

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

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## **ANNUAL REPORT (2018)**

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SUMMARY AND ANALYSIS OF KEY DEVELOPMENTS IN MEMBER STATES AND  
STAKEHOLDERS

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**List of abbreviations**

CHAFEA: Consumers, Health, Agriculture and Food Executive Agency

CME: Continuous medical education

DALY: Disability adjusted life years

DG SANTE: Directorate General for Health and Food Safety of the European Commission

EU: European Commission

MS: Member State

WHO: World Health Organization

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## EXECUTIVE SUMMARY

This is the third annual activity report of the EU Compass for Action on Mental Health and Wellbeing. It includes a summary of the key mental health activities developed in 2017 by Member States and Stakeholders, an assessment of the progress made towards the objectives of the European Pact for Mental Health and Wellbeing and the Framework for Action on Mental Health and Wellbeing, and recommendations for the future. The report is based on an analysis of data collected through the EU Compass survey and a review of the literature presented in the EU Compass position paper on community-based mental health services.

Analysis of activities developed by Member States and Stakeholders over the past year shows significant progress was made towards some of the objectives recommended by the European Pact and the Framework for Action.

In 2017, activities reported by Member States concerning legislation focused on the update or improvement of national mental health legislation, as well as in the development of new legislation in areas related to the rights of people with mental disorders and the improvement of mental health care. Several countries developed new national mental health strategies, and others have implemented new strategies with a focus on children and adolescent mental health and on including mental health across all policies.

In terms of the organization and quality of services, a significant part of the achievements reported by Member States in the past year relate to the development of new community-based mental health services, in some cases as part of a deinstitutionalization process. Some countries have created services and programmes for specific groups, such as children and juvenile drug users.

All countries reported new developments in mental health promotion and prevention. Many plans and programmes introduced aim to prevent mental disorders, as well as tackling stigma of mental illness. Important advances have also taken place with regards to the prevention of suicide and depression and programmes based in the workplace and schools.

Some countries reported progress in patient, family and NGO involvement during the development of various mental health initiatives. Results of the survey show that Member States are increasingly adopting the Mental Health in All Policies (MHiAP) framework and several countries report innovative activities in this area.

Assessing the impact of policies is still lacking in a significant number of countries, but for some Member States there is encouraging progress in this area.

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

The key challenges reported by stakeholders for 2017 included the lack of funding and organizational challenges (such as the lack of human resources).

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

During 2017, there was some progress towards meeting the policy objectives of the Joint Action on Mental Health and Wellbeing, particularly with updating and implementing national mental health strategies, the development of new services, launching of new promotion and prevention programmes, and the adoption of mental health in all policies approach. These advances, however, were not consistent across Member States. In some areas (for instance, in monitoring activities and developing information systems, improving the quality of care, development of e-mental health) little or no progress was made. While some countries reported initiatives to systematically implement a coherent mental health policy aligned with the Joint Action recommendations, others reported little or nothing had been done in this area in 2017.

The findings reported in the EU Compass position paper on provision of community-based mental health services show that, when compared with traditional hospital-based services, community mental health teams (CMHT's) are associated with lower admission rates, better quality of care, and increased service user satisfaction<sup>1</sup>.

This paper also outlined the development of newer models of effective community-based services emerging over the last decade. It also revealed how other emerging approaches represent promising advances in community mental health care; although their effectiveness is still to be established

With regards to mental health in primary care, available evidence shows that the collaborative care model is more effective compared to standard care in the treatment of common mental disorders, such as depression and anxiety.

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<sup>1</sup> Killaspy H, McPherson P, Samele C, Keet R, Caldas de Almeida JM (2018). Providing community-Based Mental Health Services. EU Compass for Mental Health and Wellbeing. European Commission.

Advances in knowledge and models of care have contributed to the development of a large set of innovative community-based mental health care interventions that have improved the quality of care in Europe over the past decade.

Based on the analysis of survey responses recorded for 2017, which identified both the advances in improving mental health care across Member States, since the EU Joint Action for Mental Health, and areas where insufficiencies remain, further recommendations are presented in this Report to complement those included in the Framework for Action.

## 1. INTRODUCTION

This Report is the third annual activity report for the EU Compass for Action on Mental Health and Wellbeing. Based on the 2017 Activity Reports of Member States and Stakeholders, which can be viewed in full in the *Annual Activity Reports Of Member States And Stakeholders (D2 2018)*, available on the EU Compass website, and taking into consideration relevant information from other sources, the Report includes a summary of the mental health policy related key activities developed in the last year by Member States and Stakeholders. It also includes an analysis of developments to tackle the priority areas selected for 2017 — providing community based mental health care and the development of integrated governance approaches — as well as recommendations for the future.

The Report has three main objectives. Firstly, to provide all those interested in mental health policy development in the EU with an opportunity to better understand the mental health activities developed over the last year by Member States and relevant stakeholders in the EU, the reasons underlying this, the progress towards their implementation and the achievements they led to. The second objective was to assess the extent of progress towards meeting the objectives stated in the European Pact for Mental Health and Wellbeing<sup>2</sup> and the Framework for Action on Mental Health and Wellbeing<sup>3</sup>. And thirdly, to identify the areas where insufficient progress had been made and suggest strategies that should be prioritized for the future.

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<sup>2</sup> European Commission (2008). European Pact for Mental Health and Wellbeing. Available at: [http://ec.europa.eu/health/mental\\_health/policy/index\\_en.htm](http://ec.europa.eu/health/mental_health/policy/index_en.htm)

<sup>3</sup> European Commission (2016). European Framework for Action on Mental Health and Wellbeing. Available at: <http://www.mentalhealthandwellbeing.eu/publications>.

We hope this Report achieves these objectives and will contribute to the dissemination of the policy recommendations included in the EU Framework for Action on Mental Health and Wellbeing, and provides important information on implementation activities and good practices across Member States.

## 2. METHODOLOGY

To assess the progress made across EU Member States over the last 12 months we analysed information collected through two annual online surveys, which were completed by Member States' and Stakeholders' representatives between September and early December 2017. We also took account of the data and information presented in the EU Compass position paper on community-based mental health services and in publications from the Joint Action on Mental Health and Wellbeing.

### 2.1. INSTRUMENT

#### *Development of the questionnaire*

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

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



### *Structure of the surveys*

The surveys included open and closed-ended questions. The survey for Member State representatives was more detailed and included 26 questions, whereas the survey for Stakeholders comprised 14 questions.

The Member States' survey was divided into five parts:

- Part A covered background information, such as contact information and country;
- Part B covered updates on key developments or those to be initiated by March 2018 (e.g. the implementation of programmes or plans implemented since the previous EU Compass survey (2016, 2017));
- Parts C and D focused on the two EU Compass themes for 2017 (providing community-based mental health services and developing integrated governance approaches);
- Part E includes details of relevant documents concerning mental health and wellbeing produced since 2016 not previously mentioned.

The Stakeholders' survey was also divided into five parts:

- Part A addresses basic information on the organization;
- Part B focuses on the key activities carried out in the organization, with questions on the organization's objectives, their target group(s), key activities and achievements, the partners they involve, available resources, strengths of the organization's activities, challenges faced, and whether or not activities were evaluated;
- Part C and D focused on the two EU Compass themes and the extent to which action on these took place;
- Part E includes details of relevant documents concerning mental health and wellbeing produced since 2016 not previously mentioned.

## 2.2. DATA COLLECTION

### *Identifying respondents and sampling*

Respondents for the annual activity surveys were identified by NOVA University of Lisbon and other members of the EU Compass consortium. Member State representatives for all EU countries, as well as Turkey, Norway and Iceland were identified following a consultation with the Group of Governmental Experts and, where necessary sub-national public authorities. Existing lists developed for the Joint Action for Mental Health, as well as lists of

relevant stakeholders of the EU Compass Consortium partners were consulted and used to identify stakeholders for the survey. These included stakeholder representatives from non-governmental organisations in health, social affairs, education, workplaces and justice and civil society groups. The total number of stakeholders identified through this process was 605. In addition, the web link was placed on the EU Compass website.

#### *Data collection process*

Once identified, Member State representatives and relevant stakeholders were invited by email to take part in the 2017 survey. Questionnaires were sent via e-mail containing a private web-link to the online survey, from August to December 2017.

To maximize response rates, reminders via email were sent out to non-responders. Member States' representatives that failed to respond to the survey by November 2017 were followed up individually through email or by phone. Also, during the EU Compass's Awareness-raising and training workshops, EU Compass representatives encouraged representatives from the Member States who had not responded so far to do so. The initial deadline for the Member State's survey was 30th October 2017. However, the deadline was extended until the 2nd of December 2017 to increase the response rate.

#### *Response rates*

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

Of the 605 stakeholders invited to complete the survey, 24 completed the survey.

### **2.3. DATA ANALYSES**

Raw data from the survey respondents were exported from Webropol onto an Excel spreadsheet, IBM SPSS Statistics and PDF documents. All data from stakeholders was similarly exported. All data were checked for any inconsistencies or missing data and were cleaned.

All quantitative data were analysed using SPSS (Statistical Package for the Social Sciences), version 21; and descriptive statistics (e.g. frequencies and cross-tabulations) on mainly binary and categorical data were performed.

Qualitative data from both surveys were cleaned from errors or misspells, and the researchers read and re-read the written answers and prominent answers and themes were identified as answer categories and analysed.

### 3. KEY DEVELOPMENTS CONCERNING MENTAL HEALTH AND WELLBEING

#### ACTIVITIES BY MEMBER STATES FOR 2017

##### *Legislation*

Several Member States took important steps in 2017 to update or improve their national mental health legislation. In Finland, for example, a complete renewal of their mental health legislation is currently underway. In Romania, amendments to the Mental Health Law (Rules of implementation 488/2016) has led to the creation of a mental health strategy for children and adolescents; and in Slovenia a working group was appointed in November 2016 to prepare amendments to their Mental Health Act.

Several countries have introduced new legislation regarding the rights of people with mental disorders. Spain passed new legislation concerning the rights and autonomy of patients. Hungary, after signing the Convention on the Rights of Persons with Disabilities, has included psychosocial disability as part of the group of disabilities; and awarded NGO's working in this area the same status other disability organizations had, which contributed to enhanced government funding for these activities. The UK (England and Wales) has implemented legislative changes through the Policing and Crime Act to prohibit the use of police cells as a place of safety for people under 18 years detained under sections 135 and 136 of the Mental Health Act 1983 (England and Wales). Also, an independent review of the Mental Health Act 1983 (England and Wales), led by Sir Simon Wessley, was launched to ensure that it remains fit for purpose and to improve the rights of people. An interim report of the review will be published in spring 2018.

Other countries have developed new legislation to improve the provision of mental health care. Cyprus has submitted to parliament for approval legislation on Community Mental Health Care. Its primary aim is the development of community residential health facilities for people with mental health issues, provided with approval from Mental Health Services either by the private sector, NGO's or Municipalities. Slovenia, has introduced an Act Regulating the Integrated Early Treatment of Preschool Children with Special Needs. This early childhood intervention in primary health care centres is intended for all children who have a developmental risk or developmental disability; and commences from the point of prenatal diagnosis to time when the child reaches compulsory school age. It includes the entire process from the earliest possible identification and detection up to the time of training and guidance assessment. The Act introduces a family representative and a

representative from a non-governmental organization, who form part of a multidisciplinary team to provide support, counselling and assistance drawn from their own experiences of early childhood or pre-school development.

### *Mental health policy and plans*

There were significant achievements in several countries regarding the development of national mental health strategies.

In the last quarter of 2017, France has prepared a new National Health Strategy, which includes an official national mental health strategy. The document is currently available online for public consultation and comments. In Bulgaria, a new version of the National Mental Health Programme and Plan of Action for the next 6 years is also under preparation. A review of Ireland's Mental Health Policy 'A Vision for Change' is underway.

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

A national strategy for mental Health, with a focus on children, young people and Mental health in all policies was launched in Norway, in August 2017, while In Ireland, a new Inter-Departmental Pathfinder initiative is being established to deliver a coordinated approach to youth mental health nationally.

In Portugal, the Ministry of Health created a Technical Commission for the Follow-up of the Mental Health Reform, in 2017. This Commission published a report with a comprehensive assessment and evaluation of the Plan's implementation, with a view to extending the plan to 2020.

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

Slovenia adopted a new Resolution on the National Health Care Plan 2016–2025 in April 2016, which included, in a chapter dedicated to Mental Health, the adoption of a national mental health programme, amendments to the Mental Health Act, a healthcare cooperation protocol with providers in the field of social protection and

education, the development of integrated community treatment programmes and support for people with long term mental health problems. Guidelines for programmes and services to be carried out by non-governmental organizations, volunteers, family members and others, and the development of the model of the national network of services for the mental health of children and adolescents were also included. In October 2017, the Ministry of Health in Slovenia launched a new working group for the drafting of a National Mental Health Programme; adopted, in May 2016, a Strategy for dementia valid until 2020, and later in 2017 launched a public tender to co-finance education programmes for the management of dementia between 2017 and 2018.

