	1.02	0.6
Cyprus	6.8	42.2	28.9		8.4
Czech Republic	11.8	28.2	2.03	0.9	0.3
Denmark	14.1				
Estonia	13.5				
Finland	28.1				
France	22.3	86.2	47.9	3.83	
Germany	15.2	56.1			
Greece	12.9		26.8		
Hungary	6.52	21.9	2.5	3.0	
Ireland	6.1	112.8	3.5	3.8	3.2
Italy	7.8	19.3	2.6	1.9	2.2
Latvia	10.8	30.8			0.4
Lithuania	17.8				
Luxembourg	21.1				
Malta	3.2	66.8	4.4	5.1	4.6
Netherlands	18.8	132.3	15.1		
Norway	30.8	120.9	0.4		
Poland	5.1	17.6	3.6	0.6	5.3
Portugal	6.1	12.1	2.1	1.0	0.5
Romania	6.4	14.1			
Slovakia	11.5	19.3			
Slovenia	7.1	69.7	4.5	3.7	1.3
Spain	8.6	6.6			
Sweden	3.5	28.9	0.9	18.4	0.5
UK					

Source: WHO (2011)

Table 5.8 shows that Norway has the highest number of psychiatrists per 100 000 population compared to other participating countries – a rate of 30.8 psychiatrists. A similar rate is found for Finland (28.1 per 100 000 population). Fewer numbers of psychiatrists are found for Malta (3.2 per 100 000 population) and Sweden (3.5 per 100 000). Figure 5.5 charts the wide range in the number of psychiatrists across participating countries.

Figure 5.5 Number of psychiatrists working in mental health services by country

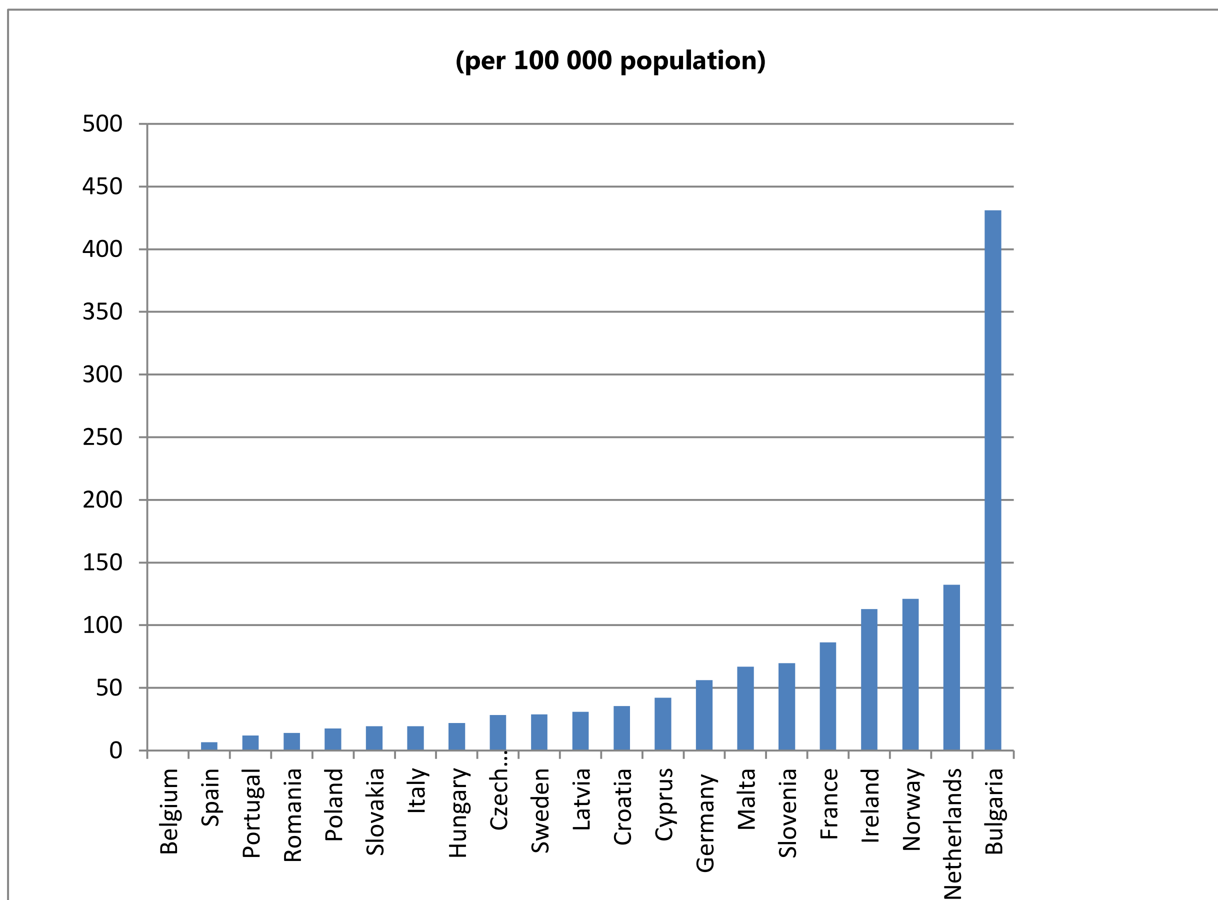


Source: WHO (2011)

The number of nurses working in the mental health sector across countries is similarly wide, although data are unavailable for eight countries. Bulgaria has an extremely high number of nurses (431.0 per 100 000 population) (see Figure 5.6).

The data for other mental health professionals are less comprehensive which demonstrate the difficulties in gathering this type of information reliably (Bruckner et al., 2011). The number of psychologists is highest for Austria (79.9 per 100 000 population) reflecting an emphasis on their mental health system on psychotherapy. The number of social workers appears relatively low, with only Sweden having a much higher number (18.4 per 100 000) compared to other countries. Occupational therapists working in the mental health sector appear few and far between, with Cyprus, Malta and Poland having relatively higher numbers.

Figure 5.6 Number of nurses working in mental health services by country



Source: WHO (2011)

It is difficult to draw any firm conclusions concerning the pattern and numbers of mental health professionals working in the mental health sector across Europe. As Semrau et al. (2011) show from their analysis that the increase in the mental health workforce in Europe is concentrated in a few high income countries. Depending on the database used (e.g. WHO Mental Health Atlas, Eurostat, OECD, etc.) the numbers for mental health workforce, and indeed for services, vary. Inevitably, this variation reveals the lack of reliable comparable data, but it can provide some pointers to general policy trends, resources and investments for participating countries.

5.4 Funding for mental health services

Several participating countries spent more than 12% of their total health budget on mental health services (France, Luxembourg, Norway and the UK) (see Table 5.9). The majority of countries spent between 4% to 8% of their health care budget on mental health services; with Bulgaria and the Czech Republic spending the least.

Table 5.9 Funding allocated for mental health services by country

	Total health budget/ expenditure spent on mental health	Finance systems	Health expenditure/ budget (% of GDP)	Year
Austria	n/k	No separate mental health budget exists. Complex system of financing mental health services, largely through state taxation, insurance and co-payments.	11.0	2009
Belgium	6%	Mental health services are financed mainly through social and private insurance, out of pocket and taxation.	11.8	2009
Bulgaria	Less than 2%	National Health Insurance Fund is the main source of funding.	4.0	2012
Croatia	n/a	No separate budget allocation for mental health. National insurance based financing.	7.8	2011
Cyprus	4.8%	Main funding sources are tax revenues, out-of-pocket, social insurance and grants.	7.4	2011
Czech Republic	2.9%	Several stable sources of funding are used: the Health Insurance Fund, subsidies from the Ministry of Labour and Health, out of pocket and direct payments by patients for private services.	7.4	2011/ 2008
Denmark	8%	Main funding sources are tax revenues.	11.2	2009
Estonia	5.8%	Main funding sources are from the Health Insurance Fund, out of pocket funds and co-payments.	6.0	2011
Finland	3.9%	Tax revenues, social and private insurance, out of pocket expenses are the main sources.	8.9	2011
France	12.9%	Primary sources of funding are tax revenues and social insurance.	11.6	2011/ 2009
Germany	11%	Statutory or private health insurance are the main sources of funding.	11.1	2011
Greece	4.4%	Main sources of funding are tax revenues, social and private insurance.	10.8	2011
Hungary	5.1%	Main sources of funding taxation, social insurance and out of pocket expenses.	7.7	2009
Ireland	5.3%	n/a	9.4	2012
Italy	5.0%	Main funding sources through tax revenues, cost sharing and direct payments from service users.	8.7	2007
Latvia	5.9%	n/a	6.2	2011
Lithuania	n/a	Financed through State Sick Fund.	6.6	2011
Luxembourg	13.4%	n/a	7.7	2005
Malta	6.7%	Financed through general taxation.	8.7	2011
Netherlands	11%	Financed through basic health insurance.	12.0	2009
Norway	18%	Financed through state funding and some out of pocket expenses.	9.1	2011
Poland	5.1%	Financed through taxation.	6.7	2011

	Total health budget/ expenditure spent on mental health	Finance systems	Health expenditure/ budget (% of GDP)	Year
Portugal	5.2%	Main sources of funding through taxation and out of pocket expenses for private healthcare.	10.4	2011
Romania	n/a	Financed through compulsory and voluntary insurance contributions.	4.0	2012
Slovakia	n/a	Financed through compulsory public health insurance.	7.3	2010
Slovenia	n/a	n/a	9.1	2011
Spain	3-8% (estimate)	Financed through tax revenues, out of pocket expenses and private insurance.	9.4	2011
Sweden	10.0%	n/a	9.4	2011
UK	13%	Mainly financed through general taxation.	9.6	2012/ 2010

Source: Country profiles and World Health Organization National Health Account database (2011)
n/a – not available n/k – not known

The proportion of expenditure for mental health services allocated to inpatient care remains high for some countries, particularly those with long-stay hospitals, although not exclusively. According to figures produced by the WHO (2011), Malta, for example, spends 96.8% of its mental health budget on hospital care. Poland, despite not having long-stay hospitals, spends 73.0% of its mental health budget on inpatient services. For Portugal, which continues to have some long-stay hospital care, the proportion is 45.0%. This high proportion of funding devoted to inpatient mental healthcare inevitably restricts the amount of investment/resources allocated to developing community mental health services. Community care has been shown to be cost-neutral compared to institutional care (Thornicroft & Tansella, 2004; 2002); and so optimising the use of available financial and staff resources by transferring these from institutions to community services is an important solution (Semrau et al., 2011).

Mental health budgets are subject to cuts in some participating countries. Ireland and the UK, for example, are currently experiencing a reduction in healthcare spending despite increased investment in previous years. In Ireland, the cost reductions for mental health for 2012 will be just under 1%. In the UK, the current plans are for the National Health Service (NHS) spending to continue rising in line with general inflation. The NHS is aiming to reduce costs to make £20bn efficiency savings by 2014/15. These savings will be reinvested to support the front line services, although it is unclear how this will impact on mental health services.

5.5 Prevalence of mental illness in the population

Gathering comparable data on the prevalence of mental illness in the general population was a difficult exercise. The data presented in the following table should be treated with caution as they are derived from studies and surveys from each participating country using different methodologies and definitions. Many countries did not have epidemiological data on mental illness in the general population (Croatia, Cyprus, Czech Republic, Latvia, Lithuania, Luxembourg and Sweden). Although several countries had hospital data by ICD10 diagnostic code (for example, Estonia, Croatia, Czech Republic and Latvia). These data are detailed within the respective country profiles presented in Chapter 3.

Table 5.10 lists the prevalence of mental illness where reported by country collaborators. With the above caveats in mind, the prevalence of any mental illness across participating countries ranges between 8% to 26%. This is comparably lower than the recent estimate of 38% (Wittchen et al., 2011), but similar to an earlier estimate of 27.4% (Wittchen & Jacobi, 2005).

Table 5.10 Mental illness in the general population (aged between 15-65 years) by country

	Any mental illness	Severe mental illness	Depression	Year
Austria	n/a	n/a		-
Belgium	26.0% (psychological distress)	14.2% (probably mental illness)	9.5%	2008
Bulgaria	19.5%	n/a	20% (common mental illness)	2002-2006
Croatia	n/a	n/a	n/a	-
Cyprus	n/a	n/a	n/a	-
Czech Republic	n/a	n/a	n/a	-
Denmark	n/a	n/a	1.4% (3.3% major depression)	2004
Estonia	8.4%	n/a	n/a	2008
Finland	n/a	n/a	16% (symptoms of depression)	2009
France	n/a	2.8% (psychotic-like syndromes)	n/a	2003/ 1999
Germany	n/a	n/a	10.7% (any mood disorder)	2008
Greece	14%	7% (severe enough for treatment)	n/a	2009
Hungary	15%	n/a	6% (chronic depression)	2002/ 2009
Ireland	14%	n/a	n/a	2007
Italy	8%	n/a	9.4% (symptoms of depression)	2009/ 2007
Latvia	n/a	n/a	n/a	

	Any mental illness	Severe mental illness	Depression	Year
Lithuania	n/a	n/a	n/a	
Luxembourg	n/a	n/a	n/a	
Malta	15%	n/a	6.6% (lifetime depression)	2008
Netherlands	18%	n/a	5.2% (depressive disorder)	2010
Norway	n/a	n/a	n/a	
Poland	n/a	n/a	n/a	
Portugal	22.9% (annual prevalence)	n/a	7.9% (annual prevalence)	2010
Romania	13.4% (estimate)	n/a	n/a	2007
Slovakia	n/a	n/a	12.8% (major depression, 6-month prevalence)	2006/ 2003
Slovenia	n/a	n/a	5%	2005
Spain	13.8%	n/a	n/a	2006
Sweden	n/a	n/a	n/a	
UK (England)	23%	0.4%	17.6% (estimate for all common mental disorders)	2007

The use of antidepressant medication can be a proxy indicator of the prevalence of mental health problems in a population. Findings from a Eurobarometer mental health survey (2010) show that the EU average for antidepressant use (over the past 12 months) is 7% (European Commission, 2010). Countries with the highest self-reported use are Portugal (15%), Malta and France (10%). Those hovering at the EU average were Denmark and Hungary (7%). Lower antidepressant use was found for Germany and Greece (3%) and Bulgaria (4%). The percentages of people not seeking help for psychological problems was alarming high for almost all participating countries (see Table 5.11).

Table 5.11 Use of antidepressants and seeking psychological help

	Taken antidepressants in the last 12 months (%)	Sought psychological help (%)	Did not seek psychological help (%)
Austria	9	16	84
Belgium	9	18	81
Bulgaria	4	6	94
Croatia	-	-	-
Cyprus	5	14	86
Czech Rep		15	85
Denmark	7	16	84
Estonia	6	17	81
Finland	6	14	86
France	10	17	82

	Taken antidepressants in the last 12 months (%)	Sought psychological help (%)	Did not seek psychological help (%)
Germany	3	12	87
Greece	3	7	92
Hungary	7	12	88
Ireland	6	12	86
Italy	6	14	85
Latvia	8	17	82
Lithuania	11	19	81
Luxembourg	5	14	86
Malta	10	14	86
Netherlands	6	18	82
Norway	-	-	-
Poland	5	9	89
Portugal	15	21	78
Romania	6	35	63
Slovakia	9	20	80
Slovenia	8	12	88
Spain	8	17	83
Sweden	8	17	83
UK	8	15	87

Source: European Commission, Eurobarometer (2010)

5.6 Risk and protective factors

The risk and protective factors for mental health, as reported by country collaborators, fit closely with those covered in the literature (see Chapter 4). Table 5.12 provides a summary of the risk and protective factors listed in the country profiles. These are presented according to a number of themes rather than by country. Themes such as migration are important determinants of health, concerning issues around access to appropriate health and social care, and levels of cohesion and integration (Davies, et al., 2006).

Table 5.12 Protective and Risk factors – common themes

	Risk factors	Protective Factors
Economic	Socio economic factors, (economic hardship, unemployment etc), uncertainly about the future, and lower socio-economic groups.	Employment, having a good job and social contact
Education	Low educational achievement, low income, less than 10 years schooling, failure at school, feeling unpopular in school and poor relationship with peers.	Completing secondary school education, good learning conditions and school environment.
Employment	Working in the public sector (e.g. health/education) and perceived lack of support from colleagues	Employment, secure employment and perception of having a good job
Migration	Being an immigrant from a minority ethnic group, asylum seeker and family crises linked to migration	
Personality	Extroversion, negative self-esteem, depressive and anxious states, aggression, low confidence and inability to socially interact	Positive self-image, resilience, self-esteem and good social skills
Relationships	Loss of friend/relative, traumatic event, separation, divorce or death of spouse, parent(s) with mental health issues, being single, limited or low social support	Social support, good friends, being married or cohabiting, close relationships with at least one family member or parent
Services	Insufficient services, uneven distribution of outpatient and inpatient facilities and lack of health professionals	
Stress	Stressful life events, hectic lifestyle, being bullied at school, stress at work and poor housing	Having time to relax and rest, being physically healthy. Having conditions for leisure time hobbies.
Substances	Drugs and alcohol misuse	
Physical	Chronic physical illness, perinatal trauma, head injury, unhealthy lifestyles (e.g. poor diet, lack of exercise)	Reduced alcohol and tobacco consumption and healthy living
Upbringing	Parents with mental illness or alcohol problems, childhood adversity, traumatic events in adolescence	Social and family support, positive parenting, suitable family environment

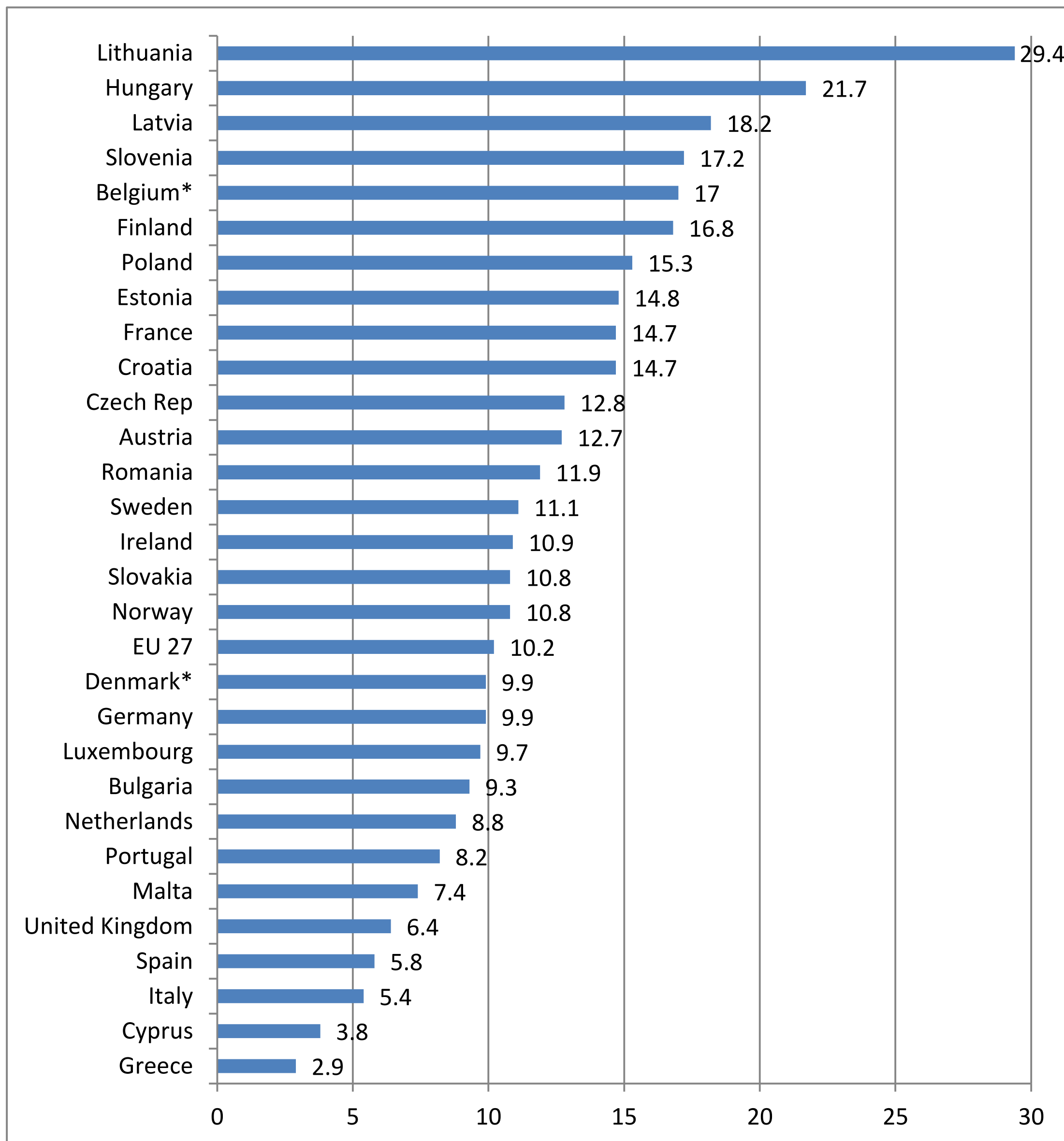
Source: Country profiles

5.7 Suicides

Suicide rates are of particular concern, and especially since the advent of the current economic crisis across Europe beginning in 2008. Stuckler et al. (2009) calculated that an increase of 1% in unemployment was associated with a potential 0.79% rise in suicides for those under the age of 65 years, although the effect size was not statistical significant at all ages.