As mentioned in the 2017 EU Compass Report, the Swedish government has adopted a national strategy for mental health for the period 2016-2020. The strategy is based on five areas of focus identified as the main challenges in relation to the promotion of mental health and wellbeing and combating mental ill health. These are: 1 - Preventive and promotional efforts; 2 - Accessible services; 3 - Vulnerable groups; 4 - Participation and rights; and 5 - Organization and leadership. Each area of focus includes people of all ages and gender – children, young people, adults and older people. Suicide prevention is also a recognized priority. One of the key elements in achieving the Government's goals and supporting the implementation of the national strategy is an agreement between the Government and the Swedish Association of Local Authorities and Regions (SALAR). In 2017, with regards to the Agreement on Support for Targeted Measures for Mental Health, the Government provided a total of 885 million SEK (approx. 91 million Euros) for this, while 780 million SEK (approx. 80 million Euros) were provided to local authorities and regions to continue working towards long-term sustainable efforts to promote mental health and mental wellbeing, and to improve services for people experiencing mental health problems. The governmental action plan gives the regions/local authorities autonomy on how the money should be distributed across the regions but all work must be based on the five areas of focus proposed by the government.

### *Organization and quality of services*

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

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

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

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

Luxembourg initiated a reorganization of ambulatory psychiatric services to improve the support provided to people with mental disorders and to support their integration into society through their leisure time, work and day to day living. This country has also increased access to counselling for refugees.

In Hungary, government funding of community mental health services was expanding and made part of social service provision. In June 2017, 169 service providers supported 8701 clients. The Government is also committed to the deinstitutionalization of five long-term care institutions (three for people with disabilities and two for psychiatric patients). The supported-living programme has been launched with home-care services offered to 660 people, which has been financed with EU funds. This is due to be expanded to 10.000 people in the planning period of 2017-2020.

In Netherlands, the Dutch Healthcare Authority published a report on the state of mental healthcare in the country. One of the Authority's conclusions is that a shift has taken place from specialized to basic/primary (mental) care, where more patients are treated in basic/primary (mental) care rather than in specialized care. Moreover, waiting list times are often very long, especially for people with autistic spectrum disorders or personality disorders. To resolve this, a national approach was launched, in which the Ministry of Health, healthcare insurers, caregivers and local authorities developed an action plan. Regional taskforces including all stakeholders have been established to minimize waiting times for people by the summer of 2018. An independent research institute (Trimbos) has published a report concerning the status of deinstitutionalization in the mental healthcare sector. The current policy is aimed at improving the quality of care provided and to decrease costs by treating people in outpatient/community based facilities or at home instead of hospital care. The report concludes that deinstitutionalization has begun but the capacity of outpatient/community care is not increasing accordingly.

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

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

The Hungarian Government, with EU structural funds EFOP/VEKOP, is aiming to improve the structural development of mental health services. This includes infrastructural improvement of child and adolescent psychiatry, addictions and mental hygiene service systems (6 bil. Ft), the conditional advancement of psychiatric out-patient services (4 bil. Ft), the development of a secure psychiatric unit (2,7 bil. Ft) and the infrastructural improvement of psychiatric and addictions departments (in which 14 acute psychiatric wards will receive support).

In Cyprus, the European Early Promotion Programme, aiming at promoting mental health and early intervention for families with children aged 0-2 years, is being implemented. Families referred to this program are seen by Health Visitors, who are appropriately trained by skilled mental health personnel.

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

In Cyprus, an Inpatient Unit for Juvenile drug users with serious behaviour problems began operating in the General Hospital of Nicosia in early 2017. In the Netherlands, an integrated approach/policy to increase the quality of care for people who are (temporarily) confused or disturbed has been launched. The causes for this state of confusion can be very diverse and the problems and needs of this group often vary widely. Therefore, an integrated approach is required involving several policy areas (housing, care, employment, debts, wellbeing) and several stakeholders. A national team stimulates and facilitates (local) stakeholders to create networks across different caregivers and institutions involved in the care for people with confused behaviour.

Some countries reported achievements in promoting and monitoring quality of care. For instance, in the Netherlands, Routine Outcome Measurements have been implemented in the Dutch mental healthcare sector. Care providers are contractually obligated by insurers to have at least 50% of their patients fill in a pre and post treatment questionnaire. Anonymised data are collected and analysed, and will be evaluated to see whether these provide a useful means by which to assess service quality. In the 2<sup>nd</sup> part of 2017, the Portuguese Ministry of Health assessed several institutions providing psychiatric care, using the WHO Quality-Rights Tool, in collaboration with WHO-Europe within the Project "Adults with Mental Disabilities Living in Institutions in the European Region". The conclusions of this project will be used as the basis for improving the quality of care, according to the Convention on the Rights of Persons with Disabilities (CRPD).



## *Prevention/promotion*

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

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

The UK (England) has also initiated a programme to deliver Mental Health First Aid training in schools. It also launched the first National Mental Health Prevention Concordat in England for local authorities to work across all local authorities and to build mental health prevention into their local Strategic Joint Needs Assessments for local communities. In October 2017, an independent government review of mental health in the workplace in England was published, providing important standards and recommendations for employers to prevent and support employees with mental health problems.

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

In Norway, the Programme for Public Health in the Municipalities 2017-2027 is a national framework and joint effort at municipal level to promote mental health and prevent drug use.

In 2017, several Public Mental Health Projects, funded by EEA-Grants, were conducted in Portugal to promote mental health in schools and in the workplace, develop innovative payment models for the mental health system, assess the impact of the economic crisis on the mental health of the population, encourage stepped

care treatments and digital solutions for depression and suicide prevention in primary care, screen for perinatal depression, build capacity in primary care, and promote access to mental health services for the children of people with mental disorders.

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

### *Mental health in all policies*

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

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

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

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

In Portugal, new psychosocial rehabilitation programmes, including residential facilities, community day centres, and home support services have been launched with funding from the National Psychosocial Rehabilitation Programme.

In the UK, the Government published its response to the Five Year Forward View for Mental Health in England in January 2017 to set out how it will implement its recommendations across government. The Prime Minister also set out a wide range of mental health reforms which included a review of mental health in the workplace, a review of the Mental Health Act 1983 and delivering Mental Health First Aid training in schools. An Inter-Ministerial Group on Mental Health was also established to oversee this work, which brings together senior Ministers across government to progress the mental health agenda. It should also be noted that in the UK equalities legislation requires non-health sector policies to take into account the needs of people with protected characteristics, which includes people with mental health needs. The Government has put parity of esteem for mental and physical health into legislation.

### *E-health*

In terms of the introduction of new information technologies, Bulgaria reported a new online portal for registering suicide attempts and introduced an Educational internet platform for General Practitioners in the field of mental health; both have been active since 2016. In Finland, the availability of digital mental health services has significantly improved.

## 3.1. PROVIDING COMMUNITY-BASED MENTAL HEALTH SERVICES

### *Organization and coordination of community-based mental health services*

The majority of Member State representatives (92%) referred to having their mental health services organized by catchment areas across the entire country or some parts of it. The level of coordination was reported as fairly good for 43% of Member State representatives. A small percentage reported very high coordination (Fig.1 and 2). It should be noted that more than 40% of the countries where services are organized by catchment area in all parts of the country refer to having less than fairly good coordination. This suggests that the fragmentation of care may continue to be a serious problem in many countries.

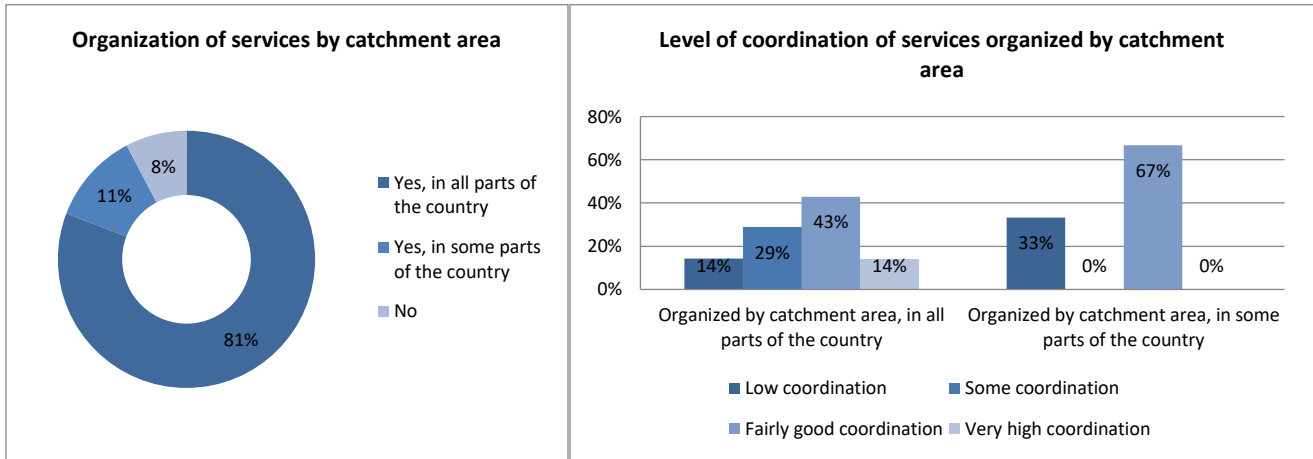


Figure 1

Figure 2

*Level of implementation of specialist mental health services in the community*

Many Member state representatives reported having significantly implemented specialist outpatient mental health services (77%). This was followed by the availability of community mental health teams (46%), 24 hours’ crisis care (42%), rehabilitation services and residential facilities (39%). Primary care liaison, early intervention and assertive outreach services were either not implemented or only implemented to a small extent (Fig.3). A more detailed analysis of the data shows that almost 23% of Member States had not implemented specialist outpatient mental health services and community mental health teams. If they had been implemented these services were very limited. In essence, a quarter of countries continue to have most, if not all, their mental health care based on institutional care.

While 77% of the countries have for the most part implemented specialist outpatient care, only 46% have significantly implemented community mental health teams. This strongly suggests that although most countries were able to develop ambulatory mental health care, in a significant number of cases this may not be carried out by multidisciplinary community-based teams. These teams are a fundamental part of a modern and effective mental health system, and this data indicates that there is still more to be done in transforming mental health care in the EU. There is an even wider gap for implementing liaison primary care services, as only 27% of the countries reported implementing these. The lack of these liaison services confirms the existence of a significant gap in the coordination between specialist and primary care services; a gap that will have a profound negative impact on the provision and quality of mental healthcare.

### Level of implementation of specialist mental health services in the community

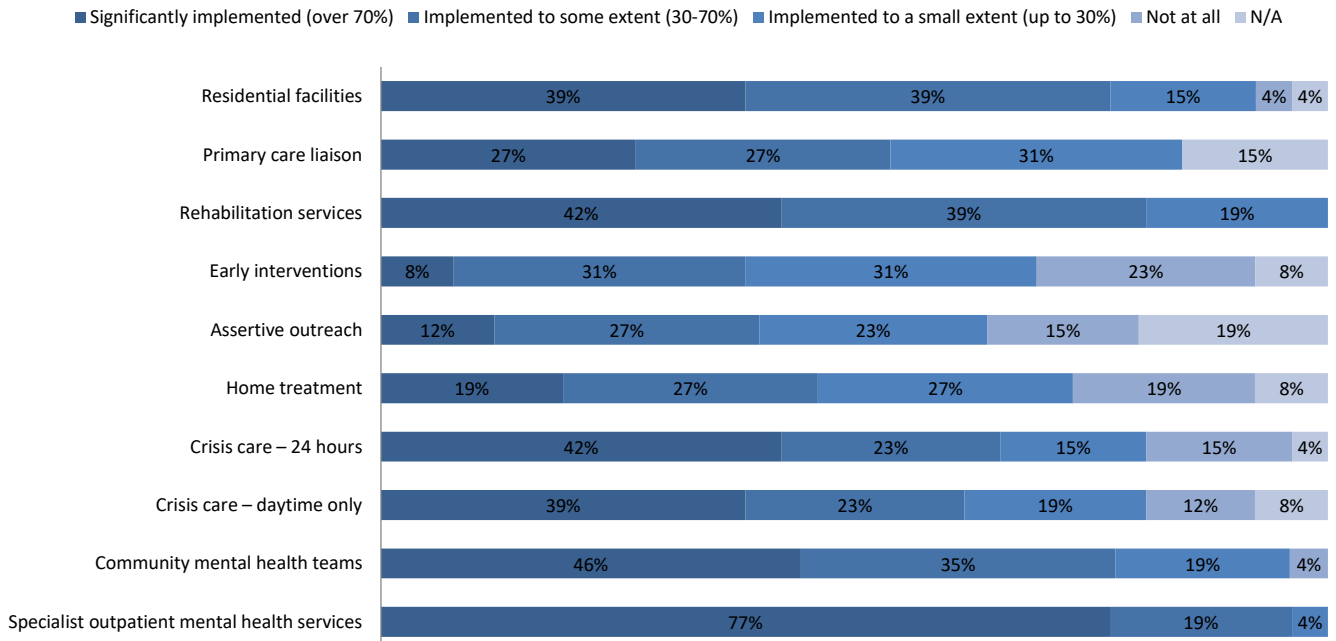


Figure 3

*Community Mental Health Centres*

Approximately half of Member State representatives were unable to provide information on the rate of Community Mental Health Centres (CMHC) available in their countries (Fig.4). The remaining other Member State representatives (with results ranging from 2014 to 2017) provided rates for the availability of CMHCs per 100.000 that ranged from 0,17 to 5,70.

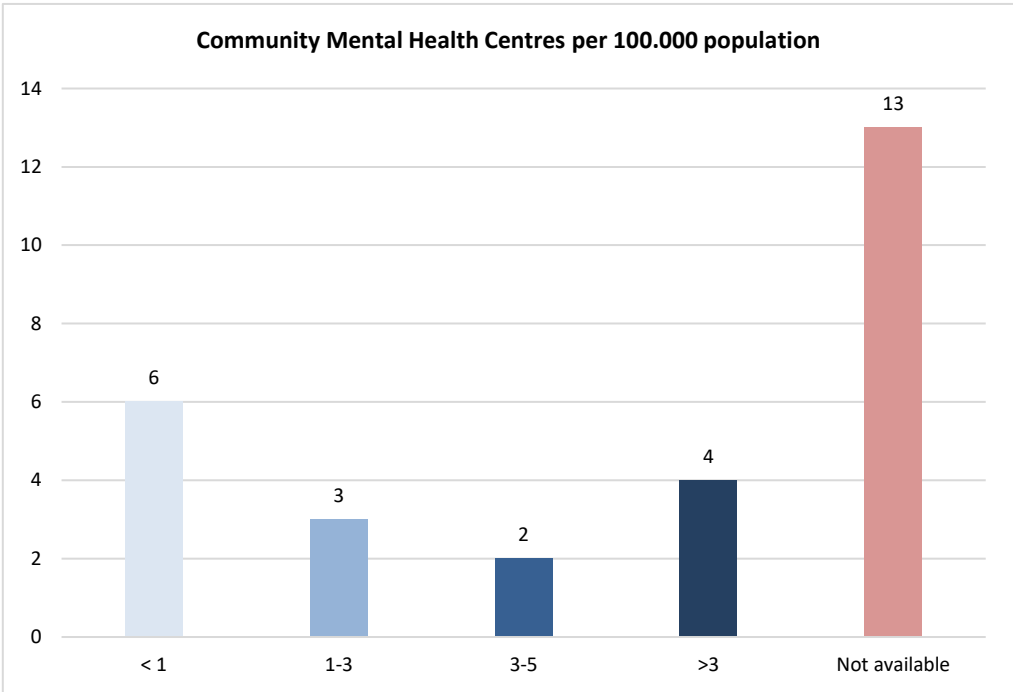


Figure 4

Country	Rate
Bulgaria	0,17
Turkey	0,20
Romania	0,38
Croatia	0,54
Hungary	1,20
Cyprus	2,84
Lithuania	4,00
France	8,20
Slovenia	0,20
Greece	0,49
Italy	3,84
Netherlands	5,70
Norway	2,9
Not available*	13

Table 1

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

The survey included questions about the annual rates of patients treated in CMHC. However, it was impossible to take consistent conclusions from the responses to these questions, as only 11 countries were able to report this information, and there are reasons to believe that the term of community mental health centre is used for quite diverse kinds of services. While in some countries mental health centres are community-based services that are responsible for providing all basic mental health care in a determined catchment area, including some beds, community mental teams, psychosocial rehabilitation programmes, mental health promotion and liaison with primary care, in other countries mental health centres only include outpatient care or even only promotion/prevention programmes.

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

Member State representatives reported that most patients with severe mental illness received routine follow-up in outpatient clinics in community-based psychiatric units, and outpatient clinics in mental health hospitals. By comparison fewer patients received follow-up care from home treatment or assertive outreach teams (Fig.5).

A more detailed analysis highlighted three important factors. First, in 16% of the countries mental health hospitals are still responsible for most or all follow-up care for the majority of patients discharged; and only 19% of the countries mental health hospitals have no other follow-up intervention. In other words, mental health hospitals have now lost their central role in the provision of ambulatory care in the majority of countries, but this has not occurred in all countries. Second, in 58% of the countries, the majority of patients now receive follow-up care in outpatient clinics in community-based psychiatric clinics. Third, home treatment and assertive outreach teams play a significant role only in a small number of countries.

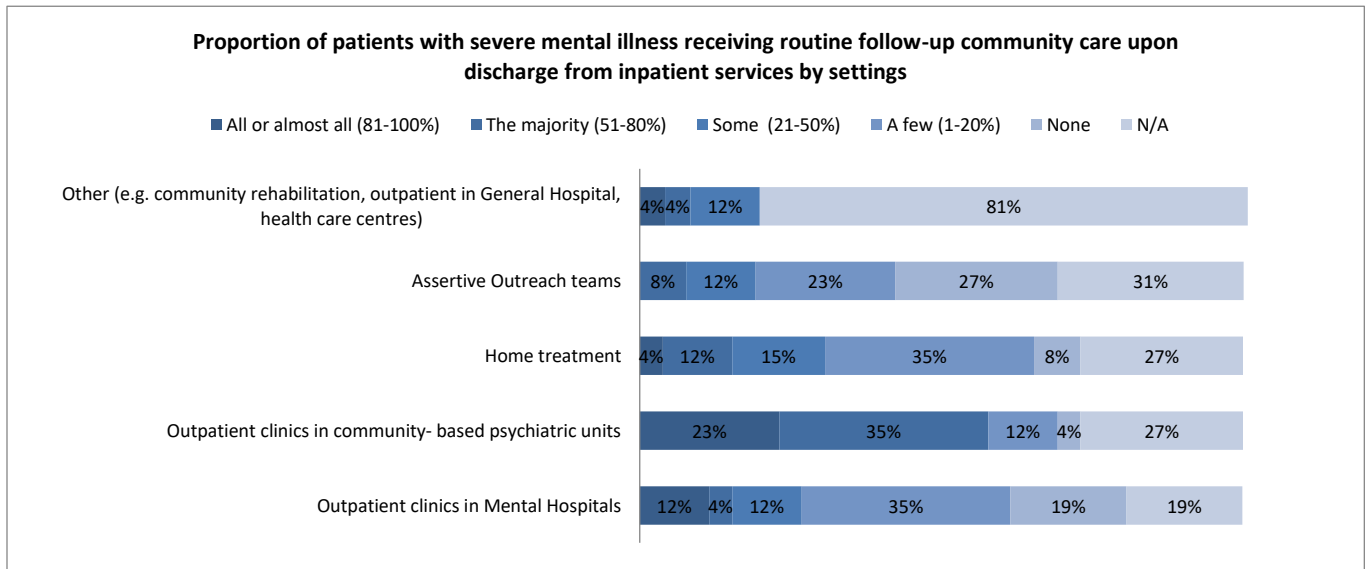


Figure 6

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

National data on the proportion of unemployed people who receive social welfare benefits or pensions because of disability due to mental health problems was available for only six countries — France, Germany, Netherlands, Slovakia, Slovenia, Spain (Table 2). Justifications for the lack of information on this issue for most of the countries ranged from “*There is no special calculation for unemployed people*” (Croatia) or “*Waiting for an answer from the Ministry of Labour and Social Justice*” (Romania), to “*Not collected in the health sector*” (Italy).

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

Table 2



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

Figure 6 shows the extent of implementation of the recommendations to provide community-based mental health services as reported by the Member States' representatives. A great proportion of the recommendations were reported to **have been implemented before 2015**, such as to:

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

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

- Develop and update mental health policies and legislation;
- Ensure that community psychosocial support is available for people with severe mental disorders;
- Promote the social inclusion of people with long-term mental disorders;
- Ensure quality of care improvement and the protection of human rights across all parts of the system;
- Promote the active involvement of users and carers in the delivery, planning and reorganisation of services;
- Develop self-help and users and carer groups.

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

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

Overall, most countries have undertaken the basic transformation needed towards the transition from psychiatric hospitals to community-based care; many of which started before 2015. In the last few years, the areas of interest for countries have shifted to updating policies and legislation, ensuring better quality of care, promoting social inclusion and more involvement of users and carers.

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

rather than something that is replacing these institutions in a well-coordinated way.

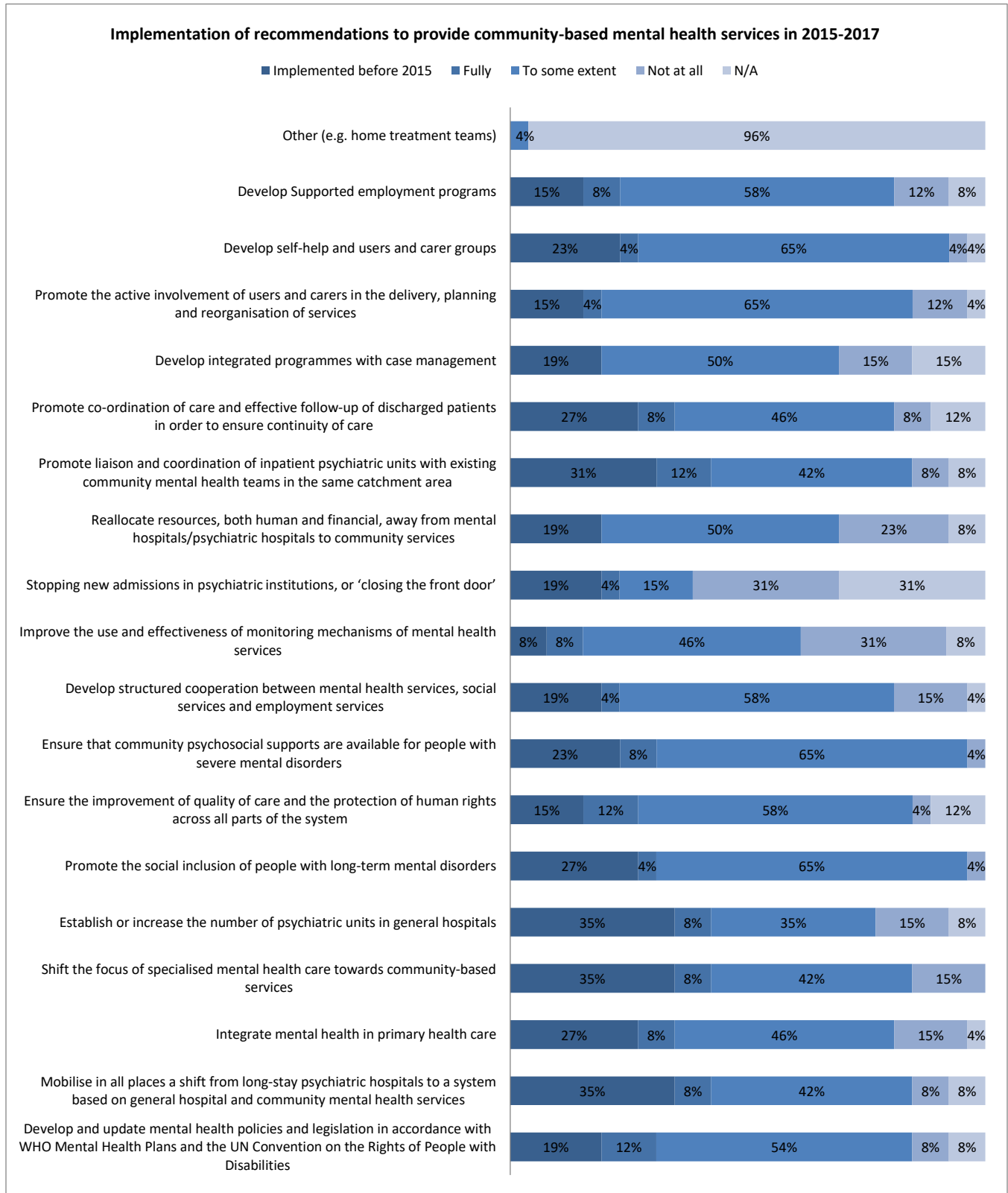


Figure 6

*Further comments regarding the implementation of the recommendations mentioned above:*