Figure 5.7 illustrates the most recent suicide rates for 2010 in participating countries reported by Eurostat (2013). The top six countries - Lithuania, Hungary, Latvia, Slovenia, Belgium and Finland - have rates exceeding 16.0 per 100 000 population, well above the EU 27 countries' average of 10.2 per 100 000 population. Countries with low rates of suicide are Greece, Cyprus, Italy and Spain – all with rates less than 6.0 per 100 000 population.

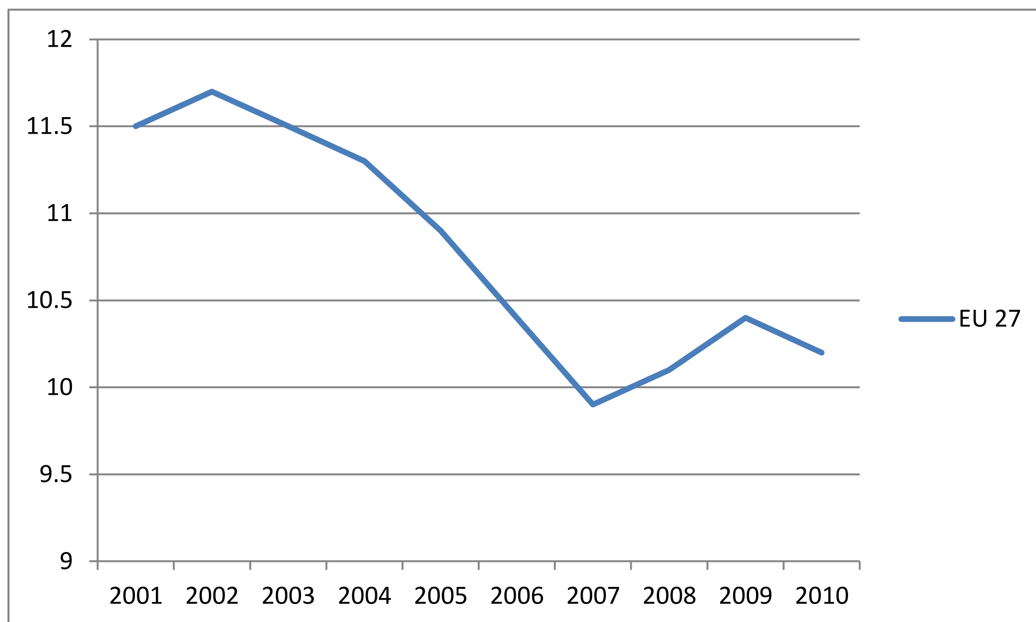
Figure 5.7 Standardised suicide rate per 100 000 population for 2010 by country



Source: Eurostat, 2013 * Figures for 2009

Since 2001, the rate of suicide across the 27 EU Member states has been declining steadily. Figure 6.8 charts the average number of suicides per 100 000 population over the past ten years. The downward trend commences in 2002 and continues to decrease until 2007, followed by an increase from 2008 onwards. Interestingly, the rate appears to be falling in 2010 despite the economic recession continuing in many European countries.

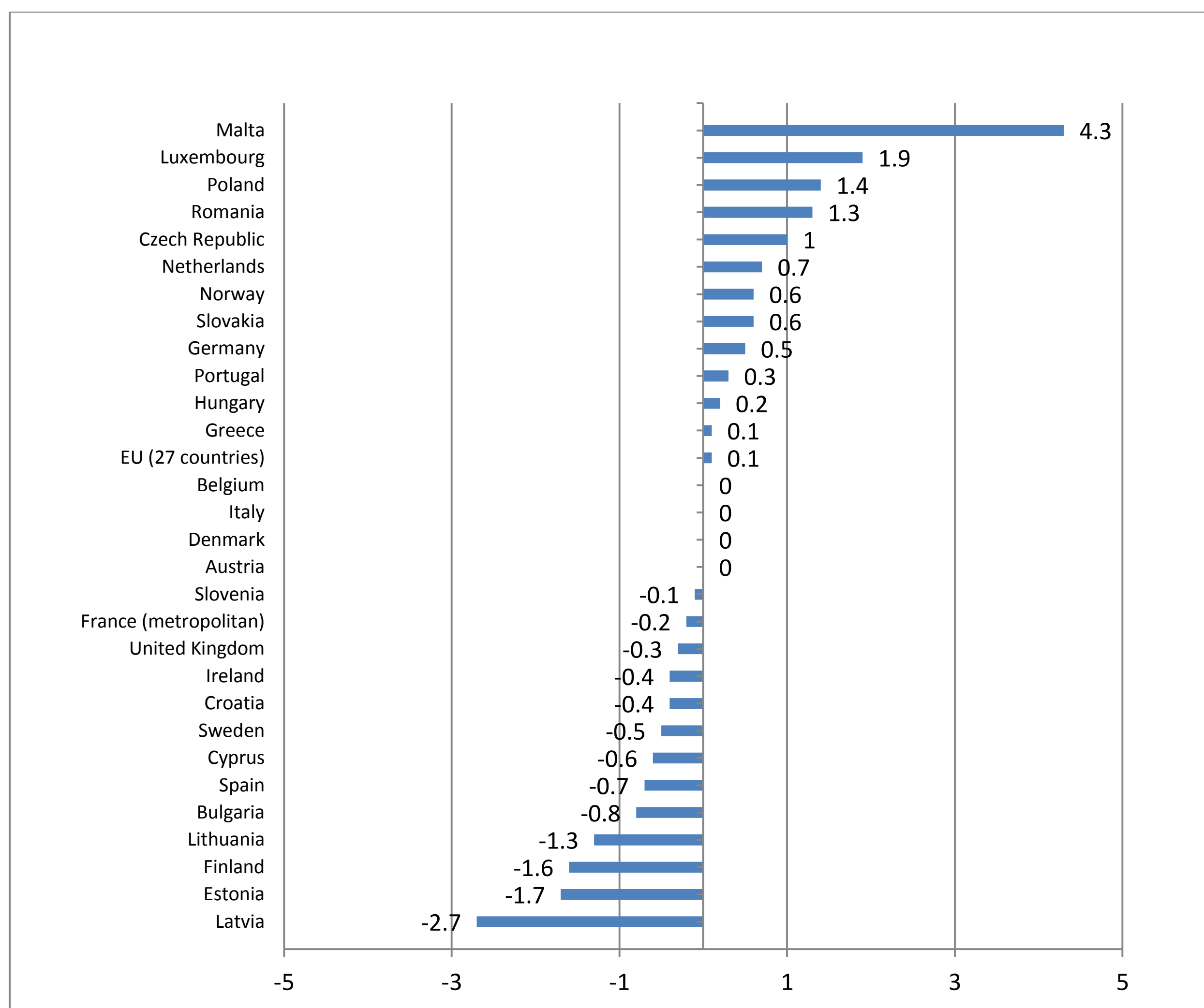
Figure 5.8 Average standardised suicide rate per 100 000 for EU Member States (2001 to 2010)



Source: Eurostat, 2013

Some countries have seen a rise in their suicide rate since the beginning of the economic crisis. Figure 5.9 shows the differences in suicide rates (per 100 000 population) from 2008 to 2010 across Europe. Thirteen participating countries have seen an escalation in their suicide rate over this 3-year period, with Malta and Luxembourg showing the greatest increases. However, the same number of participating countries have experienced a decrease in their suicide rates, with Latvia (a country with a traditionally high suicide rate) revealing the highest decline of all. While this is encouraging, Latvia (as shown in figure 5.7) still has one of the highest suicide rates in Europe. A similar picture is found for Lithuania and this, despite a decline in their suicide rates since 2008, is overshadowed by having the highest suicide rate of all participating countries (29.4 per 100 000 population). Both countries continue to prioritise suicide prevention both in policy and practice.

Figure 5.9 Differences in the number of suicides (per 100 000) between 2008 and 2010 by country



Source: Eurostat 2013

5.8 Mental health promotion and prevention of mental illness activities

Types of prevention and promotion programmes listed in the country profiles

Our country collaborators reported 381 mental health promotion (MHP) and prevention of mental illness (PMI) programmes, many of which are practice-based initiatives. The numbers and types of prevention and mental health promotion programmes listed in this section, though not fully representative or exhaustive, provide some indication of the sorts of activities that have taken place over the past five years. Table 5.13 lists the number of programmes by country. Austria and Germany reported the greatest number of programmes, but other countries have turned their attention to

investing/implementing prevention and mental health promotion, for example, the Netherlands (see figure 5.14).

Table 5.13 Number of programmes by country

	Prevention	Promotion	Combined	Total
Austria	10	12	11	33
Belgium	7	1	2	10
Bulgaria	3	2	1	6
Croatia	15	4	2	21
Cyprus	6	0	1	7
Czech Republic	16	5	3	24
Denmark	9	0	3	12
Estonia	3	2	0	5
Finland	3	4	4	11
France	11	0	0	11
Germany	30	3	7	40
Greece	4	0	3	7
Hungary	3	2	3	8
Ireland	11	0	5	16
Italy	6	0	1	7
Latvia	15	2	4	21
Lithuania	3	6	1	10
Luxembourg	15	0	1	16
Malta	6	7	1	14
Netherlands	13	2	0	15
Norway	5	4	1	10
Poland	3	0	1	4
Portugal	2	0	3	5
Romania	2	0	0	2
Slovakia	16	1	5	22
Slovenia	4	6	1	11
Spain	7	1	1	9
Sweden	4	0	1	5
UK	7	0	12	19
Total	239	64	78	381

Table 5.14 shows the reported number of programmes according to setting and approach. Just under half of all reported programmes were conducted within school settings, targeting children of school age. The second largest proportion of programmes categorised as 'general' were those targeting the general population or specific groups

at risk (e.g. people with mental illness, at high risk of addiction or mental illness or minority groups, etc.). Nearly a quarter of all reported programmes (22%) were situated in the workplace. A fairly small proportion by comparison targeted older people in long-term care facilities (6.6%), although this was widened to also include programmes in the community.

There was a predominance of prevention of mental illness programmes (62.7% of all 381 programmes), of which 41.8% (100) were based in schools, with 31.4% (75) being 'general' prevention programmes (see Table 5.14). Although relatively fewer, the number of reported mental promotion programmes were also largely concentrated in schools (62.5% or 40). Work-based programmes mostly used a combined approach (both prevention and promotion) (28.2% of 78 of these programmes).

Table 5.14 Number of programmes by setting and approach from the 29 participating countries

	Prevention	**Promotion**	**Combined**	**Total**
Schools	100	40	29	169 (44.3%)
Workplace	48	15	23	86 (22.6%)
Older people	16	5	4	25 (6.6%)
General	75	4	22	101 (26.5%)
Total	239 (62.7%)	64 (16.8%)	78 (20.5%)	381 (100%)

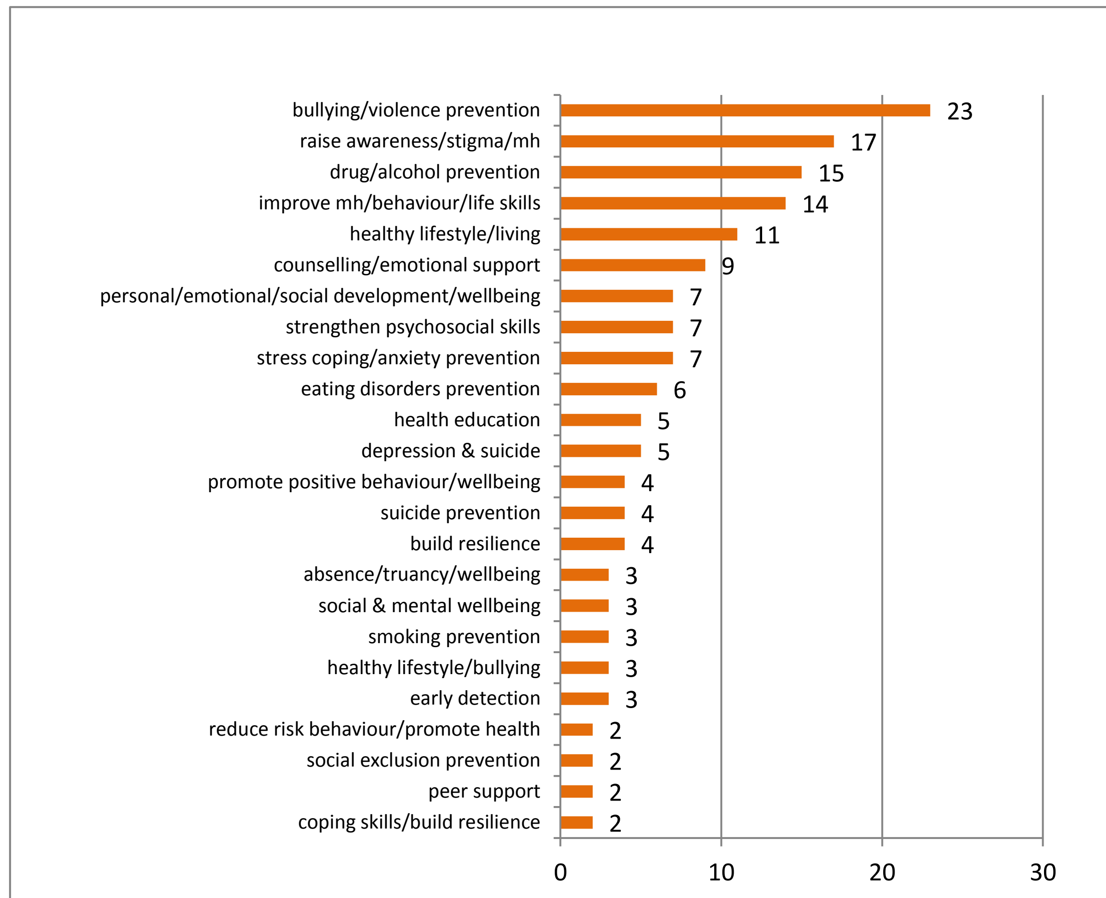
Source: Country profiles

The types of mental health promotion and prevention programmes were extremely diverse in terms of aims, target groups and approaches. Over half of all reported programmes were mental illness prevention (239 or 62.7%) and to a much lesser degree mental health promotion (64 or 16.8%). A fifth of programmes used a multi-dimensional approach that combined both prevention and promotion activities (78 or 20.5%). Although the project did not specifically aim to collect data on general prevention and mental health promotion initiatives, many were reported by our country collaborators, and constituted just over a quarter of all programmes (101 or 26.5%) listed in the country profiles.

Figure 5.10 charts the most common programmes in schools (8 programmes were excluded from this analysis). The most frequent programmes in schools were aimed at prevention of bullying (or mobbying) and violence (23 or 14.3%), particularly in secondary schools. Raising awareness, either to combat stigma and discrimination towards people with mental health problems or to promote mental health in children and adolescents, was another common programme in schools (17 or 10.6%). Preventing

the uptake of drugs and alcohol was also relatively common (15 or 9.3%). Programmes to promote mental/social well-being (3 or 1.9%) or personal and social development (7 or 4.3%) were less frequent by comparison.

Figure 5.10 Number and types of prevention and mental health promotion in schools (n=161*)

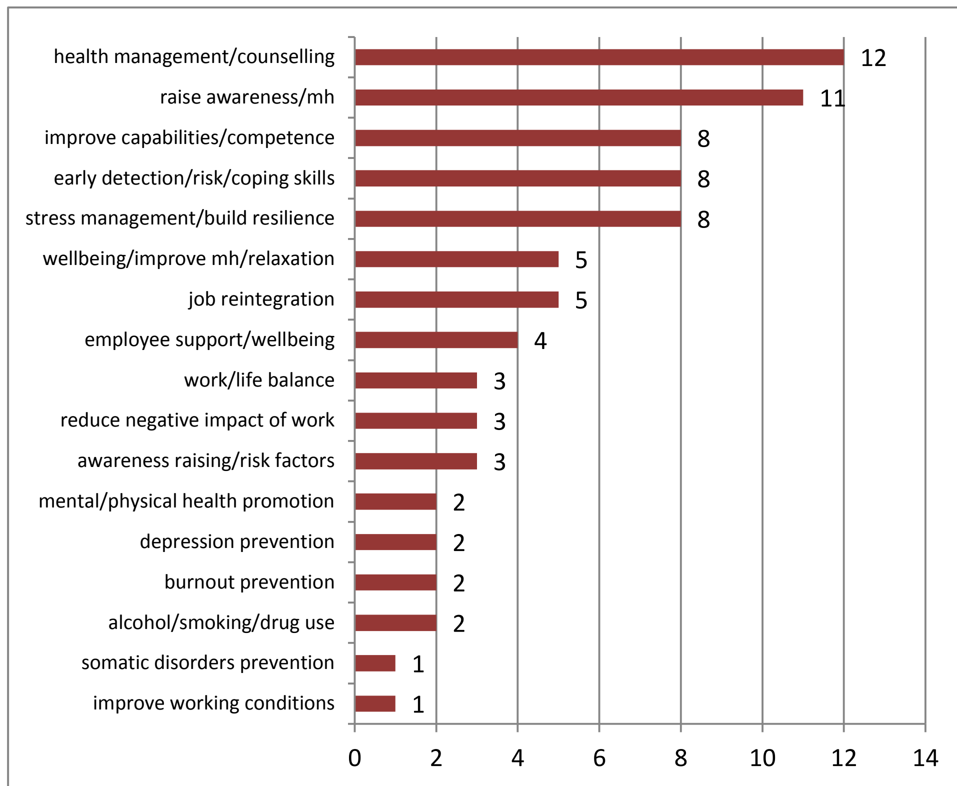


*8 programmes were 'other'

Health management and the availability of counselling services in work settings was another frequent type of prevention programme (12 or 15.0%). Programmes in the workplace also reveal an emphasis on raising awareness about mental health issues (11 or 13.8%) (see Figure 5.11). Monitoring risks for mental health problems and early detection of these and stress management were typical features of the workplace prevention programmes. As with school-based programmes, there was relatively little emphasis on mental health promotion and well-being.