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

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

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

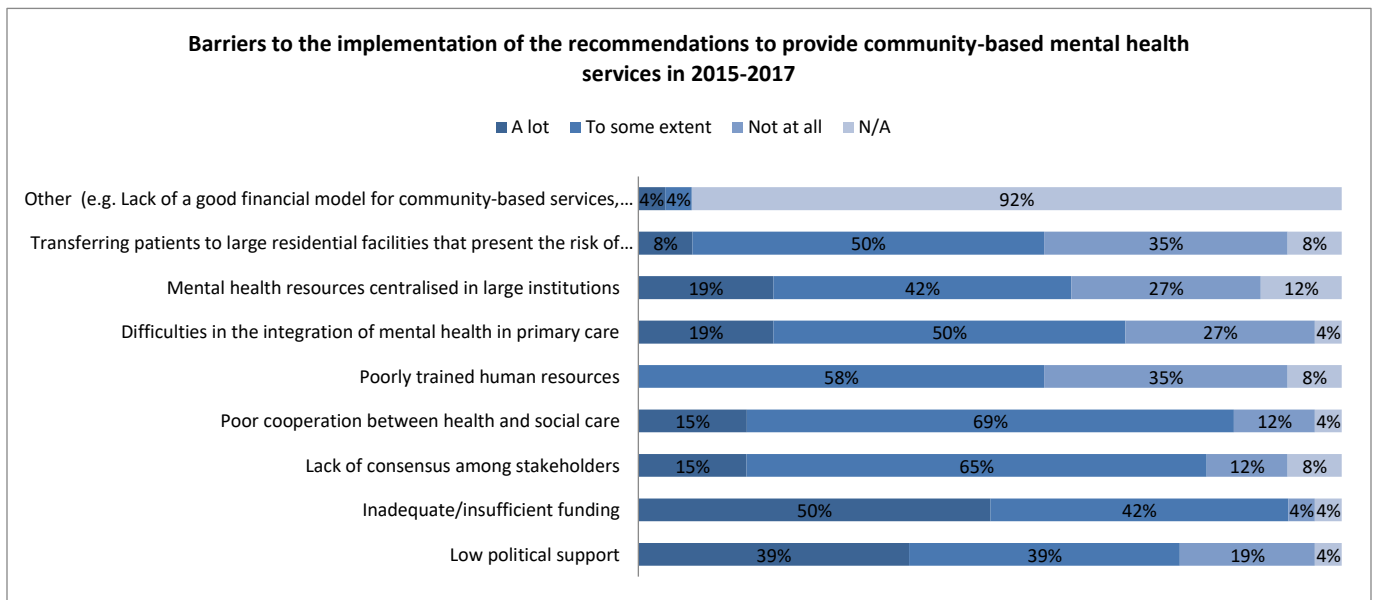


Figure 7

### 3.2. DEVELOPING INTEGRATED GOVERNANCE APPROACHES

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

When analysing responses<sup>4</sup> to the question of how mental health (MH) is taken into account outside of the Health Sector, (i.e. with the aim of identifying how mental health concerns are integrated in other policies), many barriers are reported (Fig.8). The main one is low political support in developing policy, but this is even more so in effectively implementing the policies designed for MH or MHiAP. This is also formulated in terms of *not being a priority* or remaining in a theoretical plan, which is further hampered by a corresponding lack of funding mentioned by four countries. One clarifying quote comes from Bulgaria: “Mental health problems are not among the priorities of non-health sectors' policies as well as for the health sector. There is no special interest to reform the existing institutional model of mental health care which reflects the attitudes in the non-medical sector.”

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

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<sup>4</sup> To see full responses from participating countries please see the *Annual Activity Reports of Member States And Stakeholders (D2 2018)*, available on the EU Compass website.

Fifteen countries mentioned having policy and specific plans addressing MH issues and ten have programmes to put them in practice (or are designing programmes to put them in practice in the future). These plans are mostly targeted, but there are also countries addressing MH problems in a universal way, (i.e. developing political measures to promote better MH for everyone). Austria is one of these countries: “In 2016 and 2017 the Austrian national health target #9 ‘To promote psychosocial health in all population groups’ has been elaborated by an intersectional and multidisciplinary workgroup following a mental health in all policies approach (more than 40 institutions/organizations were involved). Three strategic aims and a bundle of actions shall contribute to enhance mental health promotion, prevention, support, treatment and anti-stigma work. The 10 Austrian health targets were developed with the aim to prolong the healthy life years of all people living in Austria in the coming 20 years (until 2032), irrespective of their level of education, income or personal living condition.” Overall, many answers are more focused in specific-health measures than in integrating MH in other policies.

As for the geographical significance of these policies, some of the responses mentioned not only a national focus but also regional implementation or the development of mental health measures and even responsibility. Finally, we would like to draw attention to the small number of country representatives mentioning data collection for specific mental health indicators. We cannot conclude that there are not more countries doing this information collection, only that this was not mentioned more frequently among the Member States as a way of supporting the assumption of mental health as a priority. The lack of specific data on mental health has already been reported, for example, the rate of Community Mental Health Centres. Please see the Fig. 8 below for more information:

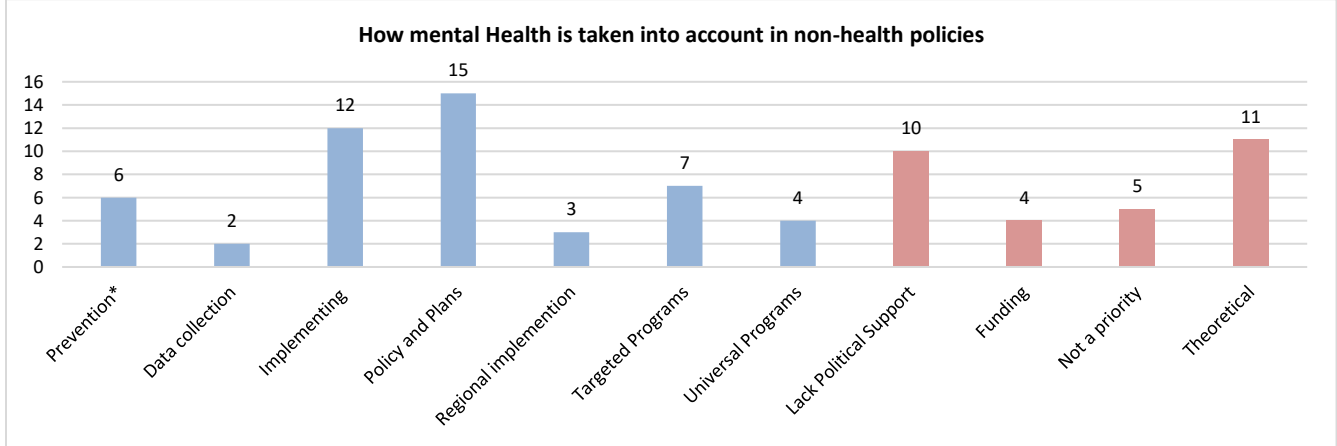


Figure 8

\*namely Awareness Campaigns or Training

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

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

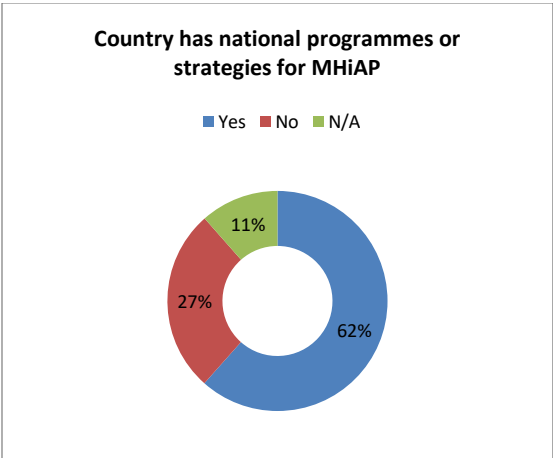


Figure 9

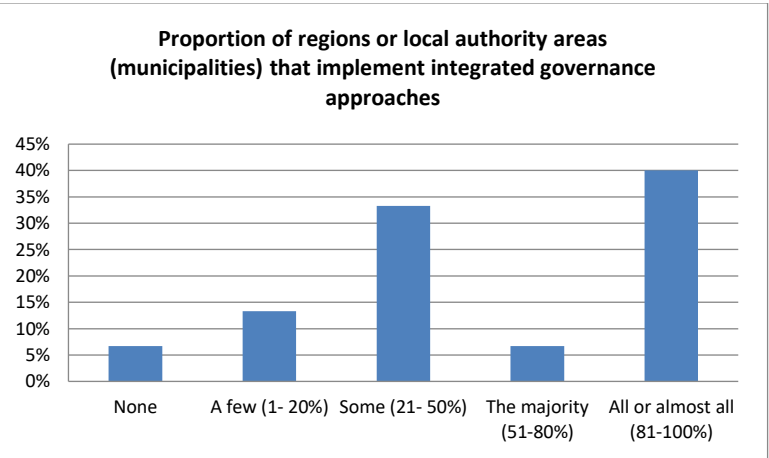


Figure 10

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

*Further description of these programmes*

When asked to describe further what these programmes entailed<sup>5</sup>, the range and diversity of answers is evident. The wide variety of responses meant that countries might be looking for solutions depending on their specific national and local contexts. Nevertheless, ten representatives mentioned types of intersectionality, be it in terms of inter-ministry coordination or non-governmental coordination between institutions from different sectors. Seven gave examples of targeted programmes (mostly in schools and in the workplace)<sup>6</sup>, and six reported official involvement of non-health actors in governing mental health issues.

<sup>5</sup> To see full countries’ responses please consult the *Annual Activity Reports of Member States And Stakeholders (D2 2018)*, available at the EU Compass website.

<sup>6</sup> Like in Slovakia: “programme Zippy's friends- for children, psychoeducation's programmes, Days of mental health days of "forget-me-not"”.

It is important to emphasize the small number of countries’ representatives mentioning the involvement of users and families in the design of the programmes or in governance initiatives, such as mental health committees in Belgium: “Catchment areas are governed by committees, including partners from non-health sectors and representation of patients and their families.”

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

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

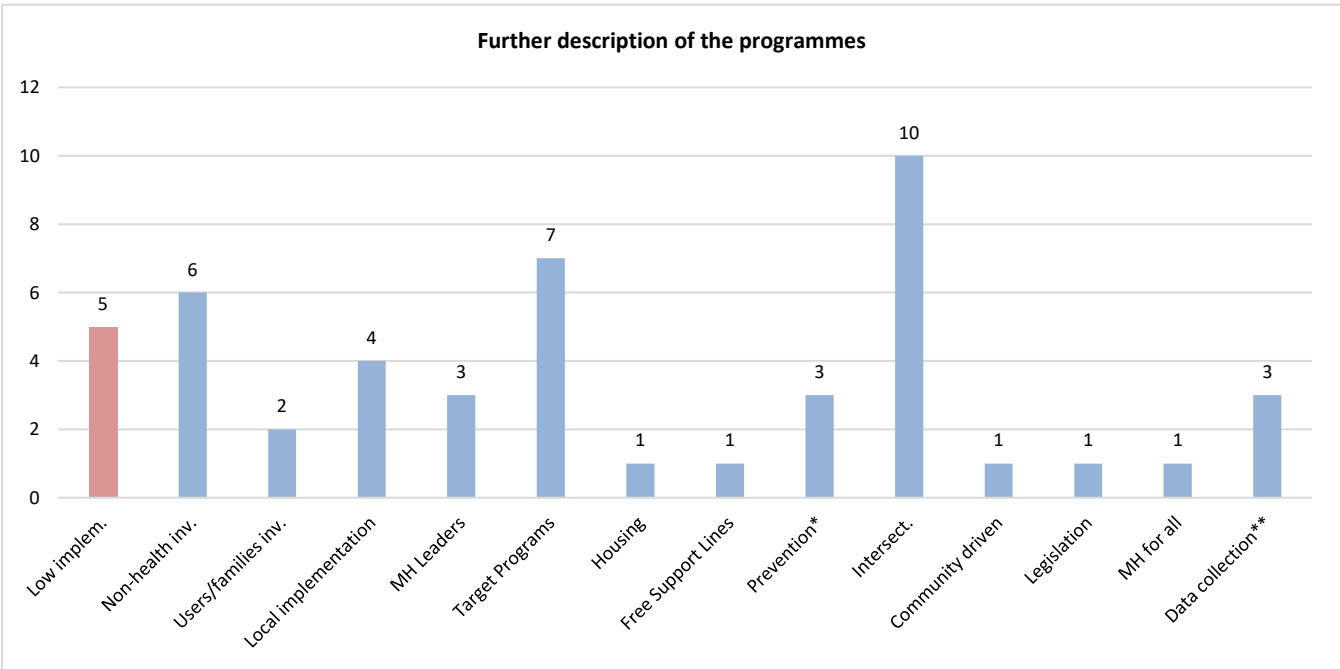


Figure 11

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

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

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

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

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

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

Further information can be found in figure 12.

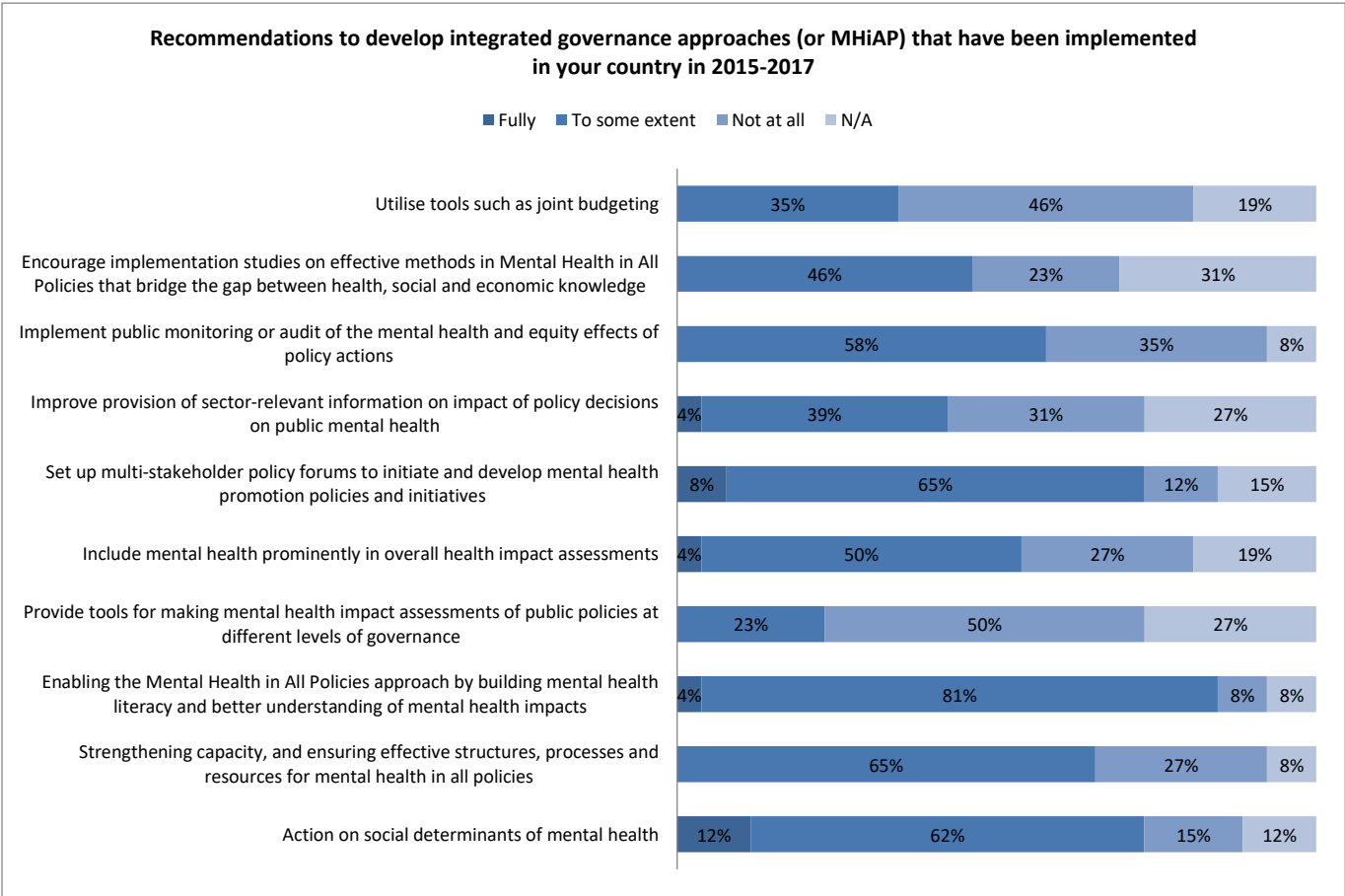


Figure 12



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

Figure 13 shows the main barriers to implementing the recommendations to develop integrated governance approaches as reported by Member State representatives. The main barriers that impacted to some extent or a lot in term of this implementation included:

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

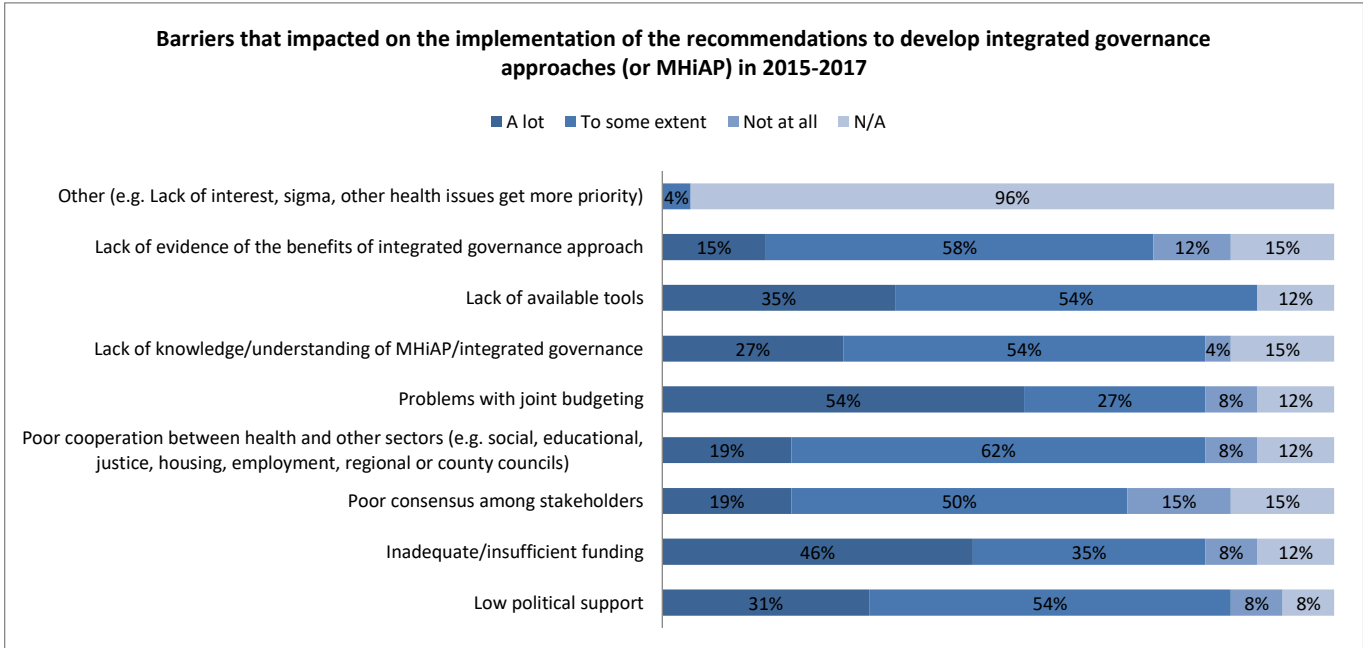


Figure 13

### 3.3. FURTHER INFORMATION REGARDING DEVELOPING INTEGRATED GOVERNANCE APPROACHES (OR MHIAP)

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

Most of the country representatives declared there was no evidence concerning the financial benefits of developing a Mental Health in All Policies approach (which may account for its low implementation rate). (N.A. accounts for “Information not available” (Fig.14)). Also, five countries did not answer this question, hence the total number of answers were 21. However, of the countries that had recognised the evidence of the financial benefits for this approach, the UK and Norway provided information on research in this area (find these countries reports in the *Annual Activity Reports of Member States and Stakeholders (D2 2018)*, available at the EU Compass website).

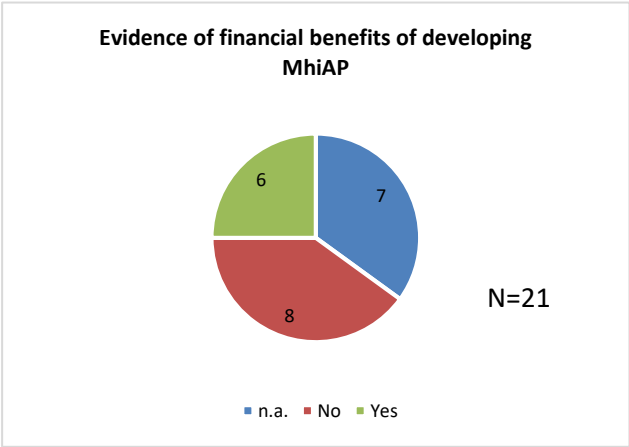


Figure 14

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

Mental Health in All Policies is mostly funded at the National or Regional/Federal levels. The “Various” categories include: National Insurance Fund; Inter-Departmental; national lottery, international funding (e.g. EU); donations, etc. Of note is that three countries mentioned not having funding for MHIAP. Please find more information below in Fig 15:

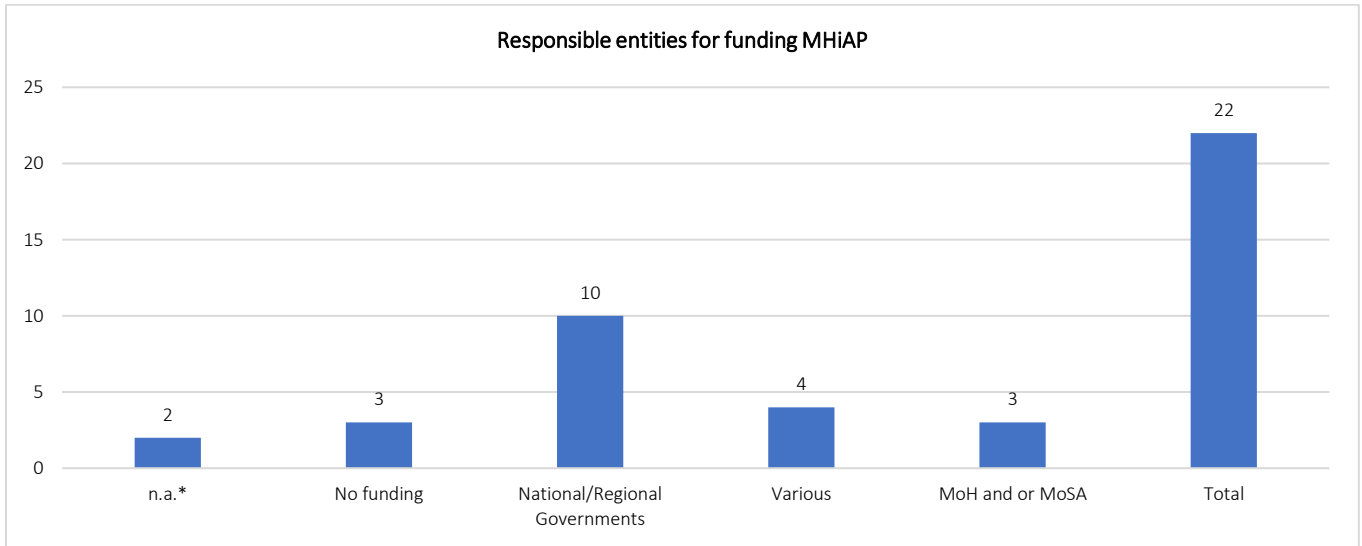


Figure 15

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

### *Responsible entities for implementing integrated governance approaches to mental health*

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

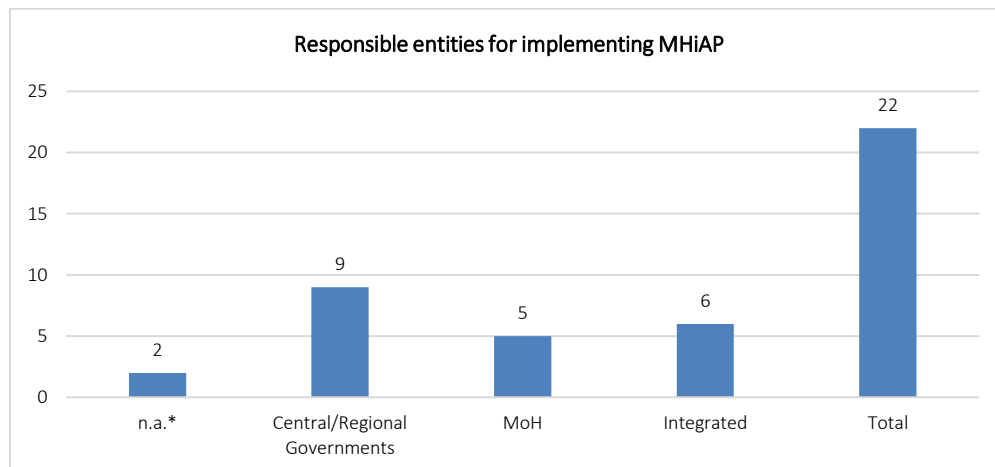


Figure 16

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

### Sectors and professionals involved

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

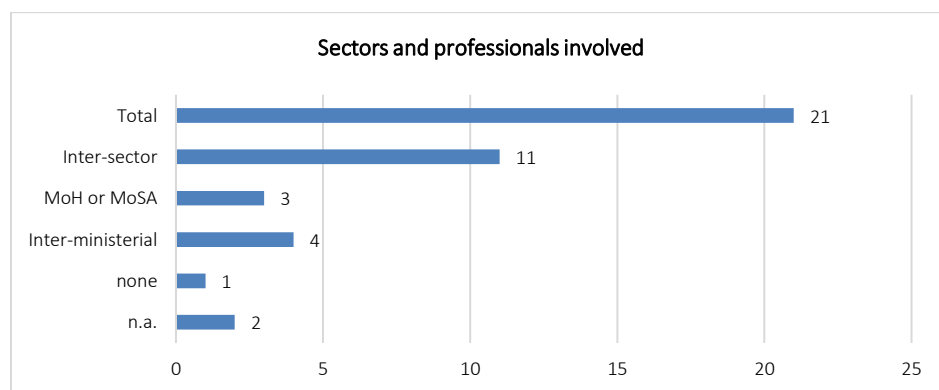


Figure 17

*Focus on targeted or universal approaches*

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

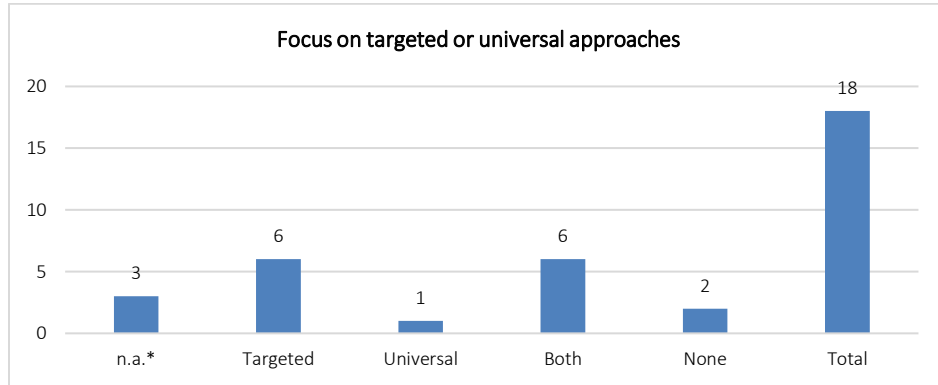


Figure 108

*\*Includes "having no information on this"*

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

Finally, most of the Member State representatives reported citizen or public involvement in implementing integrated governance approaches to mental health in their countries (Fig. 19). Only four countries reported that this involvement does not exist, and five others did not provide information regarding on this issue.

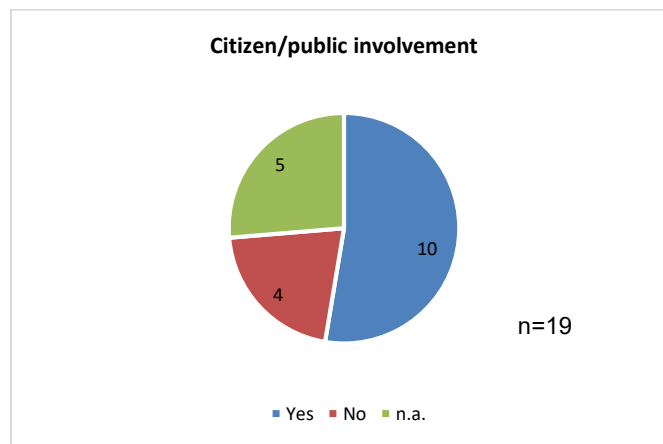


Figure 19

## 4. KEY DEVELOPMENTS BY STAKEHOLDERS

### 4.1. INFORMATION ABOUT THE STAKEHOLDERS' ORGANIZATIONS

#### *Status and Sector*

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

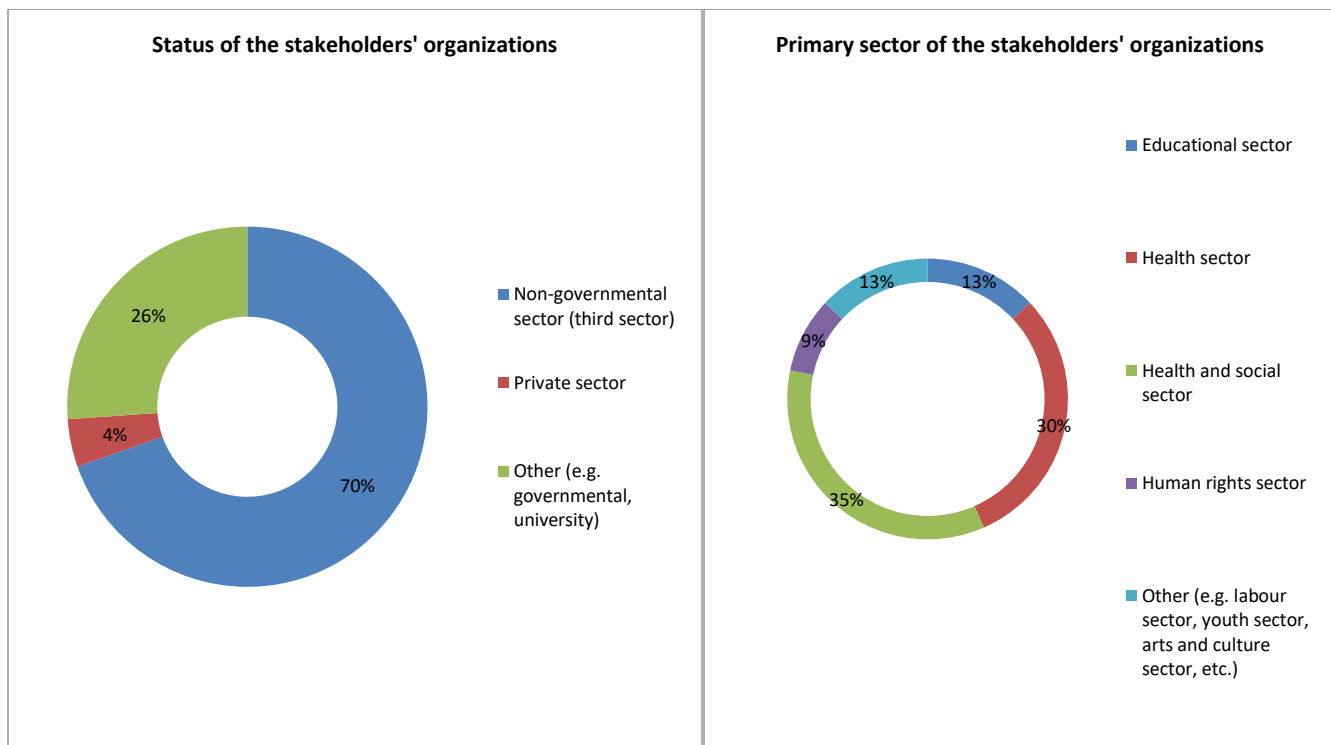


Figure 20

Figure 21

*Basic information about the organisations*

When asked to further describe their organization, many stakeholder respondents mentioned activities relating to gathering data on mental health issues, as well as doing formal research. The two most frequently mentioned themes were education and being a network of stakeholders or organizations. Improving quality of life was another important theme, not just in relation to mental health but also with a focus on physical health (two of the organizations were representatives of physiotherapists specialising in mental health issues). Finally, working as advocates either promoting mental wellbeing, reducing stigma or to influence policy were other areas of work organizations shared with us (Fig. 22).

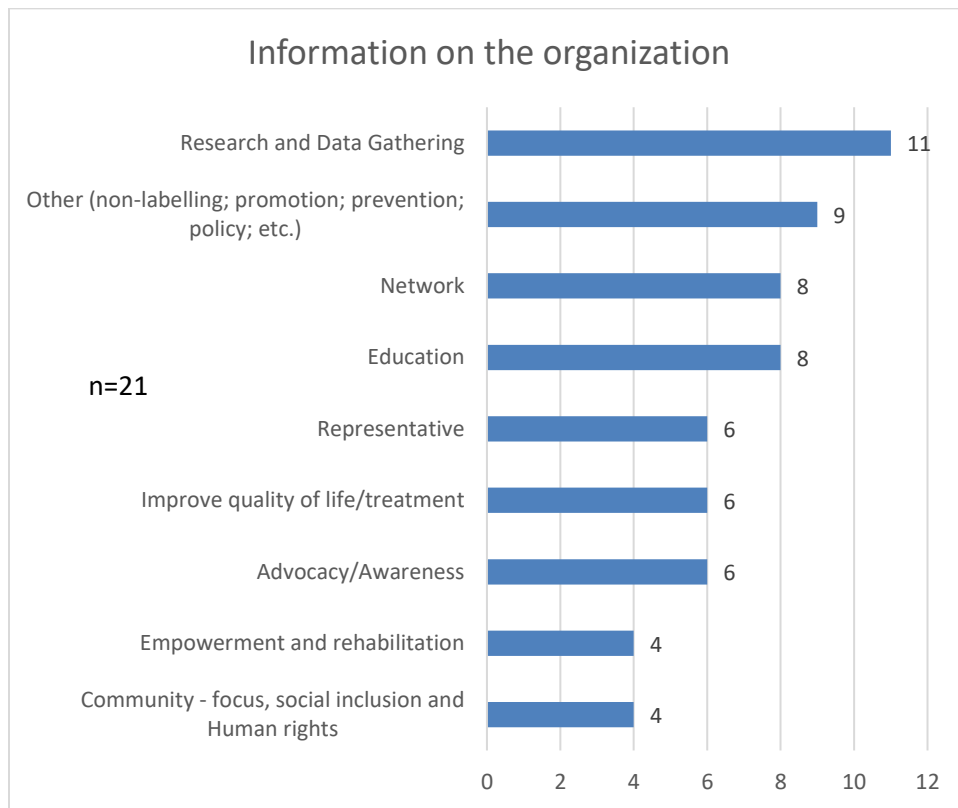


Figure 22

## 4.2. STAKEHOLDERS' ACTIONS IN MENTAL HEALTH IN 2017

### *Reasons why the organizations work on mental health*

Participating stakeholders provided written information on the reasons why they acted on mental health during 2017. The main reasons were to promote health, to provide care, to support research and/or training and to promote advocacy. However, nine out of the 24 respondents did not provide information on this.

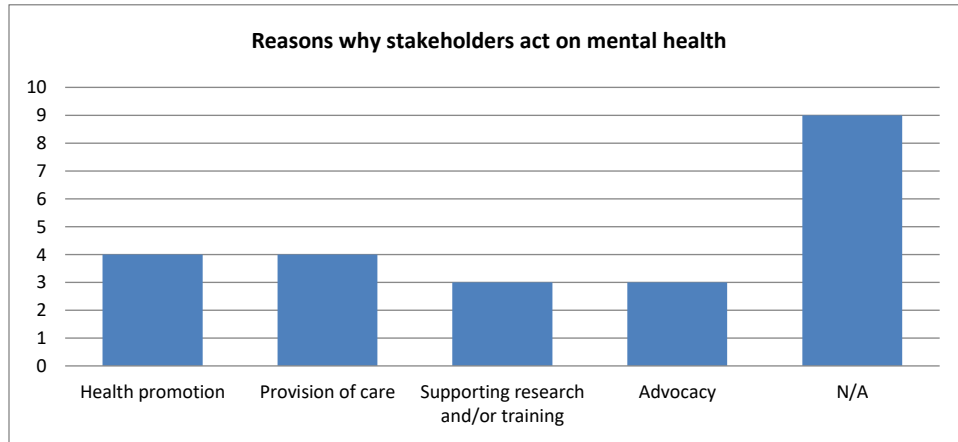


Figure 23

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

Around half of the stakeholder responses noted mental health as the main goal of their organizations' work and 13% stated that mental health is one of their core objectives of their work; although, 39% did not provide information on this.

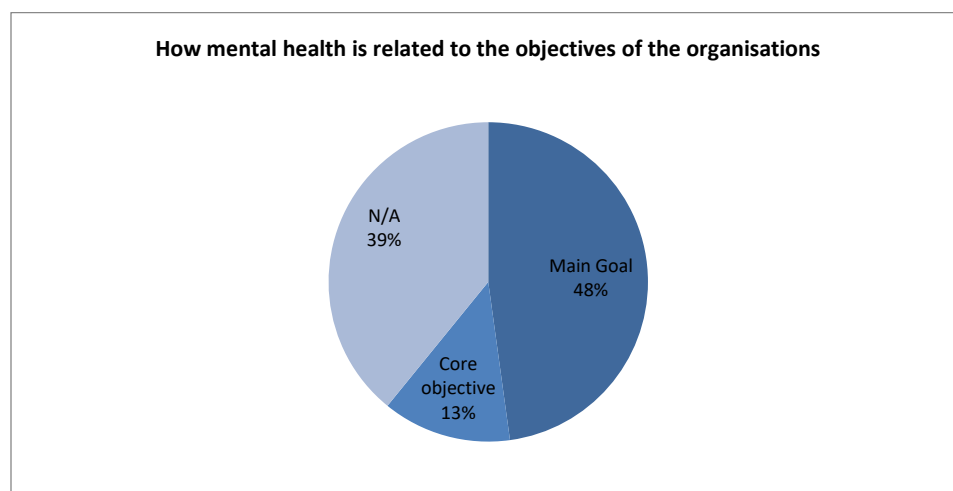


Figure 24



*The key mental health activities of the organisations*

The key mental health activities developed in 2017 as reported by the responding stakeholders were: training, endorsing advocacy and raising awareness, providing care, performing research and dissemination, acting on prevention and promotion, and establishing collaborations and networking (Fig. 25).