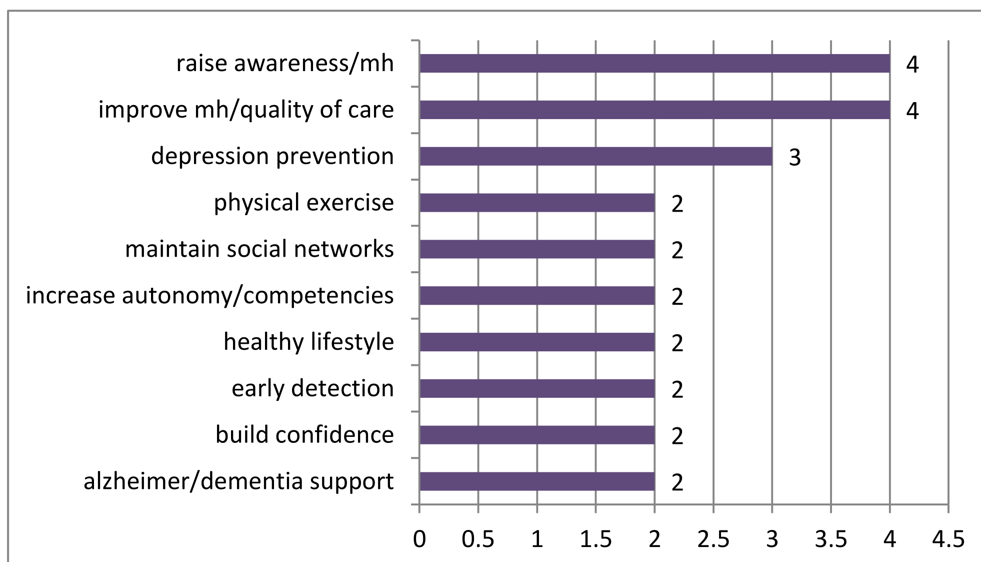
The few programmes reported for older people were focused on raising awareness regarding mental health and importantly on improving the quality of care (see Table 5.12).

Figure 5.11 Number and type of prevention and mental health promotion in the workplace (n=80*)



*6 programmes were 'other'

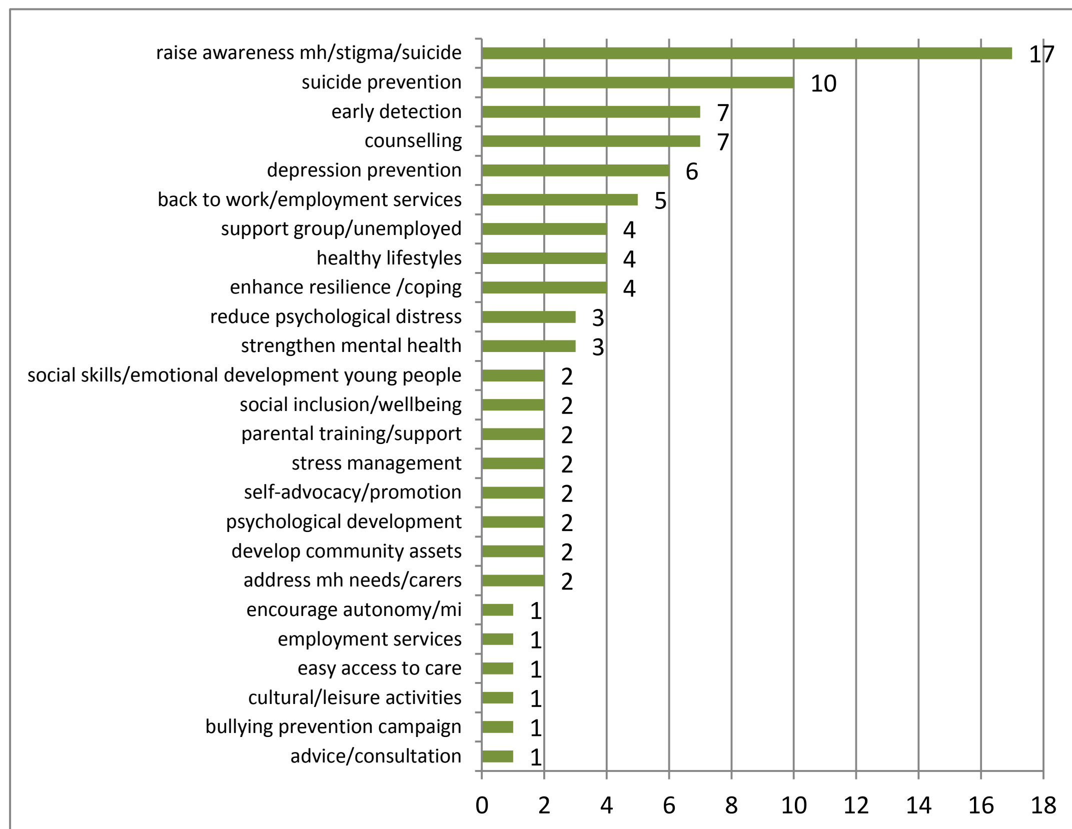
Figure 5.12 Number and type of prevention and mental health promotion for older people (n=25)



Ninety two programmes were included in figure 5.13 which targeted people in the general population, those at high risk of developing mental health problems or with existing mental health issues. Popular programmes were again focused on raising

awareness about mental health and tackling stigma (17 or 18.5%). Importantly, suicide prevention featured in some of the most common programmes (10 or 10.9%), as did early detection of symptoms or risk of mental illness and counselling (7 or 7.6%) and prevention of depression (6 or 6.5%), which reflects the key themes priorities in mental health policies for several participating countries (see Table 5.2 above).

Figure 5.13 Number and type of general prevention and mental health promotion programmes (n=92*)



* 9 programmes were 'other'

Assessing the progress of implementation of prevention and promotion programmes across participating countries

Gauging the extent to which EU Member States and other countries have implemented mental health promotion (MHP) and prevention of mental illness (PMI) programmes and activities is an important but difficult exercise. This has been attempted by the IMHPA project (Implementing Mental Health Promotion Action), described in Chapter 3 of this report, which provides some baseline information on initiatives in the first part of 2000 (Jané-Llopis & Anderson, 2006); and the WHO (2008). It is difficult to make direct comparisons with the findings of both projects given the difficulty of gathering this type of information and the different methods used. However, based on reports from 22

Member States, Jané-Llopis & Anderson (2006) found that school based programmes were available for the most part, and workplace programmes were hardly available or not available at all.

The WHO (2008) report sought to identify the number of the 27 EU Member States and other European countries that have implemented mental health promotion and prevention programmes in the five years prior to 2008. Table 5.15 lists the types of activities and extent of implementation. Programmes to tackle stigma and discrimation (93% of countries), awareness raising about mental health (89%) and promoting mental health in school children (85%) were present to some degree in most EU 27 countries.

Table 5.15 Summary of WHO (2008) findings on mental health promotion and prevention programmes in EU 27 countries

Programmes implemented	**EU 27 countries**	
	Number	**Percentage**
In schools to promote mental health in children		
yes	23	85
no	3	11
no information available	1	4
Improve parenting		
Yes	20	74
no	0	
no information available	7	26
Promote mental health in the workplace		
Yes	20	74
no	4	15
no information available	3	11
Promotion of mental health in older people		
Yes	20	74
no	3	11
no information available	4	15
Prevention of suicide (by recognition and treatment of at risk groups in primary care)		
Yes	12	44
no	14	52
no information available	1	4
Prevention of suicide (by recognition and treatment of at risk groups in specialist care)		
Yes	13	48
no	13	48
no information available	1	4
Prevention of depression directed towards the population		
Yes	13	48
no	12	44
no information available	2	7
Tackle stigma and discrimination against those with mental illness		
yes	25	93

Programmes implemented	EU 27 countries	
no	0	0
no information available	2	7
Raise public awareness about mental health and mental illness		
yes	24	89
no	2	7
no information available	1	4

Source: WHO (2008)

Our findings show similarly high proportions of countries implementing prevention or promotion programmes for school-based programmes where 96.5% (28) participating countries reported these; 79.3% (23) reporting workbased initiatives; and 72.4% (21) for general programmes. However, this was not the case for programmes for older people where only 34.5% (10) of countries reported the presence of these. Although these figures are limited by what country collaborators could identify, it is likely that there are many more initiatives that have been implemented in participating countries, especially work based programmes or those for older people, but information about them is not so readily available or in the public domain.

In terms of specific countries, general health promotion and prevention has been a important development in Austria, which was was not the case in the early part of 2000 (Jané-Llopis & Anderson, 2006). Although not shown here, the Netherlands has produced an extensive array of mental health promotion and prevention programmes over the past few years. There are several databases listing many of the activities across different settings (see Country profile 5.20). Many of these programmes have been evaluated which is comparatively unsual. Denmark, recently has put its focus on mental health promotion following a launch by their National Board of Health in 2012.

Some countries, however, are struggling to implement prevention and mental health promotion initiatives (see Chapter 6 for a overview of some of the main challenges and barriers). Countries that are transitioning from long-stay hospitals to community mental health care or still developing these are perhaps finding it difficult to prioritise both prevention and promotion in parallel with improving and expanding mental health services. Having said this, Croatia, Latvia and Slovakia with its limited community mental health care, appeared to identify a relatively high number of prevention and promotion programmes.

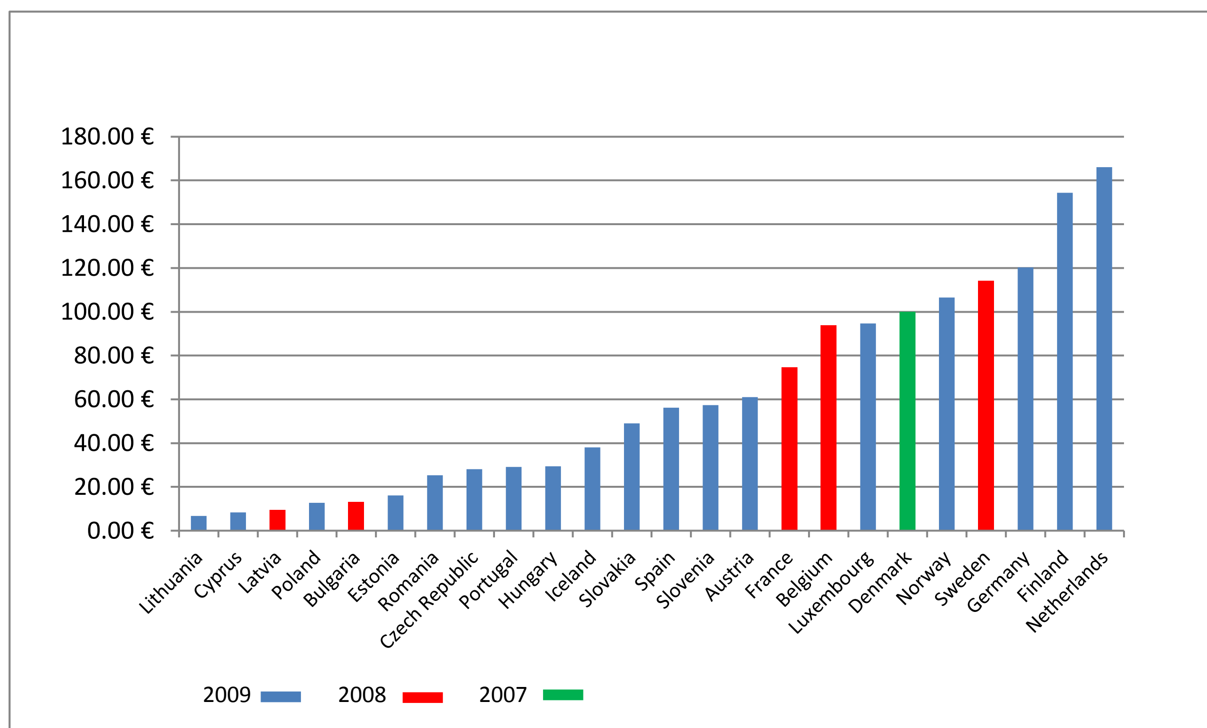
Investments in health promotion and prevention

There was very limited information available on the amount of investment for participating countries on prevention and promotion programmes specific to mental

health. Some comparative data is available, however, on general health prevention and promotion investments across EU countries. The amount allocated varies enormously.

Figure 5.14 illustrates the amount spent (in Euros) on general health prevention and promotion for 24 of the participating countries (data were not available for Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom). It shows the huge variation between highest and the lowest amounts spent for the countries listed. For example, Lithuania spent 6.80 Euros per head in 2009 compared to the Netherlands who spent 166 Euros per head in the same year for health prevention and promotion. The highest figure is almost twenty-five times greater than the lowest, though this does not take into account differences in cost of living in each country.

Figure 5.14 Euros spent per capita on general health prevention and public health services



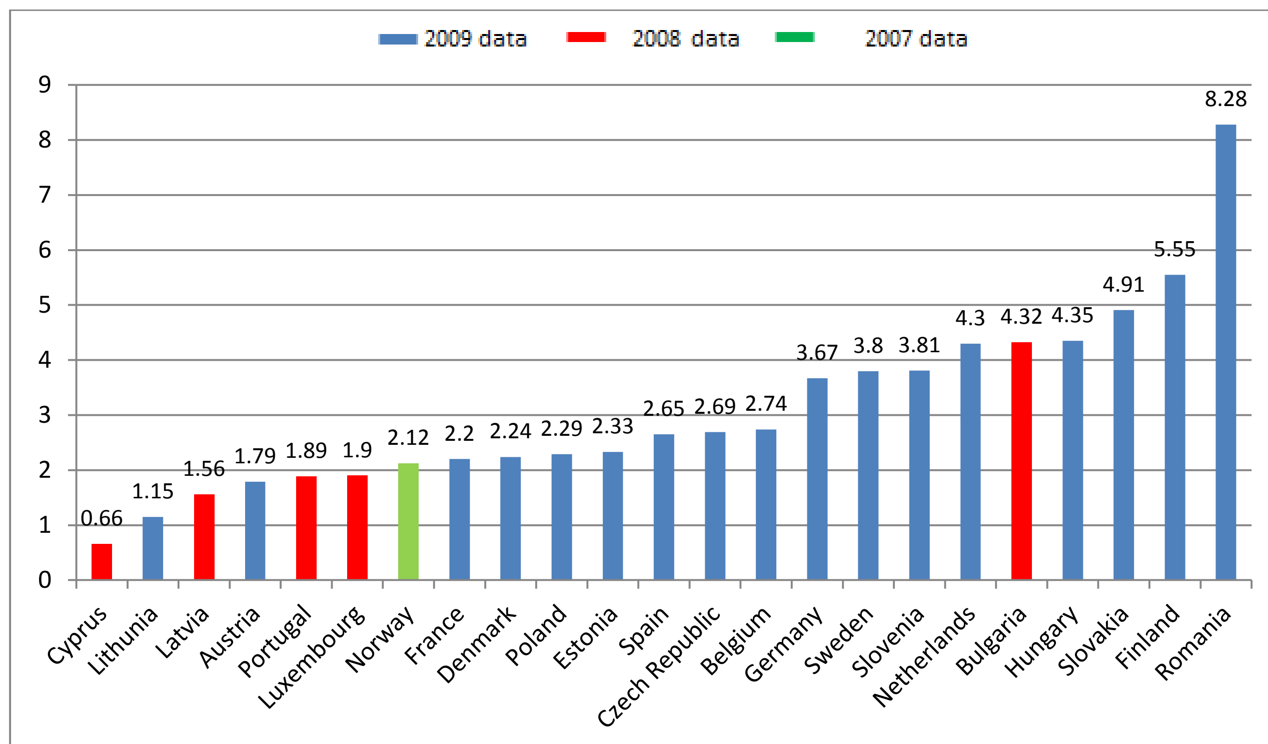
Source: Eurostat 2012

It is notable that 6 countries spend less than 20 Euros per capita on prevention of ill health and public health, whereas a further 10 spend less than 30 Euros per head. This contrasts with the highest 6 where the spend is 100 Euros or more per inhabitant.

Figure 5.15 shows the percentage of health expenditure spent on prevention and public health. Interestingly, the country that spends the highest proportion of their general health care budget on prevention and public health programmes is Romania; despite spending the lowest proportion of Gross National Product (GDP) on health compared to

other EU countries (see Country profile 4.24). Other countries such as Bulgaria, Hungary, Slovenia and Finland also spent relatively higher proportions of their health expenditure on these services.

Figure 5.15 Percentage of health expenditure spent on prevention and public health



Source: Eurostat 2012

It is alarming, however, that some countries may be reducing their investments in health prevention and promotion at a time when it is most needed. The Netherlands, for example, despite investing in their policy priorities to prevent chronic illness and promote healthy lifestyles, has seen a fall in their funding for these initiatives since 2011. In 2011, €14 million was invested in preventing chronic illness, which for 2014 is planned to be reduced to €6 million. Funding for the health lifestyle policy was €59 million for 2012, and will be reduced to €48 million for 2014.

Responsibility for mental health promotion

Country profiles also identified the organisations that are responsible for funding and delivering mental health promotion, although there were gaps in these data. This is displayed in Table 5.16 which shows a range of Non-Governmental Organisations (NGOs), government departments, social welfare and insurance schemes delivering health promotion. A prominent feature is the level of devolved responsibility and regional input into delivering health promotion and prevention.

Table 5.16 Responsibility for delivery of mental health promotion and prevention of mental illness and source of funding

	Mental health services have responsibility	Schools, NGOs and municipalities, government departments.	Source of funding
Austria			Austrian Health Promotion Foundation
Belgium	Local health networks	Local Centres for Health Promotion	Council for Health Promotion and the Service for Child and Family
Bulgaria			No specific budget for mental health promotion and mental illness prevention
Croatia			The health budget is covered by social insurance
Cyprus		Ministry of Health	Tax revenues
Czech Republic			Ministry of Education for school programs
Denmark			Ministry of Health and the Interior
Estonia			Estonian Health Insurance Fund
Finland		Municipal social and health services	
France	Mental health services		Social insurance and tax revenues
Germany		Federal State Ministries	Public Health Insurance fund
Greece		NGOs and other organisations	Tax revenues, social insurance
Hungary			Ministry of Health and NGOs
Ireland		Government via HSE	Health Service Executive
Italy	Mental health services	Ministry of Health	Mental health services
Latvia			
Lithuania		Municipalities	National Health System
Luxembourg			Health Ministry
Malta		Non-governmental organisations	Non-governmental organisations
Netherlands			Ministry of Health, Welfare and Sports
Norway			
Poland			Taxation expenditure
Portugal			Taxation
Romania			Health insurance scheme
Slovakia			Public health insurance
Slovenia			
Spain		Autonomous communities	Ministry of Health and Social Policy and Equity
Sweden			
UK		Local authorities	NHS or by Local authorities

Source: Country profiles

5.9 Limitations of the country profile data

The data collected as part of the project via country collaborators had a number of limitations. Gathering comparable data was particularly difficult and so international databases were used instead. Standardising definitions for mental health services and collecting uniform data on prevention and mental health promotion activities was also difficult. However, it was considered important to obtain a rich description of the participating countries mental health systems and priorities in relation to prevention and mental health promotion activities. Much of the data collected therefore was largely qualitative which provided an opportunity to explore the challenges and solutions to improving mental health services and implementing prevention and promotion programmes.

Summary

The presence of long-stay hospital care in over a third of participating countries demonstrates that there remains progress to be made in moving from this to community-based mental health services. Some countries are highly reliant on inpatient care which appears to be consuming a large proportion of mental healthcare budgets. Gaps and wide variations in mental health services are still evident within several countries, which include significant shortages in mental health professionals.

It is encouraging that all but two participating countries have prioritised some form of mental health prevention and promotion within their mental health policies. The number of prevention of mental illness and promotion of mental health programmes reported by our collaborators continues to show that participating countries are implementing these particularly in schools, the workplace and in general. However, more momentum is needed to ensure that certain groups, such as older people, have access to these important programmes; and that investments in them are maintained or increased rather than reduced.

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6. Strengthening systems to support promotion of mental health and prevention of mental illness

This chapter identifies some of the key lessons and challenges experienced by Member States and other countries in the implementation of programmes on prevention and promotion of mental health; the ways these might be resolved; to highlight best practice; and, how mental health systems and other systems can be enhanced to encourage further implementation of these programmes. Here, qualitative responses from the survey of 81 experts in prevention and promotion are used to gauge their perspectives, discuss emerging issues and potential solutions.