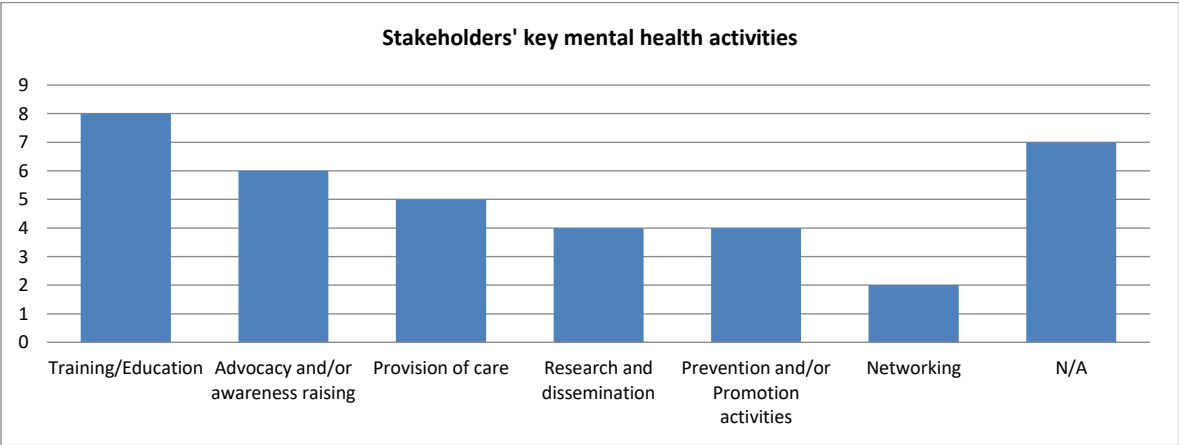


Figure 25

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

Figure 26 shows the main partners that collaborated with the stakeholders' organizations with regards to the actions on mental health implemented during 2017. Non-governmental organizations (e.g. national and international associations and foundations) and academia (e.g. universities and research centres) were the most frequently reported key partners. Moreover, four organizations worked in close collaboration with professionals and users, three organizations reported partnerships with county councils and municipalities, two with health services (e.g. hospitals and health centres), and a further two others reported the involvement of policy makers and socio-cultural centres.

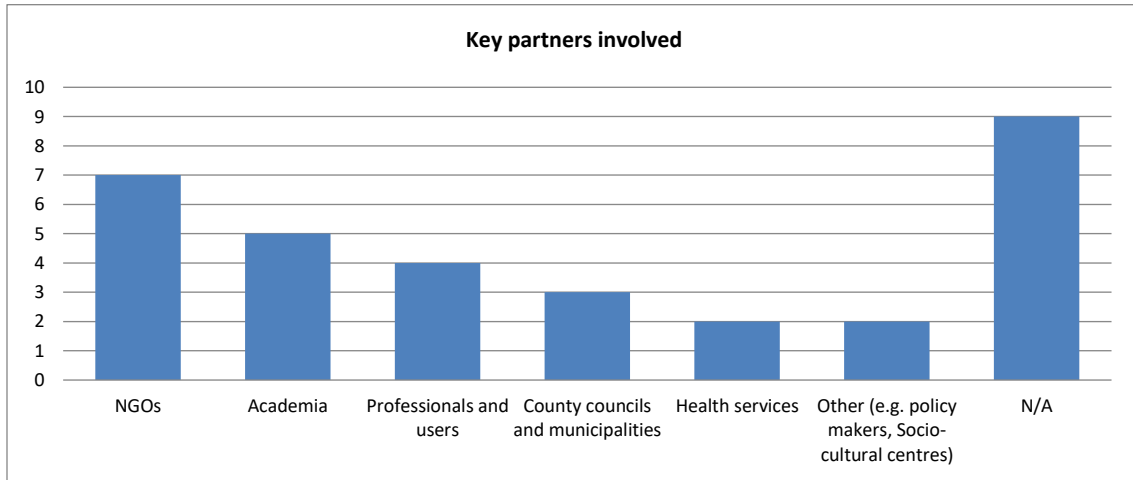


Figure 26

### Organization's target group

The main target of these organizations is what we termed “target beneficiaries” given the diversity of organizations responding to the survey. These included older people with psychosocial disabilities, people with physical illnesses, particularly cancer patients, or young people between 11-35 years. The second major target group were mental health professionals, which included not only *health professionals* but also other mental health experts, whether in social work or education. The “Other” category included many important groups, such as families and the general public (Fig. 27).

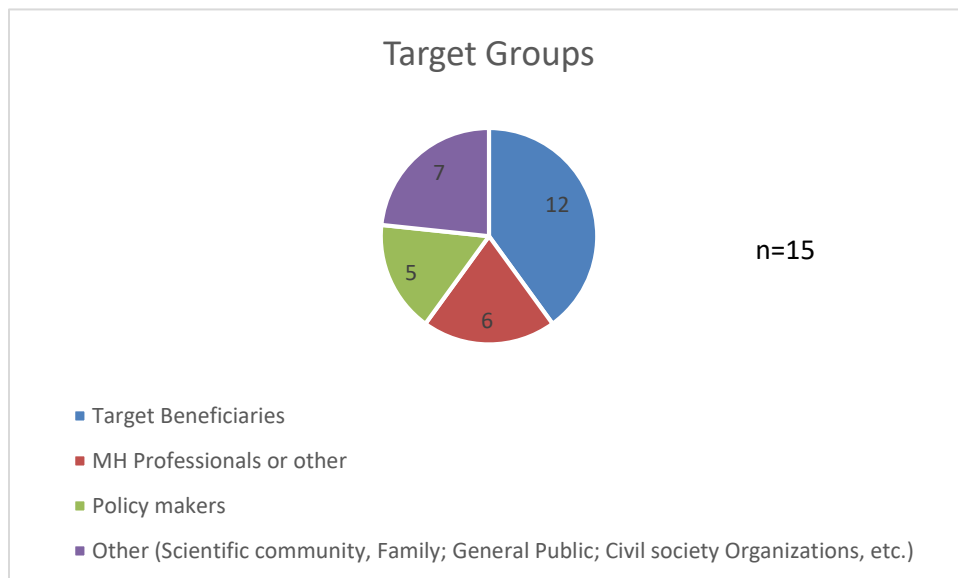


Figure 27

*Resources available for the organizations' work*

In terms of the resources available for the stakeholders' organizations to perform their work, the majority raised their own through research grants, the services they provided or via funded projects. Some had volunteers to support their work (Fig. 28).



Figure 28

*Strengths of the organizations' activities*

As described above the main strength highlighted by the stakeholders' organizations included the collection of data on mental health. This was followed by characteristics linked to accumulated work experience and integrating/involving users, clients or beneficiaries of the organization's activities in numerous activities, and not solely as recipients of their support (Fig. 29).

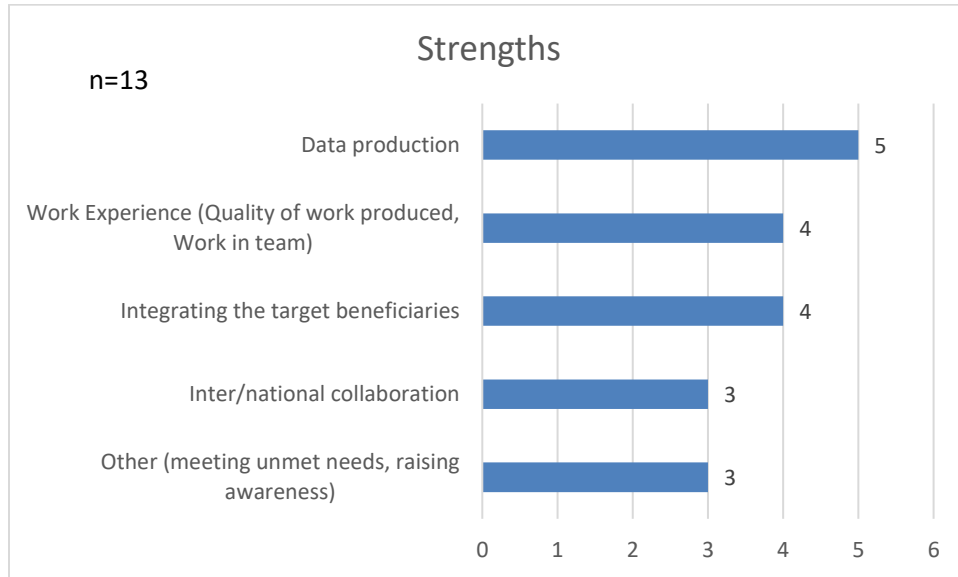


Figure 29

### Challenges encountered

The main challenges stakeholder representatives faced are the lack of funding and organizational challenges, such as the lack of human resources. Stigma was a challenge for three stakeholder respondents (Fig 30).

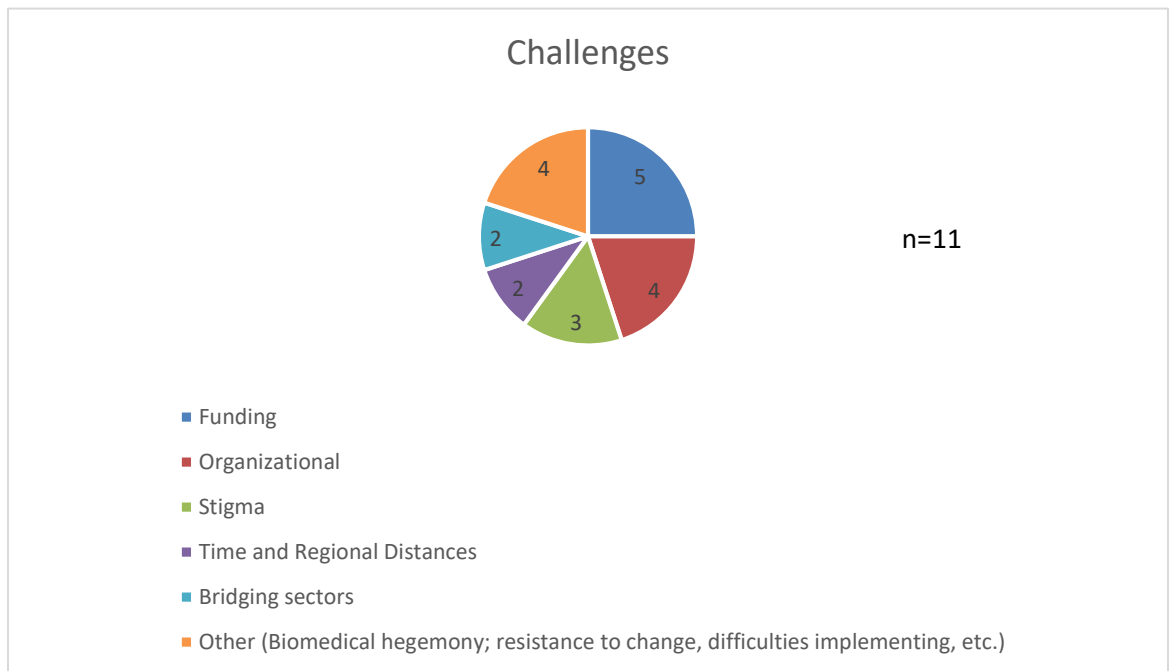


Figure 30

*Evaluation of activities*

As for the evaluation of the stakeholders' activities, the majority of stakeholders (6) answered 'yes' to this question. Four were evaluated through academic evaluations (e.g. research programmes); and the remaining two stakeholders reported evaluating their organizations work through impact assessments and feedback of their activities (Fig 31).