6.1 Strengthening mental health policies

One of the initial points made by some experts concerned existing mental health policies and what would help strengthen these in relation to prevention and mental health promotion. The adequacy of mental health policies and the amount of weight given to prevention and promotion activities was identified as an issue by a number of experts. The lack of transparency and of openly stated goals made implementation more difficult as one expert from Lithuania commented:

'There are many different programmes which together are supposed to constitute a policy. There is no clear policy document for mental health promotion; ministries have different programmes addressing some of the issues. These programmes are running in parallel and in some cases they compete among themselves for funding: e.g. occupational services run parallel with the NGO (Non-Governmental Organisation) sector, social care ministry and are [often] funded through small grants programmes.' (Experts, 30 and 31, Lithuania)

Policies need to be accompanied by plans or actions and some formal regulation to ensure their implementation and monitoring to assess their performance is also necessary as one expert suggested (Expert 43, Poland). Consideration needs to be given on how this should happen in practice, however. In Estonia, one expert explains:

'The link between priorities and detailed action is missing which leaves rather large freedom to the experts in the field to decide what action is taken in reality.' (Expert 61, Estonia)

Another issue, sometimes overlooked by policy makers, concerns how relevant stakeholders and providers are engaged with, so that activities can be implemented in

the way they were intended. This can partly be resolved by developing policies together with the providers of health care programmes (Expert 30, Lithuania).

Good practice example - Norway

A good example of where legislation, policy and implementation plans appear to have created a solid platform for mental health promotion is seen in Norway (Expert 37). Promotion of mental health and prevention of mental illness have received increased focus and are considered as the largest and most important initiative in Norway. A series of legislations, reforms and plans over the past 10 to 15 years have included a major expansion programme to improve mental health services (in both primary and secondary care), and reforms that give municipalities increased responsibility and financial resources to support health promotion, prevention and treatment, including mental health and mental health services. Some of this focus has included improving the health and support for young people with mental health problems.

6.2 Implementation issues

Another issue raised concerned the lack of coordination and integration of mental health services, particularly the interface between primary and secondary health care levels, was noted by several experts from Estonia, Finland, Greece, Germany, Spain and the UK. Poor coordination and integration of mental health services appeared to impact negatively on the implementation of prevention and promotion activities.

In countries where mental health services are still under development, implementation issues are even more acute in terms of creating a network of community based services and closing existing long-stay psychiatric hospitals. In Romania and Bulgaria, for example, mental health policies are in place and include acknowledgement of mental health promotion and prevention of mental illness. One expert in Bulgaria highlighted several difficulties around implementation. One is the lack of administration to support the realisation of the current mental health policy and its action plan; another is the importance of context, political will and commitment, and the value that needs to be placed on mental health for implementation of this policy to happen:

'The National mental health policy is somehow adequate for its users (it is oriented towards satisfying valid, existing and severely neglected needs for mental health). But, it is inadequate for the context … mental health is not recognized as a value, therefore as a priority, deserving an investment of resources for its preservation…' (Expert 9, Bulgaria).

In some respects the opportunity to develop mental health services in parallel with the application of prevention and promotion activities represents a way forward. In such

circumstances, the ideal scenario would be the simultaneous expansion of community services together with development of prevention and promotion activities. Alongside this there '*ought to be programmes that constantly inform society about mental health problems*', as this same expert adds (Expert 9, Bulgaria). By proceeding in this way, the public are more likely to be receptive to participating in prevention and promotion activities.

The gap between policies and practice in prevention and promotion activities appears wide in many of the participating countries, although not in all. A 'one size fits all' implementation approach is unlikely to accommodate the diversity between, and indeed within, countries. Some experts suggested there may be an argument that implementation of prevention and promotion policies should be made compulsory or have a legal framework to ensure their application into practice (Expert 12, Cyprus). In Spain the lack of a clear mandate at regional or local level to guide the implementation of prevention and promotion activities represented a major challenge. Even where guidelines are present, there is no guarantee that programmes will be implemented. This is the case in both Slovenia and the UK. In the Czech Republic, one expert noted that the obligatory supervision of social workers to prevent mental illness has received funding from the Ministry of Social Affairs, and this has ensured that at least some prevention activities take place in practice (Expert 15, Czech Republic).

An important model for implementing promotion of mental health is via municipal agencies who deliver services at the interface with community structures and the public. Such a model is included in some current plans in, for example, Latvia and the UK. However, it is important that this type of arrangement is well informed and coordinated well to ensure a relatively even distribution of prevention and promotion activities across municipalities. In Poland this is not the case where each district is responsible for implementing prevention initiatives (including mental health) but operates in isolation. There is no exchange of information and no obligation in this case for schools to implement activities; there is also with no unit of administrative office to oversee such activities and monitor their outcomes (Expert 39, Poland). This was also the case in Portugal where public health activities lack government coordination or evaluation, and where professionals delivering prevention and promotion did so in their own ways (Expert 44, Portugal).

There is also the question of how much energy and investment should go towards setting up administrations to implement promotion and prevention, especially in countries where resources are particularly scarce. In Latvia, for example, all public health programmes are implemented by a Public Health Agency which has two departments with supporting staff (Expert 26, Latvia). Current cuts in spending are likely to impact on these staff directly and immediately. This has happened in the UK with a number of

mental health promotion specialists recently being made redundant. Improved cross-departmental government working provides one way of making greater use of even more limited resources in times of austerity.

A key to ensuring the implementation of policies is the commitment of professionals on the ground. Part of any policy needs to persuade those responsible for delivering prevention and promotion of its importance. Incentivising clinicians is one possible means of persuasion, but perhaps some of the most successful ways of implementing these activities is by allowing professionals and recipients of programmes to actively lead on them. As Campion (2012) explains:

'The challenge for clinicians is to incorporate such interventions into non-clinical and clinical practice as well as engaging with a range of other service providers including public health. Similar strategies can be employed in both the European and global contexts.' (page 68)

However, it is not just clinicians and health care professionals who should be charged with delivering prevention and promotion activities. Non-health professionals, NGOs and key members of the community are also important protagonists in carrying out prevention and promotion initiatives, particularly as they are located close to some of the main social determinants of mental ill health (Expert 60, UK; Expert 62, Italy).

Other important groups include those who commission or contract mental health services. In the UK, a Joint Commissioning Panel for Mental Health was launched in April 2011. The panel is formed of leading organisations, including service users and carers to publish practical guidance and a framework for commissioning high quality mental health and wellbeing services (see: http://www.jcpmh.info/).

6.3 Resources, budgets and investments

Financial resources

Almost all experts were unanimous in their agreement of the lack of resources allocated to the prevention and promotion initiatives. The lack of earmarked budgets for these programmes represents a formidable hurdle to their implementation. As described in the country profiles, where information was available, a significant proportion of mental health budgets (e.g. in Poland, Malta, the UK) goes towards the treatment of mental illness particularly on inpatient care, with much less money allocated to prevention and mental health promotion. Very often, good policies or even legislation with inbuilt mental health promotion are 'heavily limited by the shortage of financial resources' as in Italy, for example (Expert 62, Italy).

As some experts described, where funding is provided, this can take the form of sporadic, patchy, time limited, 'one-off' or short-lived grants that are insufficient to cover the costs of a comprehensive intervention. There are many initiatives that are not directly funded by the government, particularly those delivered by NGOs. In the UK, for example, the Big Lottery invested £160 million in a 5-year Well-being programme between 2006 and 2012. Whereas obtaining temporary funding for prevention and promotion initiatives may not be a problem, obtaining long-term structural funding is (Expert 18, The Netherlands). Preserving and maintaining prevention and promotion initiatives over time is therefore critical.

Encouraging investments into prevention and promotion, particularly in programmes that are cost effective, is an important step. In the Netherlands some health insurers are reluctant to invest in new programmes, especially if cost-effectiveness has not yet been established (Expert 18, The Netherlands). This raises an important concern about the need for effective programmes that are not costly to run but which also yield beneficial results that are long lasting. Zechmeister et al. (2008) make this point in their paper on the importance of investing in cost effective programmes. However, making investments 'up front' on prevention and promotion programmes is difficult in the current economic climate where, as one expert from the UK explains:

'Commissioners find it very difficult to invest in order to save NHS funds in the future as this requires upfront investment. The NHS currently has to find 4% efficiency savings each year for the next four years. This makes it very difficult to invest in anything new that might save funds more longer term' (Expert 59, UK).

Getting funding into the places where it is needed was also another issue which emerged, as one expert from Sweden described:

'Financing is always problematic and could pose a barrier to implementation, but the Government has directed funding to the programmes but the trickle-down effect, to local level, does not always work very well in all parts of the nation' (Expert 57c, Sweden).

European Union funding for prevention and promotion programmes in schools and the workplace has been crucially important in stimulating these activities across many Member States, particularly in countries such as Hungary and the Czech Republic.

Adequate training and qualified personnel

The delivery of prevention and promotion of mental health programmes requires well trained personnel. Supportive policies and systems to ensure that professionals have adequate training to deliver mental health promotion and prevention were also considered important by experts. In one country, legislation was passed which suggested the development of training teams to educate school teachers about

prevention, but this does not appear to have taken place (Expert 12, Cyprus). In Lithuania, the lack of competence at ground level was also cited as a barrier to more extensive implementation of relevant policies (including suicide prevention and the mental health strategy) among many other reasons (Expert 29, Lithuania). Similarly, in Portugal one expert reported the lack of actual personnel to deliver interventions on promotion and prevention (Expert 44, Portugal).

The issue of building capacity and training health and social care personnel to deliver promotion and prevention has been recognised by the European Commission (DG SANCO). In attempt to address this issue DG SANCO funded the PROMISE project to develop guidelines for training health and social care professionals (Greacen, et al. 2012). The training programme covers ten quality criteria ranging from 'embracing the principles of mental health promotion' to 'evaluating training, implementation and outcomes' and includes resource kits and checklists in seven EU languages (see: http://promise-mental-health.com). This is another way forward in aiding the implementation of prevention and promotion of mental health policies.

6.4 Balancing roles

A related question to adequate training to deliver mental health promotion and prevention concerns the role of mental health professionals. In practice many mental health professionals will first and foremost focus their efforts on treatment rather than prevention and promotion activities (Expert 12, Cyprus). For some taking on the role of primary prevention activities may be too much given their busy work schedules and for others the lack of training will be a hindrance. Many mental health professionals are usually qualified to deliver secondary and tertiary prevention activities. Few countries reported mental health services directly contributing to primary prevention and promotion work within their usual activities. One example, however, was Malta in which a community mental health team had taken on promoting mental health locally.

Good practice example – Malta

A community mental health team had the task of promoting mental health in their local communities. This was performed through lectures, talks and activities organised with schools (including children, staff and parents), and the local Church parishioners (Expert 36). As part of prevention activities CMHTs also provide primary care services to their local communities, which include support groups, counselling, and a GP service for non-registered patients and drop in clinics for the general public. TV and media campaigns appear to have minimised fear and ignorance and encouraged people to seek help from services. Doing this work was not easy at first, as this expert describes:

'[At] the very beginning of our [mental health promotion] initiatives, we experienced problems of non-attendance by the general public, mainly due to the stigma associated with mental illness as well as our country's size where it is difficult to be anonymous in such a small island. In schools it was also an issue that some teachers tended not to take mental illness seriously and we struggled to get the attention the subject deserves' (Expert 36).

In this example there were no policy directives, resources or funding invested in these activities. They were initiated at service management level where staff were encouraged to promote mental health services and educate the public; essentially, a 'bottom up' initiative. The service has since received new ring-fenced funding to develop Primary Care Teams in other communities across the island.

6.5 Distinction between prevention and promotion

Defining, and distinguishing between, prevention and promotion on a practical level was also an issue as the two are often conflated.

Making the distinction between prevention and promotion can help with driving the agenda for each. However, as another expert explained, prevention and promotion of mental health are connected. Substance abuse control policies, for example, have the potential to:

*'Provide both a reduction in the incidence and prevalence of mental disorders, as well as promoting positive mental health. These policies interconnect in the overall National Health Programme, that is under construction, as well as the Mental Health Strategy of 2007 that embraces the bio-psycho-social model of health and multidisciplinary approach to promotion, prevention, treatment and rehabilitation of mental disorders' (*Expert 29, Lithuania).

This interconnection of different health policies is a potentially important means to promoting mental health promotion and prevention where these initiatives can be adopted or incorporated within a broader public health remit.

Inadequate methodology and a lack of knowledge about how best to apply prevention programmes also presented difficulties (Expert 9, Bulgaria). As described in Chapter 3 of this report there is growing literature on best practice and the evidence on promotion and prevention interventions. There is also work to develop collaborative approaches to implementing research into practice. One example is the National Institute for Occupational Safety and Health (NIOSH) in the US aims to reduce illness and injury in the workplace by working closely with partners to conduct research that is relevant to stakeholders and is effective, translate findings into practice, target dissemination and evaluate activities (see: http://www.cdc.gov/niosh/r2p/). The Collaboration for Leadership

in Applied Health Research and Care (CLAHRC) is a similar initiative except that it also aims to increase capacity of health care professionals and managers to engage with and implement research findings (see: http://www.clahrc-ndl.nihr.ac.uk/clahrc-ndl-nihr/index.aspx for one of nine funded CLAHRCs). This too has the potential to increase the use of best practice/the evidence on prevention and promotion of mental health initiatives for countries that find implementing these difficult.

6.6 Evaluation of programmes

A robust programme evaluation is not a cheap option, but remains an essential component of any service delivery. Very few participating countries reported the results of any 'practice based' evaluations of prevention or promotion programmes. Most were fully funded intervention studies such as, for example, suicide prevention or anti-bullying programmes with a detailed evaluation attached. Where practice based examples did occur, very often these were process evaluations that collected mostly activity data (e.g. number of events, participants, satisfaction etc.) and not outcomes of the service (Expert 30, Lithuania). Obtaining continual feedback on the impact of programmes was seen as important to knowing whether they work. This also ties in with the issue of whether the benefits derived from prevention and promotion programmes are sustainable. Sustained effects over time depend on the effectiveness of programmes and whether they are constantly reviewed, updated and conducted on a regular basis (Expert 44, Portugal).

Randomised controlled trials are complex and costly to carry out, particularly on a large scale, and as such may be well beyond the reach of many services seeking to evaluate their prevention and promotion activities. Indeed, many of the interventions examined in recent reports, for example, by Knapp et al. (2011) and McDaid, D., & Park, A. (2011) on estimating cost savings of prevention and promotion interventions were not entirely based on studies using this 'gold standard' methodology. There is a need to ensure programmes are adequately evaluated so that they can be recommended for wider use if they prove effective (Expert 43, Poland).

6.7 Strengthening all systems

It is helpful to look not just at strengthening mental health systems to support prevention and promotion initiatives, but also beyond to ensure that initiatives can be expanded and sustained over time. In essence, this requires creation of a positive culture or mind shift in which prevention and promotion are embedded within all service activity – whether in health, social, educational or workplace settings. As one Norwegian expert explains:

'We need a broad commitment to health promotion and preventive work in the field of mental health in Norway. These efforts must be carried out both within and outside the health and care services, and requires that we look beyond conventional sector boundaries' (Expert 38, Norway).

Although this reference is to the situation in Norway, this broad commitment to prevention and promotion could equally apply to many, if not all, participating countries. An expert from Portugal makes a similar point:

*'[In Portugal] there is a national mental health plan being implemented with chapters dedicated to mental health promotion and prevention of mental illness. In my view [these] plans will depend on the budget allocated for the development and consequent success of implementation. On the other hand, we will depend on the ability to build systematic work with agencies in the community (schools, public health care, NGO's, etc)' (*Expert 50, Portugal).

In times of particularly limited resources, a shift in a cultural and political focus towards mental health promotion and prevention becomes all the more important. As one expert from Spain explained:

'Attention needs to focus on positive mental health instead of mental disorders, especially in times of economic crisis, to ensure the high quality implementation and sustainability of mental health promotion programmes' (Expert 57, Spain).

Working across different sectors (e.g. health and education departments) will present some challenges, given the contending interests and the competition for limited resources between departments. But developing an adequate infrastructure by, for example, coordinating inter-department strategies and funding could go some way to ensuring that mental health promotion and prevention remain high on the agenda, and remain both sustainable and affordable. Incorporating mental health promotion and prevention into other government policies rather than relying on a vertical approach could be beneficial to furthering their implementation. It was also noted, however, that some mental health services see prevention and promotion as a threat to their resources (Expert 58, UK).

Establishing good relationships with the sectors to be worked with is absolutely critical to implementing programmes (Expert 56a, Slovenia).

Good practice example – Romania

The development of a mental health community network through the creation of 19 Mental Health Centres at national level in Romania has become an important foundation for delivering mental health promotion and prevention. This has led to an improvement in early detection of mental health problems in schools and in the primary health care system, leading to a significant increase in the number of referrals to child and adolescent mental health services. This prevention and promotion work with children and adolescents has gone hand in hand with the instruction of personnel from the Education system (e.g. teachers) on screening and intervention in mental health. Part of this work includes persuading the Ministry of Education to increase their investment in these types of activities. However, initial investments in developing community mental health services has ceased because of funding shortages which has resulted in the lack of trained personnel to deliver services (Expert 53).

In Spain there is some evidence of the extent to which mental health promotion and prevention activities are being implemented within the health care system which was happening in community and hospital based services. Some 46% of primary care services now included mental health issues with relevant prevention and promotion topics within their portfolios (Expert 57, Spain).

Strengthening mental health systems to deliver prevention and promotion programmes also involve addressing the attitudes of mental health professionals, as one expert from Sweden explains:

'The main challenge has been to address the critical attitude towards these programmes by mental health professionals, including psychiatrists. The Zero Vision for Suicide has been seen as unrealistic and as a burden for the clinical practice' (Expert 57a, Sweden).

The transfer of responsibilities for prevention and mental health promotion to municipalities appears to be growing (Expert 37). The countries that have this type of municipality systems, often decentralised from central government control, are Germany, the UK (who are moving towards this), Norway and Denmark. Local government councillors and Directors of services and policy can be instrumental in championing mental health promotion to encourage practitioners to develop their work to promote better well-being outcomes (Expert 58, UK). A better infrastructure is required to implement programmes. In the UK, there have been a number of guidance documents concerning the implementation of prevention and promotion. However, local councils are not obliged to apply these, and whether they do may be dependent the needs of their local residents. Local councils in England have suffered substantial reductions to

their funding, but the transfer of some healthcare funds is supposed to support councils' future health and well-being work. This transfer of responsibilities is perceived as a positive move given local authorities are well placed to tackle the social determinants of mental illness and improve social, emotional and psychological well-being. As one UK expert argues, the difficulty is '*in getting enough traction on this*' and incorporating well-being into a broader approach in which well-being activities can be incorporated into the various local authority sectors and plans (Expert 60, UK).

6.8 Physical and mental health

The relationship between physical and mental health also has important implications for the way prevention and promotion activities are carried out. The combination of physical and mental health problems is a growing concern, particularly for older people (Expert 5, Belgium). There are many examples of prevention programmes reported by participating countries targeting obesity, tobacco use in young people, promoting healthy living, and reducing alcohol and drug use (e.g. Belgium, Estonia, Lithuania, Latvia). These programmes are likely to have a positive impact on preventing mental illness and promoting well-being. It is worth enhancing these related programmes to include clear mental health promotion and prevention objectives/goals.

6.9 Strengthening initiatives in schools

At ground level, some of the issues concerning the implementation of prevention and promotion activities in schools are centred on the lack of a clear methodology or implementation guide that could be attached to policies and operational plans. This would ensure that these policies are implemented more consistently between schools. One difficulty arises from the varying degrees to which prevention activities, even those concerning suicide prevention, are carried out in schools. (Expert 2, Belgium)

It is also important for schools, when implementing or including mental health promotion within their activities, to have sufficient knowledge of how to assess the quality and effectiveness of programmes they use. School staff can lack competence in making assessments of mental health promotion (Expert 30, Lithuania).

Good practice example – Norway

The need to improve the mental health of young people in Norway has been identified in several government plans and within the Education Act. As part of this legislation, schools became a centre point for being responsible for psycho-social conditions of students. The 'Mental Health in Schools' programme is being implemented through a national action plan that is financed and run by the Norwegian Directorate for Health and Social Affairs. This is being conducted in collaboration with the Norwegian Directorate for Education and Training, and five NGOs working in the field of mental health. County councils are also involved in carrying out the work. Teachers receive free training along with school nurses and youth workers. Schools, from infants to upper secondary levels, receive financial support in implementing the programme in which participation is voluntary. Seventy percent of all upper secondary schools across 19 regions have participated in the programme since 2004. Formal evaluations have been conducted on a number of these programmes revealing some very encouraging findings in terms of increased coping skills, self-efficacy, knowledge about mental health, and where to get help if needed. Programmes were repeatedly extended until 2011 (Expert 37).

One approach on implementing education programmes on mental health promotion in schools is for it to be included in the school's own curriculum so that it becomes part of their routine of activities and learning. In Portugal, for example, adolescents from the age of 13 years upwards are required to receive 12 hours of health promotion education covering areas such as growing, sleeping, eating, physical activity, sexuality, bullying, sexual abuse, violence and drug abuse. Teachers are not always prepared to do deliver this, however, and frequently ask health care professionals (nurses or paediatricians, child psychiatrist) to speak with students (Expert 44, Portugal). Where programmes are implemented, the uptake and participation of students, parents and teachers appears to be good. This expert from Portugal explained the cascading effect that can also happen with these programmes:

'Students that participated in the health promotion programmes created work groups that are trying to survive in school, with the aim of raising awareness regarding suicidal behaviour and to stimulate school debates about violence and depression.'

There are positive outcomes in terms of mental illness prevention, as this expert added:

'Based upon the scale specifically constructed for the school context, after the team prevention programme adolescents were more aware of mental illness's early signs, were less violent and less depressive' (Expert 44, Portugal).

6.10 Strengthening initiatives in care facilities for older people

Few participating countries reported prevention and mental health promotion activities for older people in long-term care facilities. These types of programmes were difficult for collaborators to identify, and this appears to be a neglected area with much less emphasis by governments on the need to focus attention on older people in nursing homes. The limited return on investment is likely to be the main underlying reason for this lack of interest. The maximum gains to be made on investing in prevention programmes are for the 'pre-natal to 3 year' age group (Expert 17b, France). Dementia is a key issue given the ageing populations in many participating countries, and this cannot be overlooked in relation to prevention and promotion activities both currently and with future projects.

One expert from Belgium described the work done in establishments for older people (Expert 1, Belgium). One Community Mental Health Centre has mental health professionals doing outreach work in a nursing home for older people. Depression in new residents of this facility is a key concern, particularly during the early phases of dementia and is very often not dealt with adequately (Expert 5, Belgium). Nursing home staff were usually ill equipped and lacked adequate training to either detect or intervene. Some of the challenges relate to the difficulties of dealing with the complex set of issues presented. For example, upon entering a nursing home some older people will have lost their social network, and will have a combination of physical and mental health issues with the latter often being masked. The physical health problem will receive all the attention and it is difficult to get the different layers of healthcare to address all issues in a coordinated way (Expert 5).

Good practice example – The Netherlands

The government of Netherlands has sponsored a relatively large initiative for older people, the Dutch National Care for the Elderly Programme. Dementia and depression are major mental health issues for this population and prevention work has concentrated on optimising the well-being and quality of life of older people during transition from home or a day care centre to a long-term care facility. There are a number of social and welfare programmes promoting self-reliance and self-management in vulnerable and frail older people (e.g. the GRIP and GLANS programmes). The short-term gains were perceived as immediate for people receiving these programmes with, for example, a better and more productive life following mental health promotion and prevention interventions (Expert 18).

As described earlier, a significant barrier is the provision of sufficient qualified personnel to implement guidelines (Expert 19, The Netherlands), and this is the key to improving both care and the delivery of prevention and promotion programmes. According to one

expert, ensuring there are sufficient qualified personnel is considered better than introducing quality standards/indicators and inspection mechanisms (Expert 19). Other issues included the division between older people's care facilities and access to primary care (Expert 19). The relative lack of resources for prevention and promotion activities for these facilities is also evident. Although the benefits of investment can be limited in terms of sustainability, it is nevertheless extremely important for improving the quality of care for older people (Expert 19).

6.11 Strengthening workplace initiatives

Financial incentives for employers have stimulated mental health promotion in the workplace, but when the incentives stop so do these activities (Expert 20, The Netherlands). Changes to social security legislation appear to have been effective in enhancing secondary and tertiary prevention, but can hinder the employment of older people and those with a chronic illness.

Legal, obligatory requirements to implement psychosocial risk assessment are present in most companies, but practical implementation does not always occur. In Hungary, European funding has had a positive impact on initiatives to implement policies in workplace prevention and promotion as resources are scarce in that country. Successes include the motivation of both employees and employers, particularly in promotion (Expert 22, Hungary).

The main difficulties in implementing prevention and promotion initiatives in the workplace appear to arise from the lack of interest by a good share of employers, although their interest in mental health issues is increasing. Another barrier may be their lack of knowledge about what action they can take. This is coupled with a lack of system support to inspire employers, and a lack of guidance and finance to help them initiate such approaches (DE PsyGA-programme, CSR Europe guidance).

Good practice example – Poland

One successful programme is the mental health promotion Programme of the Kujawsko-Pomorskie Voivodeship, a regional project implemented in three cities (Toruń, Bydgoszcz, Włocławek). The main success of this programme was in the creation of a local coalition of employers. Both employers and their Human Resource specialists participated in educational activities, an assessment of their workplaces, planning further activities, and learning methods for mental health promotion (Expert 42, Poland).

6.12 Boosting the transfer and dissemination of good practice

Gaining information on how best to transfer good practice has been the subject of attention in recent years and knowledge in this area has increased enormously. The implementation of good practice however represents a different set of activities which also involve the issues highlighted above. The expert from Estonia explained this quite succinctly:

'People (i.e. health promotion specialists from municipalities and other places) are grateful for examples of best practices, training, support, training materials etc. However, it's all "a drop in [the ocean]". When these [people] are back at home they don't have money, people, time or some other resources to put the new things they learned to practice locally. As the local support structures are lacking specialists on local level are not able to take any other perspective than mere survival.' (Expert 61, Estonia).

6.13 Concluding remarks

Despite many of the difficulties and challenges described in this chapter in terms of the implementation of mental health promotion and prevention can be overcome; with commitment, guidance and focus at policy level, investment in the required resources and the use of collaborative approaches to engaging professionals and researchers to ensure best practice and cost-effective initiatives are ultimately implemented.

It is clearly important to strengthen all relevant systems, including those relating to children, young people, adults of working age and older people. Mental health services have an important role in secondary and tertiary prevention. With adequate training health and social care professionals can also help carry out mental health promotion and primary prevention initiatives. Although, the responsibility for the delivery of prevention and promotion is literally everyone's business.

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7. Expected economic and social gains of investments into mental health promotion and prevention of mental illness programmes

The initial part of this chapter provides an overview of some of the most relevant literature on identifying the financial returns from investments into mental health promotion and interventions on the prevention of mental illness. The second part describes the types of economic and social gains expected by the participating experts following the implementation of prevention and mental health promotion programmes in their countries.

7.1 Economic gains

A convincing economic case for investing in mental health promotion and prevention of mental illness has been made by Knapp and colleagues (2011). This work modelled the cash savings and 'pay offs' to society as a whole of interventions to prevent mental illness and promote mental well-being. Their analysis was largely based on the outcomes of various evaluations of initiatives including promotion and primary and secondary prevention. The amount of available robust evidence was limited, but sufficient to allow a number of cost savings models to be formulated.

Because of the wide range of risk factors for mental illness spanning from biological to social determinants, the impact of prevention and promotion interventions is potentially far reaching – and includes gains in health and quality of life. Fifteen interventions were modelled:

- health visiting and reducing post natal depression;
- parenting interventions for the prevention of persistent conduct disorders;
- school-based social and emotional learning programmes to prevention conduct problems in childhood;
- school-based interventions to reduce bullying;
- early detection for psychosis; early intervention for psychosis;
- screening and brief intervention in primary care for alcohol misuse;
- workplace screening for depression and anxiety disorders;
- promoting well-being in the workplace;
- debt and mental health; population-level suicide awareness training and intervention;

- bridge safety measures for suicide prevention;
- collaborative care for depression in individual with Type II diabetes;
- tackling medically unexplained symptoms; and
- befriending of older adults.

For the purposes of this chapter, a summary of the cost-savings in investments are reported only for the interventions listed above that were school-based, workplace-based or that targeted older adults.

School based interventions

Social and Emotional Learning (SEL) programmes

For analysis of a school-based Social and Emotional Learning (SEL) programme, a conservative estimate was made based on the international evidence. This assumed that this programme achieves a 9% reduction in transition between conduct 'health states' (that is, conduct problems as absent, mild or severe). The cumulative economic gains per child as estimated by Knapp et al. (2011) are listed in Table 7.1 below:

Table 7.1: Cumulative pay-offs per child through social and emotional learning programmes (2009 prices)

	Year 1 (£)	Year 5 (£)	Year 10 (£)
NHS	-39	-751	-1148
Social services	-4	-13	-23
Education	-26	-135	-186
Criminal justice	-14	-1,139	-1,849
Public sector total	**-83**	**-2,038**	**-3,206**
Voluntary sector	0	-4	-8
Victim costs (crime)	-30	-3,164	-4,912
Other crime costs	-12	-1,295	-2,038
Other sector/individuals total	**-42**	**-4,463**	**-6,958**
Total pay-offs	-125	-6,501	-10,164

	Year 1 (£)	Year 5 (£)	Year 10 (£)
Cost of intervention	132	132	132
Net costs/pay-offs	**7**	**-6,369**	**-10,032**

Source: Knapp et al., (2011)

Cost-savings for the school-based SEL intervention emerge after the first year and after 5 years for the education sector. The net savings largely occur through a reduction in the crime-related impacts of conduct disorder (e.g. costs derived from criminal justice involvement, victim and other crime costs). Cost savings to the NHS begin after the first year; with a more conservative assumption about the effect of SEL (reducing its impact from 9% to 3%), the savings occur after four years.

Anti-bullying interventions

Cost-savings are also apparent for school-based interventions to reduce bullying, a common programme running across many participating countries. Results from various evaluations are mixed depending on their design and how they were implemented. There is, however, a consensus in the literature that whole-school programmes that have different components operating at different levels within the school can be effective in reducing the prevalence of bullying compared with other curriculum-based programmes. One evaluation found a 21-22% reduction in the number of children victimised (Evers et al., 2007). The benefits ranged from improvements in educational attainment and school attendance to emotional and social health gains for victims. Using the limited information available on the cost of anti-bullying programmes, an estimate of £15.50 per pupil per year was made (Hummel et al., 2009). The results of the estimates were averaged across all children, whether bullied or not, and the benefit of the intervention was £1,080 per school pupil. This represents a net cost saving of £1,064 of future earnings per school pupil. The economic gains are even more pronounced when allowance is made for other benefits such as improved psychological well-being (not included in this analysis).

Workplace interventions

Depression care

Workplace enhanced depression care involves the completion of a screening questionnaire by employees followed by care management for those found to have, or be at risk for developing, depression and/or an anxiety disorder. A 12-week course of

cognitive behavioural therapy (CBT) is offered those identified with depression or an anxiety disorder. This intervention has been shown to be effective in dealing with depression and reducing lost productivity in various workplaces (Hilton, 2007). The cost of the intervention is estimated at £30.90 (2009 prices) which covers administration of the screening questionnaire, follow up of assessments to confirm depression and the care management costs (Wang et al., 2006). The cost savings analysis was performed on the basis of whether the intervention reduces sickness, absenteeism and presenteeism compared with no intervention, if 500 employees are screened, and two thirds of employees offered CBT took the treatment. The impact of the cost savings is considered via the perspectives of the health system and business, with the enterprise supporting the cost of the intervention.

Assuming the intervention is successful, the estimated reduction in presenteeism[7] is equivalent to an extra 2.6 hours of work per week. At year 1, the assumed benefit occurs after 36 weeks following the course of CBT, and if successful would reduce absenteeism by 27.3 days per annum. A conservative model assumes that health and personal social services cost relating to depression and anxiety would occur in year 2.

Table 7.2: Total net costs/pay-offs from business and societal perspectives for a company with 500 employees (2009 prices)

	Year 1 (£)	Year 2 (£)
Intervention cost	20,676	0
Health (including social care)	0	-10,522
Absenteeism (productivity losses)	-17,508	-23,006
Presenteeism (productivity losses)	-22,868	-30,050
Total	**-19,700**	**-63,578**

The cost saving, from a business perspective, is gained through a reduction in absenteeism and an improvement in productivity in the workplace (presenteeism).

Estimates from another review of the positive effects of work-based interventions in reducing depression suggest that the net economic benefits that these programmes could gain during a 1-year period ranges between €0.81 to €13.62 for every €1 spent;

[7] Presenteeism is the term used to refer to reduced productivity when employees come to work, but are either not fully engaged or perform at lower levels as a result of ill health.

and the net economic gains in terms of reduced costs and lost output ranges from -€3 billion to €135 billion (Matrix Insight, 2012). Further analysis also shows that these programmes represent a good investment despite any reduction in effectiveness when transferred into practice (Matrix Insight, 2012).

Mental health and well-being interventions

Improved well-being in the workforce can potentially lead to less mental and physical health problems. These types of initiatives vary widely and include flexible working arrangements, ergonomics and environment, stress audits and identification of psycho-social risk factors for poor mental health by line managers. A particular model assessed by McDaid and colleagues (and included within the Knapp et al., 2011 report) included a multi-component health promotion and well-being intervention in 500 white collar workers. The costs and savings were examined from the business perspective. Employers bear the cost of the intervention in this model. Estimates of the effectiveness were based on a study by Mills et al. (2007) evaluating the impact of health promotion in a large multi-national company (lost productivity, absenteeism, presenteeism and uptake of intervention at 43%). A significant return on investment was found at year 1. The initial outlay for the intervention was £40,000 but the gains from reduced presenteeism and absenteeism rates amounted to £387,722.

Interventions for older adults

Befriending programmes for older people are often provided by volunteers and are aimed at reducing isolation and increasing social inclusion. An informal relationship is built between volunteers and participants which can also facilitate improved mental health. One review noted that befriending has a modest but significant positive effect on depressive symptoms (Mead et al., 2010). Contact is usually for an hour a week or fortnight, and the cost to public services of 12 hours of befriending contact is around £85.

The analysis used to calculate cost savings included an assumed intervention that targeted people over 50+ years who were lonely or isolated. Based on estimates of savings linked to reduced treatment of depression, a cost saving to the NHS was estimated at approximately £40 (at 2008/9 prices) in year 1 for every £85 invested in the intervention. However, this intervention becomes a better return on investment if the model includes the quality of life benefits associated with reduced depressive symptoms with a return of £270 per person.

The authors emphasise that these findings are not definitive, but that they provide a ‘platform for discussion’. The issue of ‘value for money’ is certainly important with many

health systems across Europe attempting to reduce their health budgets and make significant cost savings, and yet still expecting to achieve 'more for less'. Clearly, investing in prevention and promotion in mental health makes good sense.

7.2 Social gains from investments

Understanding the social gains that may derive from implementing prevention and mental health promotion is critically important given that many of the determinants of health and ill health are social – e.g. poverty, disadvantage, inequality, unemployment. Investment in prevention and promotion activities is justified not only in terms of the economic returns, but also, as Friedli (2009) explains:

'*Improving mental health [or well-being] is a worthwhile goal in itself: most people value a sense of emotional and social well-being; in addition, good mental health has many other far reaching benefits. Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes*.' (p. III).

Economic and social determinants are powerful influences on health and mental health, and there exists a great deal of evidence to confirm this. People in low socio-economic positions have a higher risk of developing mental illness (see for example, McManus et al., 2009; Hatch et al., 2011). Reduced well-being is also associated with high income inequality, as are low levels of trust and social connectedness. Prevention and promotion programmes therefore have a critical role in tackling economic and social inequality and disadvantage.

A review by Campion (2012) provides a comprehensive overview of the evidence on the social factors linked to mental illness. The importance of the association between physical and mental health make the case for prevention and promotion of mental health and resilience even more compelling. Promotion of mental well-being also has a role in the recovery of mental illness. As listed by Campion (2012) and based on existing evidence, positive mental health and well-being is associated with:

- improved educational attainment and outcomes;
- greater productivity and less sickness absence;
- improved cognitive ability;
- better physical health;
- reduced mortality;
- increased social interaction and participation;
- reduced risk of mental illness or suicide;

- reduced risk-taking behaviour such as smoking; and
- increased resilience to adversity.

7.3 Expected benefits from investments according to participating experts

When asked about the expected benefits of investing in prevention and mental health promotion, participating experts gave a wide range of responses. Many were clear about the economic and social gains that could be achieved, and the majority felt these were sustainable. The table below lists the responses received by country and by type of programme. For schools, the emphasis on the expected economic gains were focused around prevention of mental illness, early identification of symptoms, improved mental health and well-being and less future costs for specialized mental health care. The expected social gains emphasised the development of more resilience, better educational attainment, less violence, delinquency and prejudices connected to mental illness.

For work-based programmes, the gains in economic terms revolved around reducing the costs associated with mental health problems in employees. These included well-known factors such as increasing productivity, reducing sickness absence and work-related stress and decreasing the costs of health and social care, and costs to the employer. The social benefits included the creation of a healthier/happier workforce, increased psychological well-being, improved job satisfaction and competence, increased awareness about mental health issues and improved organisational climate.

Only two experts commented on the gains for older people in long-term care facilities. The economic benefits were centred around reducing the costs directly associated with mental and physical problems, but there was also emphasis on reducing staff turnover with improved well-being in residents of nursing homes. The social benefits were concerned with improved coping skills/resilience, greater awareness among staff and residents, and improved quality of life.

The economic and social gains are quite considerable. The expectations of preventions and mental health promotion programmes are very high and a balance needs to be struck between being realistic about what programmes can achieve when mainstreamed or rolled out on a large scale. Many of the important effects found in relatively small studies could be diluted when disseminated or delivered on a wider scale. It is also important to be realistic about recommending return-to-work initiatives for those with a long-term illness, particularly when the rates of unemployment are high.

Convincing policy makers and governments to devote scarce resources to prevention and promotion programmes, possibly by redirecting budgets allocated to treatment

services, will present a major challenge. However, it is evident from the information we have gathered both from our country collaborators and experts that awareness of the need for prevention and promotion and the commitment generally towards implementing these programmes is relatively well established. The main challenge now is ensuring the momentum continues.

Table 7.3: Expected economic and social gains of investments in prevention and promotion programmes according to participating experts

	Programmes	Expected economic benefits	Expected social benefits
Belgium	Long-term facilities for older people	Less mental distress Less physical problems Less admissions to hospital Less cost for social security system Less staff turnover with improved general well-being in residents Prevent depression and delay process of dementia	Stigma campaigns should lead to better understanding of mental illness in nursing home residents with more communication among the residents Increased mastery and resilience
	Schools	Reduce the number of suicide and suicide attempts	Break the taboo surrounding mental illness Improved educational attainment
	Workplace	Increased productivity and well-being	A happier workforce
Bulgaria	General programmes	Increased efficiency of the labour force Increase in the number of disabled people in work	Greater compassion and support for people with mental illness generally
	Schools	Less money required for specialised services	Increased autonomy and resilience of individuals and stronger communities Improving the quality of life and sense of happiness
	General	Decreased institutional dependence Prevention of institutionalisation.	Decreased social exclusion due to the stigma and discrimination connected with the mental illness.

	Programmes	Expected economic benefits	Expected social benefits
Cyprus	Workplace	More disabled individuals In the workforce Less job losses Higher productivity, less sickness absence. Decreased social care costs	Increased psychological well-being
	General	Prevention of mental illness and associated costs of this Less admissions to hospital and need for long-term care	Better understanding of mental illness and support within families and units Better relationships with families Improved quality of life for people with mental illness
Czech Republic	Workplace and general	Reduced costs of job changing due to stress and conflicts Reduced costs of hospitalization and Pharmacotherapy Less anxiety and depression	Improved job satisfaction, i.e. Improved creativity and burnout protection Destigmatisation of patients and families Improved social and employment inclusion Improved quality of life; faster recovery
France	All	Reduction in health spending for older people with promotion programmes for this group For employees - reduced absenteeism, sick leave and accidents Less mental illness in young people	It is mainly the domain of mental health which is concerned, with expected gains in terms of a reduction in absenteeism, sick leave, and accidents at work. Better social integration for older people Increased well-being in young people
Hungary	General promotion		Increased social capital
	Workplace	Reduced level of absenteeism, labour injuries and work related illness Increased productivity both at personal and at company level	Increased awareness of mental health Better mental health of employees, Higher workplace satisfaction
	Schools	Improved mental and physical health in young people Reduced burden of mental illness	
Italy	Schools	Reduced health care costs for long term psychiatric care	Improved communication skills, cooperation, achievements, solving problems, impulse control and empathy.

	Programmes	Expected economic benefits	Expected social benefits
Latvia	General	Decreased mental healthcare costs Decrease lack of capacity in the workforce	Decrease of burden on families Maintenance of social skills in older people
	Workplace	Decrease costs associated with mental illness in working aged adults	
Lithuania	General, schools		Increased social networks to facilitate more active citizens Better educational attainment in young people and so better employment prospects Better quality of life Less violence and drug use
Malta	General	Less sickness absence	Less mental illness Healthier, happier population Less drug and alcohol use More social inclusion More tolerance for people with mental illness Reduced negative consequences of mental illness (e.g. unemployment, housing issues)
Norway	Schools	Earlier identification of mental health problems and so less treatment costs	Reduction in violence, misconceptions and prejudices about mental illness Increased community support
Poland	Schools, general	Better education and associated benefits Fewer students with emotional problems or mental disorders and fewer difficult situations for teachers and other adults,	Better functioning in families and in social environment Better quality of life
Portugal	Schools	Reduction in mental illness rates Less healthcare costs Less financial burden for families of people with mental illness	Increased mental health Increased resilience and coping strategies by adolescents Reduction in violence and delinquency in adolescents Reduce impact on families and society Less social isolation, greater teamwork

	Programmes	Expected economic benefits	Expected social benefits
	Workplace	Increased productivity Lower financial burden for employers	Increased in the organisation climate and in the well-being, Increased coping with stress Healthy and competent workforce
	Long-term care facilities for older people	Less burden of disease and delaying institutionalization	Better quality of life, active aging Less family care needed
Romania	General	Decreased rate of hospitalisation Reduced days for sick leave Decreased costs in treatment Reduction in mental illness prevalence Reduction in numbers retiring due to mental illness	Better social functioning Reintegration of people with mental illness into society
Slovakia	General	Reduction in the number of unemployed people due to mental illness	Integration of people with disabilities
Spain	Workplace	Reduction of sick leave due to mental health problems Reduction in indirect costs related to absence from work Reduction in costs related to treatment of depression and mental health care costs, social welfare benefits	Greater life satisfaction Positive mental health Reduction in work-related stress
UK	General promotion	Lower usage of health and other public services Improved productivity Boost to the economy by keeping people in work	Better educational attainment Reduced crime More cohesive and supportive society Safer neighbourhoods Improved educational attainment Better mental and physical health outcomes

It is interesting to note that many of the expected benefits listed by country experts were relatively general. This may reflect the lack of systematic evaluation of many of the prevention and promotion programmes that were implemented. The full impact of these programmes therefore may not always be known. Evaluating prevention and promotion programmes, particularly those developed by professionals (e.g. practice based initiatives), can be difficult given the lack of investment devoted to such a purpose. There

is thus a need to ensure that programmes are adequately evaluated and that resources are dedicated to this end.

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8. Indicators and monitoring systems

This chapter provides an overview of the main comparable mental health indicators for Europe that are currently in place. We report on some of the key indicators and minimum datasets currently used by participating countries. We also report on current efforts to develop indicators and collect data on levels of well-being in a population, and on proposed future indicators.

Monitoring a population's health, the health services delivered and the treatment provided are important to the understanding of a country's state of progress. Measuring indicators of mental health is difficult, however, due mainly to problems associated with definition, with measurement standards, and with real or perceived difficulties within Member States in collecting cross-national comparable data (Lavikainen et al., 2006). A number of EU funded projects have made proposals for indicators to measure mental health (for example, Korkeila et al., 2003; Lavikainen et al., 2006) and more recently to measure user empowerment in mental health (WHO, 2010).

8.1 Main sources of mental health data for Europe

The WHO European Health for All Database (HFA-DB) provides a selection of health statistics. These include demographics, health status, health determinants and risk factors, healthcare resources, utilization of health services and expenditure in 53 Member States of the WHO European Region. The WHO Mental Health Atlas (2011) is a compendium of the latest estimates on the available resources for the treatment and prevention of neuropsychiatric disorders. This recent edition includes more quantitative information on a number of mental health indicators compared to that published in 2005. This was to enable easier tracking of the progress made by countries which participate, and to allow greater compatibility with the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) – a tool which assesses in detail a country's mental health system.

The OECD provides overall health indicators which contain some information on mental health. These are mostly focused on the number of psychiatric care beds, the number of unplanned hospital re-admissions, the type of provider consulted for mental illness, the number of psychiatrists, and the yearly consumption of antidepressant medication. The *Health at a Glance* document provides the most recent data available on the above indicators for all 34 OECD member countries (OECD, 2011). In addition, the EU-funded

report Health at a Glance Europe 2012 provides data on suicide for the 27 Member States and other European countries (OECD, 2012).

In 2002, the OECD initiated the Health Care Quality Indicators project to measure and compare the quality of health service provision across the different countries and to assess the impact of particular factors affecting the quality of health services. A set of quality indicators has been developed by an Expert Group which also aims to complement and coordinate the work of national and other international agencies. There are five areas of work: health promotion, prevention and primary care; mental health care; cancer care; patient safety and patient experiences.

Eurostat provides statistics that allow comparisons between the 27 EU Member States, but is limited in terms of specific mental health indicators. It collects, for example, recoding only the number of psychiatric care beds in hospitals (per 100,000 population), hospital discharges for mental disorders, suicide rates or self-reported depression. Eurostat does, however, include a number of related indicators to measure the progress of EU policies such as European 2020 agenda, with indicators on employment and social policy (equality and migration). In addition, Eurostat will collect some data on well-being thanks to the EU-SILC 2013 module (see: http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/legislation).

The European Community Health Indicators (ECHI) were defined and developed by several EU supported projects. The purpose of the ECHI shortlist of 88 health indicators is to serve as a basis for harmonization of data collection, which will lead to comparable indicators for all MS. The indicators cover general demographic and socio-economic situation, health status, health determinants, health interventions - health services and health promotion. In relation to mental health the following indicators have been developed (see: http://ec.europa.eu/health/indicators/echi/list/index_en.htm):

- 13. Disease-specific mortality, including suicide
- 23(a). Depression: self-reported prevalence
- 62. Hospital beds, including psychiatric hospital beds
- 67. Hospital in-patient discharges, limited diagnosis including for mental or mood disorders
- 74. Medicine use, selected groups including for depressive disorders.

Around 26 indicators from the European Health Interview Survey (EHIS) 2008 collection round have covered topics on health status, health determinants and health care for 19 countries and all Member States for 2013 round under an implementing regulation (see: http://epp.eurostat.ec.europa.eu/cache/ITY_SDDS/EN/hlth_ehis_esms.htm and http://eur-

lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:047:0020:0048:EN:PDF). The Eurobase provides indicators in relation to mental health such as psychological distress and well-being, and consultation with a psychologist (see: http://epp.eurostat.ec.europa.eu/portal/page/portal/health/public_health/data_public_health/database). Some first and partial results on care of dependent elderly were computed and are available on request. These concern care by family and/or home care services for people aged 65 and over who experience limitations in their daily activities.

The Survey of Health, Ageing and Retirement in Europe (SHARE) collects data on older people aged 50 years and above. The first wave of data collection commenced in 2004 and fieldwork for Wave 5 started in spring 2013. These surveys are based on 85,000 individuals (around 150,000 interviews) from 19 European countries and Israel; and include data on health, socio-economic status and social and family networks (see: http://www.share-project.org/home0.html).

Table 8.1 below provides some of the key mental health indicators listed by the WHO, OECD and Eurostat databases on European countries.

Table 8.1: Key mental health indicators for WHO, OECD and Eurostat

	WHO European Indicators	**OECD Indicators**	**European Commission/ Eurostat**
Primary mental health care			
Primary mental health care - diagnosis, referral to specialist services and treatment for common and severe mental illness	Yes	No	No
Inpatient and community-based mental health services			
Mental hospitals			
Community psychiatric inpatient units in general hospitals	Yes		No
Number of public psychiatric care beds in hospitals or other facilities	Yes	No	Yes
Number of inpatient admissions	Yes	No	Yes
Length of inpatient admission	Yes	N/K	Yes
Unplanned hospital re-admissions for mental illness for schizophrenia and bipolar disorder	No	Yes	No
Mental health facilities – outpatient clinics, day treatment facilities, psychiatric ward in a general hospital, community residential facility, mental hospital	Yes	No	No

Type of provider consulted for mental illness (selected EU countries)	No	Yes	No
Workforce, training and informal resources			
Workforce – medical doctor, nurse, psychologists, social worker, occupational therapist	Yes	No	Yes
Number of psychiatrists from 2000 onwards (per 100 000 population)	Yes	Yes	No
Human resources training	Yes	No	No
Informal human resources: family and user associations	Yes	No	No
Prevalence of mental illness (proxy measures)			
Antidepressants consumption from 2000 onwards	No	Yes	No
Suicide per annum	Yes	Yes	Yes
Budget on mental health			
Spending on mental health	Yes	N/K	No
Expenditure for medications to treat mental illness	Yes	No	No
Other			
People at risk of poverty and social exclusion	N/K	No	Yes

Source: WHO Atlas 2011; OECD Health at a Glance Health Data 2012; Eurostat database, http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home)

Other statistics include the EU-Statistics on Income and Living Conditions (EU-SILC), with comparable data available for indicators on income, poverty, social exclusion, housing, labour, education and health on a yearly basis (see: http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/data/database.

The European Social Survey (ESS) is carried out biennially and covers a range of social variables including media use; social and public trust; political interest and participation; socio-political orientations; governance and efficacy; moral; political and social values; social exclusion, national, ethnic and religious allegiances; well-being; health and security; human values; demographics and socio-economics. The European Quality of Life Survey (EQLS), conducted every four years, asks a sample of European citizens about their circumstances and their lives in general covering the areas of employment, income, education, housing, family, health and work-life balance. The third EQLS 2011-2012 includes 34 countries in Europe. In 2010, a Eurobarometer (EB) on mental health was carried out and comprises 1000 face-to-face interviews per country (see: http://ec.europa.eu/health/mental_health/eurobarometers/index_en.htm). Additionally, Special EB surveys and EB Qualitative Studies provide in-depth information on particular

areas and are integrated with the Standard Eurobarometer's polling waves (see: http://ec.europa.eu/health/eurobarometers/index_en.htm).

The EU Labour Force Survey (EU LFS) provides results on a quarterly basis of labour participation for those aged 15 years and above, and people outside the labour force. This database contains a large amount of information with a domain on 'employment and unemployment', and tables on population, employment, work time, job permanency, professional status and so forth. This information is listed according to age, gender, educational level, economic activity and occupation (see: http://epp.eurostat.ec.europa.eu/portal/page/portal/microdata/lfs).

A related survey includes the European Working Conditions Surveys (EWCS) in operation since 1990. The EWCS aims to cover a series of themes such as duration of work time, work organisation, training, physical and psychosocial risk factors, health and safety, work-life balance, employee participation, earnings and financial security and work and health (see: http://www.eurofound.europa.eu/ewco/surveys/).

Each of these statistical databases has been updated to reflect the requirements of policy makers in tracking the progress of social and health policies emerging over the past few years.

8.2 Monitoring indicators in participating countries

This section provides an overview of some of the key indicators and minimum datasets reported by our country collaborators. Table 8.2 below lists these.

Table 8.2: Key mental health indicators and data sets available in participating countries

Objective indicators	**Number of countries**	**Countries**
Budget (health spending/expenditure)	13	Austria, Estonia, Finland, France, Italy, Latvia, Lithuania, Malta, Norway, Poland, Slovakia, Spain (partial data), Sweden, UK
Diagnosis (via psychiatric facilities)	16	Austria, Croatia, Czech Republic, Estonia, Finland, Germany, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Poland, Slovakia, Spain, Sweden
Health determinants	2	Austria, Norway
Healthcare facilities (type and/or number of services)	17	Austria, Belgium, Bulgaria, Czech Republic, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Luxembourg, Malta, Slovakia, Spain, Sweden, UK
Hospital bed numbers	14	Austria, Bulgaria, Czech Republic, Estonia, France, Germany, Italy, Latvia, Malta, Poland, Romania, Spain, Sweden, UK
Hospital discharges	2	Austria (by main diagnosis), Czech Republic

Objective indicators	Number of countries	Countries
Incidence (number of first visits to services, not epidemiological data)	6	Czech Republic, Estonia, Italy, Lithuania, Poland, Slovakia
Medication prescribing/consumption	1	Austria
Minimum psychiatric data	3	Belgium, Netherlands, Sweden, UK
Patient journeys (via GP data)	1	France
Prevention	2	Denmark, Netherlands
Promotion	2	Denmark, Netherlands
Service use/activity	14	Austria, Czech Republic, Denmark, Estonia, France, Ireland, Italy, Luxembourg, Malta, Poland, Romania, Slovenia, Sweden, UK
Suicide	26	Austria, Belgium, Bulgaria, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Netherlands, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, UK
Treatment episodes	1	Sweden
Workforce	15	Austria, Czech Republic, Croatia, Estonia, Greece, Finland, Italy, Lithuania, Malta, Poland, Portugal, Romania, Slovakia, Spain, Sweden, UK
Population level epidemiological data		
Depression/anxiety prevalence (epidemiological data)	3	Austria, Croatia, Belgium
Prevalence (epidemiological data)	11	Bulgaria, Croatia, Denmark, Hungary, Italy, Malta, Portugal, Romania, Slovakia, Spain, UK
Protective and risk factors	4	Netherlands, Spain, Ireland, UK
Subjective indicators (data derived from surveys)		
Attitude and awareness	2	Ireland, UK
Health behaviour	1	Latvia
Health and wellbeing	3	Hungary, Spain (Health only), UK
Health status (perceived health/health impairments)	2	Austria, Netherlands
Patient reported outcomes of treatment (follow up)	1	Sweden
Psychological distress	3	Belgium, Hungary, Norway

Source: Country collaborators' data templates

This list of indicators is not comprehensive and comprises the key mental health ones available. Three commonly reported mental health indicators were: suicide (26 countries), the type and number of healthcare facilities (17 countries); diagnosis of people using psychiatric facilities, usually inpatient services (16 countries); and number of mental health professionals (15 countries). Service use/activity data was the next most frequent

indicator (14 countries). This included the number of admissions to hospital, visits to mental health services and/or consultations with professionals. Fourteen countries reported data from epidemiological surveys on the prevalence of mental disorders in the general population. It is notable that 12 of the 29 participating countries do not appear to be collecting basic mental health data on the types and number of services. Similarly, only 14 countries seem to be collecting data on psychiatric bed numbers and reporting them on standard health information systems. It is also interesting to note that six participating countries (Czech Republic, Estonia, Italy, Lithuania, Poland and Slovakia) have very good data on the number of first visits to mental health services by ICD-10 diagnosis. Almost all participating countries recorded suicide rates.

Establishing the prevalence of mental illness in the general population is enormously difficult. It was not unexpected that 18 participating countries did not have national data on the prevalence of mental illness. National surveys of this magnitude are both labour intensive and costly. Many of these epidemiological studies are becoming relatively dated and it appears unlikely that they will be repeated in the near future. Basing policy decisions on out of date prevalence data may pose problems. However, as Wittchen & Jacobi (2005) and Wittchen et al. (2011) have shown, the overall prevalence of mental disorder appears not to be rising compared to figures reported in 2005.

Only two participating countries (Denmark and the Netherlands) appeared to be collecting information on prevention or promotion activities. There were far fewer countries collecting data on subjective indicators, such as well-being, attitudes, and awareness of mental health issues.

The above list shows a heavy focus on objective indicators in the existing datasets. Clearly, there is a need to know the extent to which mental health services are being used and how they are performing. However, it is interesting to note that only Sweden appears to have an indicator for patient reported treatment outcomes. The UK has recently moved towards a similar indicator for 'patients' experiences of healthcare' as part of its focus on improving patient outcomes and the quality of care (NHS, 2010).

8.3 Indicators of mental health and measures of well-being

Korkeila et al (2003) focused attention on the domains of mental health indicators based on the scientific literature. In a review of the literature seeks associations from research between mental health and ill health various characteristics (e.g. individual, social, economic etc), the authors cover specific domains as a starting point for establishing a set of mental health indicators. These domains include: socio-demographic, social

networks, stressful life events, positive mental health, subjective experience of the individual, services (supply, use and demand), morbidity (general), morbidity (disease specific), disability and mortality. The importance of establishing mental health indicators is to ensure mental health issues remain visible and can be used to estimate how health policy targets are met and whether there is a decline in disease and disability (Korkeila et al 2003).

As described in the introduction of this report, the well-being agenda has played a significant role in influencing mental health policy in Europe since 2005. This has led to several initiatives to identify a set of appropriate indicators to assess the levels of well-being in the population. The most recent includes an additional module on well-being to be included within European statistics concerning income and living conditions introduced by Eurostat Legislation on EU-SILC 2013 (see: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2012:022:0009:0015:EN:PDF). Within the context of the well-being and sustainability agenda ESTAT in collaboration with other EU services are developing a multi-dimensional measure of quality of life, which among other things will include well-being.

As part of its 'Better Life Initiative', the OECD is developing a framework to identify the main drivers of well-being and to assess the overall impact of alternative policy options on people's lives. The framework will evaluate the benefits and costs of policies and will also map the best approaches that translate well-being measures into policy-making decisions. The ultimate aim of this work is to make well-being a central part government decision-making, and to advise on the effects on well-being of policy options.

National Accounts of Well-being also collects cross-national data for 22 European countries on overall well-being, personal well-being, social well-being and well-being at work. This data is reported online (NEF, 2012). The European Social Survey (2010) (ESS5-2010 edition) was released in March 2012 and includes a module on Work, Family and Well-being.

A good example of a core set of national mental health indicators has been developed in Scotland (UK). This includes details of a validated measure, the Warwick-Edinburgh Mental Well-Being Scale (WEBWBS; Tennent et al., 2007) that has become an important part of capturing positive mental health. A well-being indicator in England and Wales (UK) was finalised recently by the Office for National Statistics. The first findings of the national well-being data, collected during April 2011 - March 2012, were published in July 2012 (ONS, 2012). The initial results show that nearly 1 in 5 (18%) of those who reported good or very good health reported low satisfaction with life overall. Nearly 2 in 5 (38%) of those who reported bad or very bad health reported high or medium levels of

satisfaction with life overall. So, almost 40% of people who report having bad or very bad health do not report feeling dissatisfied with their lives.

Huppert and So (2011) have developed a new conceptual framework for defining well-being. They identify a series of ten positive features to define flourishing (the experience of life going well, feeling good and functioning well). These included competence, emotional stability, engagement, meaning, optimism, positive emotion, positive relationships, resilience, self-esteem and vitality. Using indicator items from the European Social Survey (2006/2007) to correspond as closely as possible with these items, Huppert and So were able to propose an operational definition of flourishing. Their analyses revealed a prevalence of 40.6% for Denmark (the highest) and of 9.3% for Portugal (the lowest). Other countries with high levels of flourishing included Switzerland (30.2%) and Austria (27.6%). Those with lower levels of flourishing were Russian Federation (9.0%) and Slovakia (10.0%). The differences between countries are stark and, according to Huppert and So, indicate which features may be worth targeting for policy makers seeking to improve well-being.

8.4 Future indicators

A number of new health indicators have been proposed under several projects. An initial ECHI project was conducted under the Health Monitoring Programme and Community Public Health Programme 2003-2008. During a second Health programme (2008 – 2013), the ECHIM (European Community Health Indicators Monitoring) joint action aims to consolidate and expand the ECHI Indicator system towards a sustainable health monitoring system in Europe (Kilpeläinen et al., 2008). A list of 88 public health indicators on health and health determinants was shortlisted. Among those of relevance to mental health are: the prevalence of self-reported depression, register-based depression and suicide attempts, subjective measures of psychological distress and psychological well-being.

The OECD, together with an international expert panel on indicators for mental health, was working on establishing a set of quality indicators. Current health care quality indicators (HCQIs) include rates of unplanned re-admissions to hospital within 30 days for people with schizophrenia and bipolar disorder. Others focus on the treatment of depression, continuity of care and follow up after hospital discharge, and mortality in people with mental illness. Interestingly, there is an attempt to measure disparities in mental health between ethnic groups, although with no inclusion of positive mental health indicators. The expert group acknowledges the gaps in this proposed list of

indicators, particularly the poor data collection in particular areas such as psychotherapeutic treatments.

As with any proposed indicators, there will be issues concerning the availability of data for cross-national comparisons. Potentially, data for these 12 indicators could be drawn from hospital administrative databases, national surveys and national registries, although this particular OECD project has now closed.

8.5 Other indicators

The need for a different approach to setting indicators has been proposed by the WHO, with the introduction of indicators based on data collected from patients and their families now seen as a priority. The WHO Euro statement (2010 http://www.euro.who.int/__data/assets/pdf_file/0020/113834/E93430.pdf) on user empowerment in mental health proposes 17 indicators for user empowerment and integration. The project highlights the importance of users' and carers' perspectives. It will identify good practice and make recommendations at each of the four levels to ensure the human rights of users and carers are protected by, for example, ensuring that they can access and receive high quality care and that they are included in all decision-making.

8.6 Summary

The focus of existing of many of the key mental health indicators has been on the provision of mental health care; many of which were found to be lacking the participating countries examined. Where they do exist, they often prioritise a country's own information needs, making comparability between countries difficult. Over the past few years there has been a growth in attempts to develop and measure well-being both at national and cross-national levels in Europe. This focus on subjective rather than objective indicators of mental health reflects the important shift in attitude and thinking among governments and policy makers. There is a desire to understand how policies impact on people's well-being and what features in particular lead to improved well-being. The challenge is to refine measures and interpret the results of well-being surveys so that they can add value to what is already known about good mental health and improve policy making.

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Table 8.3: Table of government health and general statistics websites

Austria	http://www.statistik.at/web_en/
Belgium	http://statbel.fgov.be/
Bulgaria	http://www.nsi.bg/index_en.htm
Croatia	http://www.dzs.hr/default_e.htm
Cyprus	http://www.mof.gov.cy/mof/cystat/statistics.nsf/index_en/index_en
Czech	http://www.czso.cz/eng/redakce.nsf/i/home
Denmark	http://www.dst.dk/en
Estonia	http://www.stat.ee/
Finland	http://www.stat.fi/index_en.html
France	http://www.insee.fr/en/default.asp
Germany	http://www.destatis.de/jetspeed/portal/cms/
Greece	http://www.statistics.gr/portal/page/portal/ESYE
Hungary	http://portal.ksh.hu/portal/page?_pageid=38,119919&_dad=portal&_schema=PORTAL
Ireland	http://www.cso.ie/; http://www.hse.ie/eng/
Italy	http://en.istat.it/
Latvia	http://www.csb.gov.lv/
Lithuania	http://www.stat.gov.lt/en/pages/view/?id=1358
Luxembourg	http://www.statec.public.lu/en/
Malta	http://www.nso.gov.mt/site/page.aspx
Netherlands	http://www.cbs.nl/en-GB/menu/home/default.htm
Norway	http://www.ssb.no/helsetilstand_en/
Poland	http://www.stat.gov.pl/english/
Portugal	http://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_princindic
Romania	http://www.insse.ro/cms/rw/pages/index.en.do
Slovakia	http://portal.statistics.sk/showdoc.do?docid=359
Slovenia	http://www.stat.si/eng/drz_stat.asp
Spain	http://www.ine.es/en/welcome_en.htm
Sweden	http://www.scb.se/Pages/List____139369.aspx
UK	www.ons.gov.uk/

9. Future of prevention and promotion of mental health

This chapter outlines the anticipated future of prevention and promotion activities as described by the experts consulted from within participating countries and addresses whether these activities are being sustained. The chapter also includes a discussion of the importance of continuing the progress made in implementing prevention and promotion of mental health over the past few years and how best to take this forward in light of the recent economic crises in Europe.

9.1 Future plans of participating countries

Country collaborators and prevention and promotion experts were asked to specify any new or forthcoming initiatives, plans and future developments for prevention and mental health promotion. Table 9.1 summarises the responses received by country. The responses centre around policy and service level plans and/or efforts to continue prevention and promotion initiatives in mental health. For the most part, forthcoming plans appear to be highlighting the continuation of prevention and promotion implementation or enhancing this where necessary. Judging from these, the future remains reasonably optimistic, although the current economic crises will make the journey harder and much less certain. There remains much to be done, however, to ensure efforts on prevention and promotion of mental health are sustained in those countries that have invested a great deal over the past few years, and are strengthened in those countries that still have some way to go.

A number of countries are 'between' national mental health plans where previous ones have just completed their five or six year terms. This provides an important opportunity for governments to incorporate much of the learning and understanding accumulated over the past 10 to 15 years and to continue to 'invest to save' or start the process. Only a few participating countries reported no future plans (or none were known) with regards to prevention and mental health promotion priorities (e.g. Bulgaria, Czech Republic, Estonia and Slovakia). These countries are still experiencing difficulties in making the transition from institutional to community-based mental health care.

Further implementation of prevention and promotion is important, as is the transition to community mental health services. All participating countries have initiated the process of introducing prevention of mental health promotion and prevention of mental illness; some are more advanced than others, depending on their policy commitment and

investments, infrastructures and resources. But all have made some attempt to carry out prevention of mental illness and promotion of mental health initiatives which is encouraging. Several countries appear to have clear general health promotion and health prevention strategies, policies and specific financial resources allocated to them. These are policies that will have direct and indirect positive effects on mental health. For example, Hungary with their schools and workplace initiatives to improve healthy eating and increase physical activity, Lithuania and Poland in aiming to consolidate their preventive efforts to reduce drug and alcohol use, and Sweden's future plan to continue implementing and evaluating effective interventions; all of which will lead to positive mental health and prevent mental illness. But these strategies will need to include specific priorities designed to improve mental health and prevent mental illness.

Table 9.1 Next steps and future of prevention and promotion plans in participating countries according to our collaborators and experts

Country	Area(s) of focus	Brief description
Austria	Health promotion	• General health promotion is to continue, with mental health being included within this broader framework.
Belgium	Suicide; older people; workplace	• A health conference in December 2011 on suicide prevention to outline the new policy lines. • A future mental health operational service plan is to listen to the specific needs of the elderly instead of providing a 'fixed menu'. We will try to find the most appropriate approach to tackle mental health problems which will include the needs of residents in nursing homes and explore those of the family and staff too. • The future of prevention of mental illness in the workplace is viewed as dependent on the economy. If the economy weakens, less money will be spent on psychosocial wellbeing, as it is still perceived as a 'luxury' and not considered as a 'basic need'.(5) • Future policy directives mention that prevention activities should be the focus of attention in a more goal-directed way.
Bulgaria		• No plans.

Country	Area(s) of focus	Brief description
Croatia		• National Mental Health Strategy 2011-2016 - prioritises promotion and prevention. • However, action plans, funding and future outcome indicators have not yet been set. This is the same for the Strategic plan for development of public health for period 2011-2015.
Cyprus		• Mental Health Services are now in the process of developing a National Strategic Plan on raising awareness and prevention of Depression and Suicide. • National Strategic Plan on Alzheimer's disease is under way, in cooperation with the Multidisciplinary Committee on Alzheimer's. However, with the economic recession and the necessary cuts in the public sector, funding for programmes is becoming extremely difficult.
Czech Republic		• Not known.
Estonia		• No specific plans for mental health policy in Estonia but one long-term one is likely to emerge.
Finland	Drug use	• Important to free up resources from institutional treatment to allocate this to secure primary-level mental health and substance work in the future.
France	Youth suicide; anti-bullying in schools	• The government is currently working on preparing the next plan of Mental Health and Psychiatry to take over from the previous 2005-2008 plan. • The Minister of Education has commissioned a report on the prevention of youth suicide. The report, which should be released by January 2012, will provide public policy recommendations. • Also expected is a plan on 'bullying at school' in the wake of the focus on the harassment that took place in May 2011.

Country	Area(s) of focus	Brief description
Hungary	Workplace; schools	• The National Institute for Health Promotion (OEFI) will implement ENWHP's next initiative in Hungary 'Promoting Healthy Work for People with Chronic Illness' as of 2012. This will develop guidelines for the workplace on how people with chronic mental illness can stay at work/return to work and be disseminated to companies • Work on health promoting network for all participating schools so will be built upon to implement all the four fields of school health promotion (healthy eating; every day physical activity; mental health promotion; knowledge in health).
Italy	Schools	• Important to implement and keep going current initiatives particularly in this economic recession.
Latvia	General	• To continue to implement current initiatives with mental health as a second priority after skeleto-muscular health in the next Framework Policy Document 'Fields of Labour Safety 20014-2020'.
Lithuania	Drug and alcohol	• There are efforts to consolidate preventive efforts in the area of Tobacco, Alcohol and Drugs Control. This might be the most effective way to promote health and prevent illness in Lithuania. • There are financial incentive mechanisms for services facilitating health but there is still a lack of defined indicators for these incentive services in mental health. This will be important for future mental health promotion and secondary prevention, since it focuses on prevention of unnecessary hospitalizations and early hospitalisations as well as prevention of use of institutional services.

Country	Area(s) of focus	Brief description
Malta	Mental health promotion and prevention	• At community mental health service level there will be an increase in services both to young and old in educational and awareness programmes; and more psycho-educational programmes to prevent relapses.
Netherlands	Older people; youth	• Future plans are not certain yet for older people, depend on the results of the different programmes of the Dutch National Care for the Elderly Programme which will become clear in 2012/2013. • Youth Vision, a major policy document includes six goals for Mental health policy for young people and seen as an investment in 'mental capital'.
Norway	General	• The Norwegian Institute of Public Health – fifty recommendations.
Poland	Drug and alcohol	• Mental health and its promotion has become one of the priorities of the Governmental Population Council. MH promotion and prevention are seen as an important part of the policy which will be recommended by the Council. • The State Agency for the Prevention of Alcohol-Related Problems is planning to develop special corrective programmes for various services and to evaluate them. • Next step would be legislative changes and implementation of alcohol prevention programmes. • WHO consultant, in cooperation with Polish Ministry of Health, is working on a report concerning assessment of the promotion and prevention in the workplace and guidelines for the Ministry of Health on how to improve them. However, it is not certain that this report will be transformed into policies or plans.

Country	Area(s) of focus	Brief description
Portugal	General	• A new national mental health plan in place with decentralisation and a focus on local structures, with sections on promotion and prevention. • Some projects are however on 'standby' due to government changes and will depend not only on budgets allocated to them but also on the ability to build systematic work with agencies in the community (schools, public health centres, NGO's, etc).
Romania	Suicide prevention	• Some plans for suicide prevention programmes and programmes for prevention of mental illnesses among teenagers.
Slovakia		• Not known.
Slovenia	Children and young people	• National Mental Health Program is forthcoming and a more elaborated action plan in the field of children and adolescents that emphasises prevention and the promotion of mental health for this target group.
Spain	Pilot evaluations	• Department of Health is to evaluate all current and future initiatives in mental health promotion and disorder prevention with several pilot studies planned or underway (e.g. 'Prevention of depression in primary care', results expected in 2012). Others pilot studies planned include social prescribing for MH (to increase social networks) and an effective family programme for the prevention of mental illness in children.
Sweden	Evaluations	• Future plan is to continue implementing and evaluating programmes in a rigorous scientific setting, by implementing randomised controlled trials of different preventive interventions aimed at comparing their effectiveness and cost-effectiveness. Combined effects of the interventions should also be measured.

Country	Area(s) of focus	Brief description
UK	General	• Awaiting several evidence reviews from the Dept of Health; and the outcome of the Public Health White Paper consultation to see if there are initiatives that back up the mental health promotion work. There is a large section on workplace approaches which appears promising. • The public health outcomes framework is currently being developed and will include key indicators for preventing mental illness and mental health promotion. These indicators should drive action to improving outcomes in these areas. • Measuring national wellbeing through the ONS should also help to promote PMI and MHP initiatives. • Improving access to psychological therapies (IAPT) programme continues to develop new services such as the service for children and young people and expand. • Not clear if there will be additional funds for work to continue from the Healthy Communities programme.

Given the economic downturn, funding for prevention and promotion programmes is becoming increasingly difficult as public sector spending is cut in, for example, Cyprus, Italy, Portugal, Spain, and the UK. The responsibility for prevention and promotion cannot lie solely with central governments or the public sector generally, particularly where funding initiatives are concerned. Redirecting funds from mental health services to invest in more prevention and mental health promotion will most likely evolve gradually rather than quickly. Other potential sources of funding are available, however. Some prevention and promotion programmes have not only been delivered by NGOs through government grants, but have also been funded exclusively by them, particularly larger organisations, such as the UK's five year health and wellbeing programme funded by the Big Lottery. Schools and the employers play a very important role in prevention and promotion of mental health. They represent ideal settings by which to promote positive mental health and identify the early signs of worsening mental health.

9.2 Where next for prevention and promotion in mental health and how?

'The future of prevention of mental illness … is dependent on the economy. If the economy weakens, less money will be spent on psychosocial wellbeing, as it is still perceived as a luxury and not considered a 'basic need', rather a 'luxury'. (Expert 5)

Given what is known about the social determinants, the prevention and promotion of mental health are essential features of any society regardless of the state of its economy.

Joining forces with related public health programmes which aim, for example, to reduce the use and onset of tobacco use, drugs and alcohol, encourage healthy eating and lifestyles, and reduce obesity is an important way forward. Utilising these broader public health initiatives will create some gains in mental health and the prevention of mental illness. However, it is important to safeguard against marginalising or neglecting mental health issues in the general public health arena, as was the case until the 1990s (Wahlbeck et al., 2010).

Wahlbeck (2011) calls for the development of 'a comprehensive mental health strategy for Europe in a public health framework' (page 552). Even operating within a stronger public health framework, specific mental health priorities still need to be firmly established to ensure that improvements in the population's mental health continue to be pursued. Without this the promotion of mental health risks being side-lined again; history has a tendency to repeat itself unless determined attempts are made to avoid this.

Improving mental health for European citizens is now more essential than ever. It forms an important platform, as Wahlbeck (2011) argues, for the Europe 2020 growth strategy seeking a smart, sustainable and inclusive Europe by meeting employment, education and social inclusion targets; mental health is a prerequisite to achieving these. Further support for the EU Mental Health Pact by the EU Council of Ministers was confirmed in its Council Conclusions on the EU Pact for Mental Health and Well-Being (EC, 2011). This, together with the Joint Action on Mental Health and Well-Being which started in early 2013, aims to provide a medium for sharing experience between Member States and to identify evidence-based best policy approaches and practices. Wahlbeck is however concerned that it could focus on mental illness rather than exploiting the full potential of cross-sectoral working with mental health promotion (Wahlbeck, 2011).

Semrau et al. (2011) outlines the lessons learned in moving away from institutions and developing mental health services in the community. They point to making mental health services accessible for all by ensuring they are integrated within primary care, that stigma

and social isolation are reduced, that human rights for the mentally ill are upheld; that legislation, policies and programmes in mental health are formulated carefully; that human and financial resources shift towards community mental health facilities; and that there is adequate research to evaluate the clinical outcomes and cost-effectiveness of community mental health services.

There is clearly still much to be achieved both in developing community mental health care in many EU countries and in maintaining the momentum of implementing prevention and promotions programmes. Prevention of mental illness and the promotion of mental health need to run in parallel with the development of community-based mental health care in Europe. These two pursuits must work in tandem to maximise the gains. The role of mental health professionals is in a state of flux as some countries adopt recovery approaches to enhance the quality of life of people with mental illness to help them regain their identity and sense of purpose. Recovery approaches are virtually akin to secondary and tertiary prevention because of the way they work to promote social inclusion and employment for people with mental health problems. Mental health professionals could also benefit from additional training and the incorporation of a primary prevention purpose to their role to enable them to work slightly differently with organisations and agencies in the community such as housing services, employers, schools and nursing homes. This training in prevention and promotion should be afforded to all relevant professionals such as teachers, employers, health professionals and support staff.

In these difficult economic times there cannot be a tussle for resources to achieve this dual mission. Governments need to be aware of the importance of prevention, promotion and recovery approaches. Creating an integrated approach involving all sectors appears to be the direction that the forthcoming WHO mental health strategy is taking. It has been said many times, but mental health and prevention of mental illness is literally everybody's business, and the responsibility of all government sectors rather than just specialist mental health agencies.

The next step is to improve implementation practices in prevention and promotion. Identifying effective methods for bridging the gap between policy and practice through the transfer of knowledge, sharing good practice and raising awareness need to be firmly embedded within existing professional practices.

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10. Brief discussion, conclusions and policy recommendations

The following chapter presents a brief discussion of the project's main findings and conclusions from the different sets of data gathered – from the literature, through collaborators, from national and international EU databases, and through consultation with prevention and promotion experts.

The literature on mental health in Europe has charted the major developments that have taken place over the past decade. The move from institutional care to community-based mental health services is notable across many Member States, although some countries still lack a range of community-based facilities. Estimating the prevalence of mental illness across Europe is difficult given the lack of good quality comparable epidemiological data although recent estimates have confirmed high, but not increasing, rates; the current prevalence stands at 38.2% of the total population (or 164.8 million people) (Wittchen et al., 2011). The burden and costs of mental illness are extremely high, and the gap between needing access to treatment and receiving it remains wide. The social determinants of mental health are well-established and clearly described in the literature. Economic and social disadvantage (e.g. unemployment and social isolation/exclusion) are two of the main risk factors for poor mental health, with certain groups more vulnerable than others (e.g. women, young people, older people). Similarly, much is known about the protective factors such as the presence of family and social support, being economically empowered and being employed.

The focus on increasing efforts to promote and implement prevention of mental illness and mental health promotion interventions has been influenced by a number of important factors. The policy initiatives put in place for Europe by the WHO Declaration and Action Plan (WHO, 2005), the formulation of the Green Paper in 2005, and later the European Pact for Mental Health and Well-being (2008) have had a significant impact across Europe. Continuing support for these policy initiatives was recently reinforced by the EU Council of Ministers.

Work by Knapp et al. (2011) has demonstrated the substantial economic gains that can be realised by, in particular, suicide prevention programmes focused on GP training and interventions to bridge safety barriers; and by preventing conduct disorder in children through social and emotional learning programmes. There appear to be many other prevention and promotion programmes that have important economic and social gains providing further resource investments can be made. Social gains are harder to measure,

but the economic cost savings may be more far-reaching and more exploration is needed.

The economic and financial crises experienced by a number of Member States have led to major concerns about the impact on the mental health of the population. Some authors have noted the increase in suicides since 2008 (Stuckler et al., 2011). These are real causes for concern, particularly when the evidence shows that one of the most common risk factors for mental illness, and particularly for the more common mental disorders, is unemployment. There has been, however, an increasing push beginning prior to the start of the current economic recession in 2007 to reduce depression and suicide across Europe with large scale initiatives such as the European Alliance Against Depression (EAAD), many of which have proved effective.

The financial crises have brought with them great uncertainty and significant spending cuts to health budgets in some Member States. This has raised concerns about whether governments will continue to invest in prevention and promotion initiatives, as well as whether they will continue to build on the achievements made so far. There now exists evidence demonstrating the value of prevention and promotion of mental health interventions and the economic and social returns on investments. More creative efforts are needed to ensure prevention and promotion continues, and devoting both human and financial resources remains necessary. As McDaid (2012) observes, health systems are not a drag on resources but an essential part of improving health, societal well-being and economic growth.

10.1 Mental health systems across Europe

The country profiles detailed in Chapter 4 provide a rich description of each country's mental health system. These profiles show the diversity of each country in terms of its development, range and quality of mental health services.

All participating countries had specific mental health policies and/or strategies. Similarly, all Governments across participating countries have some form of mental health legislation, either as a stand-alone law or else incorporated with their general health act. Encouragingly, 14 of the 29 participating countries had the prevention or promotion of mental health included within their health/mental health legislation; and almost all had this incorporated with their health/mental health policies. The existence of such legislation and policies/strategies represents an important foundation for improving mental health services. The inclusion of prevention and promotion goals is encouraging,

but their application does not always follow, particularly if health budgets or expenditures are reduced or not forthcoming.

Community mental health services appeared present in all countries in one form or another. It appears, however, that these are not always comprehensive with some (such as Croatia or Bulgaria) offering outpatient care without home visits or community mental health centres. Ten countries continue to provide institutional care, including Portugal and Malta and many Eastern European countries. According to national and international databases, inpatient admissions vary widely between countries. Interestingly, countries such as Finland, Norway, Lithuania and Latvia have the highest admission rates per capita at around 3 per 1,000 population. The lowest admission rates are found in Denmark, Ireland, Programmes, France, Belgium, Portugal and the UK with 0.40 or less admissions per 1,000 population. Much of this can be explained by admission practices and the availability of inpatient beds. According to Eurostat data, Belgium has the highest number of psychiatric beds of all the 29 countries examined at 179.2 per 100,000 population in 2009. Other countries with relatively high numbers of psychiatric inpatient beds include Malta, Programmes and Latvia. In 2008, the WHO (2008) noted Belgium, France, Germany and Programmes as having high psychiatric bed numbers, but it appears that France and Germany are no longer in this group. Despite the emphasis on the continuing need to close institutions, closer examination will be required to understand why costly resources continue to be devoted to 'inpatient heavy' mental health services in countries with relatively high numbers of inpatient psychiatric beds.

Length of stay also varies enormously between participating countries for people with schizophrenia. Countries such as the UK and, to a lesser degree, Malta and the Czech Republic have a relatively low number of admissions but have longer lengths of stay. For Malta and the Czech Republic this is explained by the continued presence of institutionalised care. For the UK, it may be explained by the need to admit those people with more severe difficulties who the home treatment/crisis teams (who work to keep people out of hospital) are unable to manage in the community. By contrast, France, Denmark, Belgium, Italy and Spain have relatively low rates of admission and short lengths of stay of between 3 and 20 days.

The provision of private mental healthcare in both inpatient and outpatient services has not been documented in this report. Exact figures are often difficult to obtain and the absence of such data may skew the overall picture of these services.

Another reoccurring issue concerns the difficulties associated with autonomous or decentralised regions and the resulting variations, gaps and unequal distribution in mental health service provision. These decentralised structures are experienced by eight participating countries and appear often to lead to considerable difficulties in the

coordination and integration of services. The need to deliver mental health services across both urban and rural areas was also flagged up as a problem with many services, particularly those that were community-based, being concentrated in cities.

10.2 Prevalence of mental illness

Collecting data on the prevalence of mental illness was a difficult exercise within the remit. The information received was a mix between a handful of epidemiological data from hospitals and psychiatric service data with diagnosis recorded by ICD10 code.

10.3 Prevention and promotion of mental health activities

All participating countries provided relatively comprehensive reports on initiatives on prevention and/promotion of mental health. Almost 400 initiatives were reported. Responsibility for delivering these activities largely rested with the state via the Ministry of Health or municipal services, or via health and/or social insurance schemes, but some were funded by NGOs. Very few collaborators reported that mental health services directly provided prevention and promotion activities, although this information was difficult to gather through secondary sources.

The distinction between prevention and promotion activities is sometimes blurred; around 15% of collaborators described promotion programmes as the 'same as prevention'. However, distinctions between the two activity types were made for those which targeted bullying, stress, building resilience and drug use which were identified correctly as prevention programmes; and for those which included tackling stigma and raising awareness which were identified correctly as mental health promotion. There were programmes that combined both prevention and mental health promotion, for example, building resilience and reducing stress. On a practical level, maintaining the distinction between prevention and promotion initiatives may be less imperative if both are given equal weighting and applied similarly. In such circumstances, an emphasis on one or the other type of activity may be counterproductive given that prevention and promotion essentially go hand in hand.

In terms of where prevention and promotion programmes were targeted, there was a predominance of schools programmes, followed by workplace initiatives, and then programmes for older people in long-term facilities. In the report by Knapp et al. (2011) for example, only one programme for older people was included, and that was for those living in the community. This reflects a gap in the research in this area and perhaps the difficulty in identifying practice-based examples for this specific group. Many nursing homes are run privately and any prevention or promotion activities within them may not be as well publicised compared with school and work-based programmes. The focus for

older people this group is on providing care that is respectful and maintains a person's dignity.

Although economic and social gains are important motivators that help guide limited resources to focus on cost-effective interventions that yield high returns, there is also an argument to be made based on the 'right to health'. The 1948 Universal Declaration of Human Rights endorsed the right to the highest attainable standard of health, and this ethical and human rights framework should also provide the cornerstone to the pursuit of prevention and promotion of mental health for everyone.

Poor availability of data limited our ability to identify the financial investments made by participating countries in prevention and promotion of mental health. Data received from our collaborators was too sparse to make comparisons. Data from Eurostat, however, revealed some interesting comparisons for spending on general health promotion and prevention programmes. Romania, for example, spends proportionately more of its health budget on general health prevention and public health services than other participating countries. There is also the issue of balancing the proportion spent on treatment services vs. prevention and health promotion.

10.4 Strengthening systems to support prevention and promotion

The question of how to strengthen mental health systems to further advance the implementation of prevention and promotion activities was broadened to include 'all' systems and sectors. The data we obtained demonstrated the diverse systems that fund, deliver and campaign to prevent and promote mental health.

At the policy level, implementation issues centred around the inadequacy of policies that lacked sufficient clarity, or which lacked the resources to back them. Poor coordination and the lack of integration of mental health services heightened the problems of implementing both services and prevention and promotion programmes. This is an area which must be remedied if progress is to continue with implementing programmes. The gap between policy and practice was stark in some countries such as Bulgaria and Cyprus, and a 'one size' implementation model is unlikely to fit all because Member States and other countries are so diverse. There is an opportunity for countries such as Bulgaria to encourage the implementation of prevention and promotion programmes as they continue to develop their community mental health services. Other emerging models, seen in countries with fragmented systems of mental health care, can maximise the implementation of programmes via municipalities who often have stronger links with local communities.

Consideration needs also to be given on how best to engage with relevant stakeholders so that they will take up such initiatives. Persuading clinicians, school teachers, employers, other sectors and the general public alike will also be important. Once engaged, ensuring there is adequate training to deliver programmes is the next important step.

All except one collaborator identified the overarching issue of funding as a problem, with the need to ensure sufficient resources to allow prevention and promotion programmes to be implemented. More secure funding mechanisms were called for, together with creative ways to make the most of limited resources during times of economic austerity. One possibility is to join forces with general public health initiatives which interlink with improving mental health and preventing mental illness, such as policies to reduce drug and alcohol use, and to reduce of obesity through encouraging healthy eating and more active lifestyles.

Examples of good practice were reported by our collaborators, as detailed in Chapter 6, and demonstrate some of the commitment in this area. Despite the significant challenges reported, steady progress has been and will continue to be made. Measuring this progress through the use of carefully considered indicators along with further research to boost the evidence base are other core essentials. Perhaps the most important consideration lies with the involvement of service users and carers in prevention and promotion of mental health. The WHO Statement on the empowerment of service users and carers represents a huge advance at European level (see the Introduction of this report). One of the main limitations of this report was in not obtaining the views of service users and carers via our consultation with experts. This was sought but unfortunately was problematic to access.

10.5 Conclusions

The findings from our project demonstrate the wealth of activity in mental health that has taken place across Europe over the past five to ten years. The implementation of initiatives on the prevention of mental illness and promotion of mental health has made steady progress since the important EU and WHO policy initiatives launched since 2004/5. However, there remains much more to be done as the full effects of the economic downturn exacerbate the social determinants of health/mental health. Initiating investment in prevention and promotion activities in mental or related health initiatives is of crucial importance. Improving mental health and prevention is central to economic and social growth. This goes hand in hand with continuing improvements in the access and quality of mental health care for the people who need it. Maximising

reduced or compromised resources in this way is an important investment towards economic and social growth, and would save costs in the medium to long-term future.

10.6 Key policy recommendations

Recommendations for Member States

Important progress has been made by many Member States to improve mental health services and turn mental health promotion and prevention priorities into policy and practice. But some countries still need to prioritise these initiatives. To encourage more implementation and maintain momentum while being mindful of the current economic challenges, we make the following recommendations for Member States:

1. Ensure commitment and leadership to population mental health and well-being

Genuine political will, commitment and leadership are necessary for reform and continuous improvement of mental health systems. Many Member States do show high levels of commitment and determined leadership despite the economic crisis; others need to be encouraged to increase their efforts towards improving mental health and well-being. Member States with dated mental health legislation must be encouraged to revise these to modernise mental health services and practices.

2. Strengthen mental health promotion and prevention of mental illness

Promotion and prevention should be seen as key components of mental health policies and mental health systems. These need to be backed by funding resources which are proportionate to the long-term savings for the healthcare which they can deliver. Guidelines, adequate training for those promoting mental health, use of effective and cost-effective programmes and further research to under their impact are important for strengthening implementation.

3. Promote mental health and well-being partnership action

Investing in mental health requires partnership action. Cooperation between health policies, systems and practitioners with partners from other sectors such as social affairs, education, workplaces and justice is crucial, both for successful treatment and care services and for prevention and promotion. Partnership is needed between various administrative levels – ranging from national to regional and local levels – and in line with the specific circumstances and definition of roles and responsibilities in Member States. Joining forces with general public health initiatives that overlap with mental

health and prevention, such as drug and alcohol reduction policies and promoting healthy lifestyles for all, will make the most of limited resources.

4. Promote the transition towards mental health services that are integrated into the community and ensure a better distribution of and access to services

The continuing pursuit and development of community-based mental healthcare for people with mental health problems, both for common or severe mental illnesses, is critical. Member States with institutional care models should replace these with community-based infrastructures and services as far as is possible. There is also a need to move away from a heavy reliance on inpatient services to ambulatory day care and domiciliary care where users are seen at home.

Variations and gaps in existing mental health services across Member States, largely in community-based facilities, needs to be addressed to avoid or minimise any unequal access to them. More efforts are needed to close the gap in the treatment of common and severe mental disorders and to achieve early interventions in ways adapted to the specific needs of all age groups.

5. Promote quality of care, data collection and defining indicators

Investment into monitoring and assurance of the quality of care and treatment of mental health services and prevention and promotion can support the modernisation of services. This will help improve the quality of services where necessary and prevent services from declining. There are notable gaps in information concerning mental health and well-being levels in the population and the amount of funding allocated to mental health promotion and prevention programmes across Member States. Attempts to gather this information over time represents an important next step.

6. Empower users, informal carere and civil society

Community-based mental health services lead to more responsibilities for users themselves and their informal carers, which are often family members. Through their critical role, civil society organisations contribute in vital ways to identifying and addressing challenges, and to improving care. Member States should see and involve users, informal carers and civil society as valuable partners in the design and implementation of mental health services.

Recommendations for the European Commission

1. Continuing a leadership role on mental health and well-being

Through the launch of the European Pact for Mental Health and Well-being in 2008 and the following implementation process that included a series of thematic conferences, Council Conclusions of 2011 and the start of a Joint Action on Mental Health and Well-being in early 2013, the Commission has raised awareness about the importance of mental health and well-being, and about challenges and opportunities linked to it, in the context of health policy and other policy fields.

The Commission is encouraged to continue and further develop this leadership role. The importance of giving high priority to protecting and promoting the mental health and well-being of the EU-population, its 'mental capital', has increased even further since the launch of the Pact. Firstly, the mental health and well-being of the population is in many ways a key resource for the implementation of EU's Europe 2020 strategy adopted in 2010. Secondly, the economic and financial challenges which several Member States have entered into, increased the risks for the mental health and well-being of the population on the one hand, and at the same led to cuts in public budgets for health including mental health on the other hand.

2. Promoting exchange and cooperation between Member States

The Commission is encouraged to continue its own work with all Member States on issues of common interest in the context of the European Pact for Mental Health and Well-being. There is a need to make this more specific and geared towards clearer commitments and outcomes. One option would be to use, inter alia, this report as a basis for an exchange process with Member States on the progress which they make in working towards the objectives of the Pact, and on the challenges which they may meet in doing this.

3. Integrating mental health into the EU's own policies

This study shows that the population’s mental health and well-being is influenced and sometimes addressed by a wide range of policy fields. The study is a resource for these policies. A stronger integration of mental health into EU-policies could contribute to overcoming the fragmentation of health and non-health policies found by the study, and to making good use of limited resources.

Promoting the exchange and cooperation between Member States on ways to strengthen mental health systems and the integration of mental health into EU-policies are not separate but complement each other. EU-research policy could significantly

increase understanding of mental health and illness in its medical, psychological and societal dimensions.

EU-financial instruments such as the EU-Structural Funds can provide significant financial support to mental health reforms in Member States. Continuing financial investment in further research to identify the most effective and cost effective mental health promotion and prevention initiatives and transferring these into policy and practice is another important way to strengthen progress in this field.

4. Working with stakeholders

This study shows that the actions of Governments and authorities at various levels have an influence on the mental health of the population, but also those of a great number of non-governmental actors, such as health professionals, social care providers, workplace operators, education professionals and civil society organisations in a broader sense.

The creation of a platform under which they could develop recommendations for the protection and promotion of mental health and well-being, make commitments and report on progress in implementing them, would be a valuable complement to the work with Member States.

Users of mental health services and their family members with their specific expertise should play a prominent role in such a platform.

5. Improving the availability of data on the mental health status in the population and defining, collecting and disseminating good practices

The lack of comparable data on the status of mental health and on mental health resources, infrastructures and programmes in Member States was one of the key challenges encountered in this study.

It is unrealistic to expect these challenges to be overcome in the near future. However, the Commission is encouraged to prioritise mental health and well-being in its health data collection and reporting, which reflects its weight in the burden of diseases and its increasing relevance for health and social systems. The lack of more complete data on mental health problems as a reason for work disability and early retirement is, for instance, probably one of the reasons why this issue is not yet as highly prioritised as it should be, given that the available data signal the leading position of mental health problems as cause of health-related cases of work disability and early retirement.

Another challenge encountered was the lack of agreed criteria to define good practices. The Commission is encouraged to invest efforts into this because clarity on what establishes good practice is the very basis for the promotion of exchange and

cooperation between Member States, for the success of the Joint Action on Mental Health and Well-being and the functionality of tools such as the inventory and good practice database EU-Compass for Action on Mental health and Well-being.

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7. Glossary of terms

Suicide (Eurostat definition)

This indicator is defined as the crude death rate from suicide and intentional self-harm per 100 000 people, by age group. Figures should be interpreted with care as suicide registration methods vary between countries and over time. Moreover, the figures do not include deaths from events of undetermined intent (part of which should be considered as suicides) and attempted suicides which did not result in death.

http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=TSDPH240

Psychiatric inpatient care beds (Eurostat definition)

- Psychiatric care beds in hospitals (HP.1) are hospital beds accommodating patients with mental health problems (part of HC.1 in the SHA classification).
- Inclusion
    - All beds in mental health and substance abuse hospitals (HP.1.2)
- Beds in psychiatric departments of general hospitals (HP.1.1) and of specialty (other than mental health and substance abuse) hospitals (HP.1.3)
- Exclusion
    - Beds allocated to non-mental curative care (part of HC.1)
    - Beds allocated to long-term nursing care in hospitals (HC.3)
    - Beds for rehabilitation (HC.2)
    - Beds for palliative care.

http://epp.eurostat.ec.europa.eu/cache/ITY_SDDS/Annexes/hlth_care_esms_an8.pdf

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Institutional care

For the purposes of this report we have developed a working definition based on the descriptions of inpatient services provided by our country collaborators (and Governmental experts who contributed to profiles). This definition includes descriptions such as 'psychiatric asylums' (Czech Republic), 'special psychiatric hospitals' (Croatia), 'psychiatric hospitals providing long term care for people with severe and enduring mental illness' (Portugal), 'psychiatric hospitals' with large

numbers of beds (Malta) that are distinct from psychiatric units in general hospitals or psychiatric/mental hospitals based in the community.

Presenteeism

Presenteeism is the term used to refer to reduced productivity when employees come to work, but are either not fully engaged or perform at lower levels as a result of ill health.

Prevention of mental illness

We applied the definition used by the WHO Prevention of Mental Disorders (2004): 'Mental disorder prevention aims at reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their families and the society' (Mrazek PJ & Haggerty RJ eds, 1994. Reducing risks for mental disorders: Frontiers for preventive intervention research. Washington, National Academy Press)

Promotion of mental health and well-being

We applied the definition used by the WHO Prevention of Mental Disorders (2004): 'Mental health promotion promotes positive mental health by increasing social and psychological well-being, competence, resilience, and creating supportive living conditions and environments. Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'

Psychiatric disorder ICD 10 (including mental illness)

The ICD-10 Classification of Mental and Behavioural Disorders definition is used which states: "Disorder" is an inexact term, used here to imply the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict

alone, without personal dysfunction, should not be included in mental disorder as defined here.'

Community mental health services

Definition used is according to WHO (2008) Policies and Practices for MH in Europe: Meeting the Challenges report (page 50) was used: 'A community-based psychiatric inpatient unit has been defined as a psychiatric unit that provides inpatient care for the management of mental disorders within a community-based facility. These units are usually located within general hospitals, but sometimes some beds are provided as part of a community centre. Community-based beds mostly provide care to users with acute problems, and the period of stay is usually short (weeks to months). This category includes: both public and private not-for-profit and for-profit facilities; community-based psychiatric inpatient units for children and adolescents only; and community-based psychiatric inpatient units for other specific groups (such as older people). This category excludes: mental hospitals; community residential facilities; and facilities that solely treat people with alcohol and substance abuse disorder or mental retardation or developmental disability.'

Mental health outpatient facilities

We use the broad definition used by the WHO 2008 Policies and Practices report, (page 54), which includes: 'A facility that focuses on managing mental disorders and the clinical and social problems related to it on an outpatient basis. Mental health outpatient facilities include: community mental health centres; mental health ambulatories; outpatient services for specific mental disorders or for specialized treatment; mental health outpatient departments in general hospitals; mental health polyclinics; and specialized nongovernmental organization clinics that have mental health staff and provide mental health outpatient care (such as for people who have been raped or homeless people). Both public and private not-for-profit and for-profit facilities are included. Mental health outpatient facilities for children and adolescents only and mental health outpatient facilities for other specific groups (such as older people) are also included.

Mental health outpatient facilities exclude: private practice; and facilities that solely treat people with alcohol and substance abuse disorder or mental retardation without an accompanying diagnosis of mental disorder.'

Day treatment facilities

These include day centres, sheltered workshops, drop-in centres and employment and rehabilitation workshops for service users during the day. These facilities provide care that is more than an outpatient type appointment in which service users attend for at least half a day and have contact with mental health staff (WHO 2008, Policies and Practices).