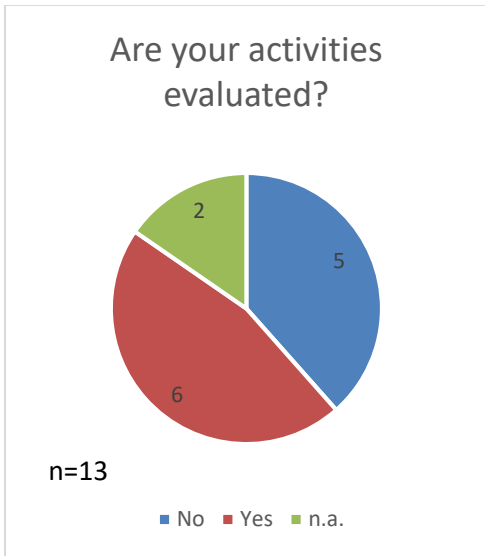


Figure 31

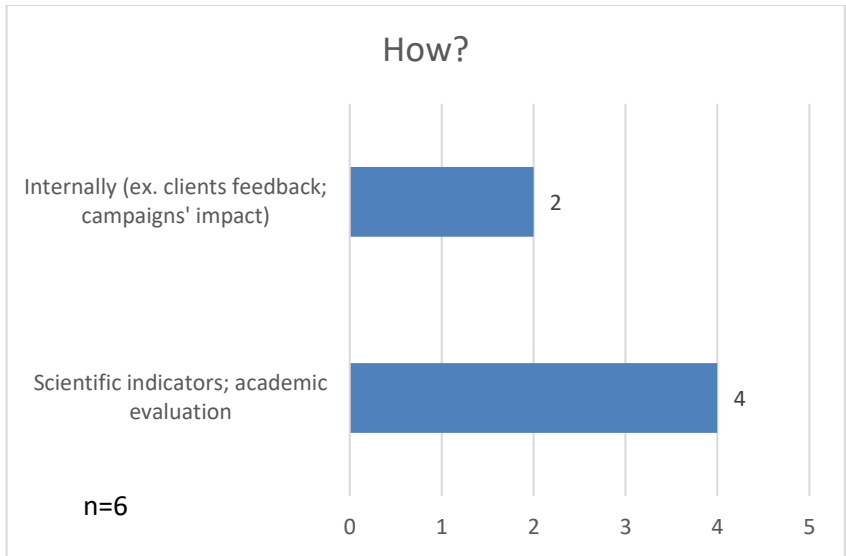


Figure 32

## 5. FINDINGS AND INNOVATIVE PRACTICES IN COMMUNITY MENTAL HEALTH CARE

As the EU Joint Action Report on the Transition to Community Care showed, community care is associated with promoting recovery (living a full and contributing life in spite of the challenges presented by mental ill health), continuity of care, greater user satisfaction, increased adherence to treatment, better protection of human rights, and the prevention of stigmatization. It also contributes to improved access to services, enables people with mental disorders to live in the community as participating citizens, maintain family relationships, friendships, and employment while receiving treatment; so facilitating early treatment and psychosocial rehabilitation<sup>7</sup>. For this reason, according to the WHO mental health care pyramid<sup>89</sup>, specialist community mental health services are a core component of mental health systems. They are also important for ensuring good coordination with general hospital inpatient units and fundamental to specialized responses to the mental health care needs of a population.

The literature review carried out by the EU Compass position paper<sup>10</sup> on “Providing community-based mental health services” (see Annexes) confirmed these benefits, and showed that, when compared with traditional hospital-based services, community mental health teams (CMHT’s) are associated with lower admission rates, better quality of care, and increased service user satisfaction.

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

In relation to mental health in primary care, the Liaison Primary Care and the Collaborative Care models, created to overcome the insufficiencies usually found in the coordination of care between primary care and specialist mental health services, are associated with improved patient satisfaction and treatment adherence. Furthermore, all the available evidence to date showed that the collaborative care model is clearly superior to

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<sup>7</sup> Caldas Almeida JM, Mateus P, Tomé G (2015). Joint Action on Mental Health and Wellbeing Situation Analysis and Policy Recommendations in Community-Based approaches to Mental Health, European Commission. Retrieved on 31 Oct 2017 from: <http://www.mentalhealthandwellbeing.eu/publications>.

<sup>8</sup> World Health Organisation (2003). Organization of mental health services. Geneva: World Health Organisation.

<sup>9</sup> World Health Organisation (2007). The optimal mix of services. Ment Heal Policy, Plan Serv Dev Inf Sheet. 2007; 1–6. [http://www.who.int/mental\\_health/policy/services/2\\_Optimal Mix of Services\\_Infosheet.pdf](http://www.who.int/mental_health/policy/services/2_Optimal Mix of Services_Infosheet.pdf)

<sup>10</sup> Killaspy H, McPherson P, Samele C, Keet R, Caldas de Almeida JM (2018). Community-Based Mental Health Services. EU Compass for Mental Health and Wellbeing. European Commission.

standard care in the treatment of common mental disorders, such as depression and anxiety. This means that strategies to decrease the huge gap found in the treatment of common mental disorders must consider scaling up collaborative care.

Specialist community mental health teams, such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM) have been associated with reduced hospitalizations, increased patient engagement and improved social functioning. It is important to note that the effectiveness of these more intensive and systematic interventions appears to be dependent on the context within which they operate. More recent studies suggested that their effectiveness is less evident when standard community services are well developed and well resourced.

Early intervention services (EIS) prove that it is possible to ameliorate the individual and economic consequences of psychotic illness through the early identification of individuals at high-risk of developing psychosis, or those in the early stages of the illness. There is evidence to support the use of various alternatives to inpatient treatment, for example, crisis outreach and intervention in the community, day centres/hospitals and short-term residential crisis houses.

Where vocational interventions are concerned, Individual Placement and Support (IPS) outperformed standard vocational services across all vocational outcomes and in some non-vocational outcomes, such as quality of life and occupational engagement.

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

All these advances have contributed to the development of a large set of innovative community-based mental health care practices that have diversified and improved the quality of care in Europe over the last decade. Examples of these innovative practices in various domains — e.g. collaborative care, integrated programmes based on case management and assertive community approaches, mobile teams, peer support, Individual placement and support programmes, deinstitutionalization strategies, among others — have been described in

the EU Joint Action Report on Community Care<sup>11</sup> as well as in the previous EU Compass Annual Reports<sup>1213</sup>, the EU Compass Position Papers on Access to Care<sup>14</sup> and Community-Based Mental Health Services<sup>15</sup>, and in the EU Compass Good Practices in Mental Health and Wellbeing Booklet<sup>16</sup>.

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

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

Significant progress was made in several countries in the development of national mental health strategies. In the last quarter of 2017, France was working onto develop a new National Health Strategy, which includes an official national mental health strategy, and in Bulgaria a new version of the National Mental Health Programme and Plan of Action for the next 6 year period was also under preparation. In Iceland, the Mental Health Policy

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<sup>11</sup> Caldas Almeida JM, Mateus P, Tomé G (2015). Joint Action on Mental Health and Wellbeing Situation Analysis and Policy Recommendations in Community-Based approaches to Mental Health, European Commission. Retrieved on 31 Oct 2017 from: <http://www.mentalhealthandwellbeing.eu/publications>.

<sup>12</sup> Caldas de Almeida JM, Mateus P, Frasilho D, Parkkonen J. (2016). EU Compass For Action on Mental Health And Wellbeing: Annual Report 2015: Summary and analysis of key developments in member states and stakeholders. European Commission. Available in: [https://ec.europa.eu/health/sites/health/files/mental\\_health/docs/2016\\_compassreport\\_en.pdf](https://ec.europa.eu/health/sites/health/files/mental_health/docs/2016_compassreport_en.pdf)

<sup>13</sup> Caldas de Almeida JM, Mateus P, Frasilho D, Antunes A, Parkkonen J. (2017). EU Compass For Action on Mental Health And Wellbeing: Annual Report 2016: Summary and analysis of key developments in member states and stakeholders. European Commission. Available in: [https://ec.europa.eu/health/sites/health/files/mental\\_health/docs/2017\\_compass\\_activityreport\\_en.pdf](https://ec.europa.eu/health/sites/health/files/mental_health/docs/2017_compass_activityreport_en.pdf)

<sup>14</sup> Barbato A, Vallarino M, Rapisarda F, Lora A, Caldas de Almeida JM (2016). Access to mental health care in Europe. EU Compass for Mental Health and Wellbeing. European Commission. Available at: [https://ec.europa.eu/health/sites/health/files/mental\\_health/docs/ev\\_20161006\\_co02\\_en.pdf](https://ec.europa.eu/health/sites/health/files/mental_health/docs/ev_20161006_co02_en.pdf).

<sup>15</sup> Killaspy H, McPherson P, Samele C, Keet R, Caldas de Almeida JM (2018). Providing Community-Based Mental Health Services. EU Compass for Mental Health and Wellbeing. European Commission.

<sup>16</sup> Available at: [https://ec.europa.eu/health/sites/health/files/mental\\_health/docs/2017\\_mh\\_work\\_schools\\_en.pdf](https://ec.europa.eu/health/sites/health/files/mental_health/docs/2017_mh_work_schools_en.pdf)



and Action Plan (2016-2020) has been actively implemented and monitored. In Norway, a national strategy for Mental Health, with a focus on children and youth and mental health in all policies was launched in August 2017. In Ireland, a review of Mental Health Policy 'A Vision for Change' is underway, and a National Youth Mental Health Task Force was established and has completed its work.

In Slovakia, a new Programme for Mental Health was created with the involvement of cross-sectoral partners, and in October 2017 the Ministry of Health launched a new working group for the drafting of a National Mental Health Program. In Sweden, the Government allocated 170 million euros to support the mental health national strategy for the period 2016-2020.

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

In Hungary, the government increased its financing of community mental health services, as part of social service provision, committed to the deinstitutionalization of five long-term care institutions, and launched, with EU funds, a supported living programme with home-care services. In the Netherlands, a report on the state of mental healthcare in the country was published, a national approach to solve waiting lists in mental healthcare has been launched, and an independent research institute published a report about the state of the deinstitutionalization in the mental healthcare sector.

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

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

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

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

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

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

Finally, some advances took place in the use of new information technologies: for instance, Bulgaria reported a new on-line portal for people who feel suicidal and an educational internet platform for General practitioners in the field of mental health; and in Finland the availability of digital mental health services has significantly improved.

Overall, we can say that some progress towards the policy objectives of the Joint Action on Mental Health and Wellbeing were made in 2017, particularly in the updating and implementation of national mental health strategies, the development of new services, the launching of new promotion and prevention programmes, and the adoption of mental health in all policies approach. These advances, however, did not occur in a homogeneous way. On one hand, in some areas (for instance, in monitoring and development of information systems, improvement of quality of care, development of e-mental health) little or no progress has been made. On the other hand, while some countries reported initiatives that denote an effort to systematically implement

a coherent mental health policy aligned with the Joint Action recommendations, others reported that in 2017 little or nothing had been done with this purpose.

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

The results of the survey show that the basic transformations that occurred in the EU in the transition from institutional to community-based care occurred before 2015, in fact long before that date in many countries. These transformations consisted mostly in the development of specialist outpatient mental health care in the community, provision of inpatient treatment in psychiatric units of general hospitals, improvement of quality of care in the existing mental hospitals, and organization of mental health services in catchment areas. All this represented a huge advance in terms of access to care, quality of care and continuity of care. However, it is important to note that, although most countries (76%) have significantly implemented outpatient care, only 46% were able to develop ambulatory mental health care carried out by multidisciplinary community-based teams. If we consider these teams are a core component of a modern and effective mental health system, we have to conclude that a lot has yet to be done in the transformation of mental health care in the EU.

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

Mental hospitals have certainly lost a central role in the provision of mental health care in many EU countries. Yet, almost 23% of the countries have not implemented at all or have only implemented to a small extent both specialist outpatient mental health services and community mental health teams, which means that a quarter of the countries still concentrate all mental health care on institutional care. Moreover, although in 58% of the countries the majority of patients now receive follow-up care in outpatient clinics in community-based psychiatric clinics, the truth is that community mental health teams continue to be underdeveloped in more than half of the countries, and other effective interventions (e.g. home treatment and assertive outreach teams) have a significant role only in a small number of countries.

As mentioned before, in the last few years the areas of interest of countries have moved to updating policies and legislation, ensuring better quality of care, promoting social inclusion and more involvement of users and carers. However, some of the recommendations that proved to have a more important role in the process of deinstitutionalization (for example, stopping new admissions to psychiatric institutions, integrating mental

health in primary health care; and reallocating resources away from psychiatric hospitals to community services) were among the least implemented, which seems to indicate that the development of community services is being made more as something that is added to the existing institutional care than something that is replacing the it in a coordinated manner.

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

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

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

## 7. RECOMMENDATIONS

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

### 7.1. INFORMATION SYSTEMS AND MONITORING

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

### 7.2. LEGISLATION AND POLICY

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

### 7.3. COMMUNITY MENTAL HEALTH CARE

- Develop/update mental health policy aiming at moving away from institutional care to integrated and well-coordinated community-based mental health care, including inpatient treatment in general hospitals and comprehensive community-based services for each catchment area, according to local and national needs;
- Promote actions that ensure the efficient use of available resources and those to be reallocated from long-stay psychiatric hospitals to community-based services;
- Integrate mental health in primary health care and scale up collaborative care;
- Promote the active involvement of users and carers in the delivery, planning and reorganization of services;
- Monitor and substantially improve the quality of care and respect of human rights for people who continue to reside in long-stay psychiatric institutions, abolishing any practices that involve physical restraints;
- Develop a concerted effort to reduce and ultimately cease admissions to long-stay psychiatric hospitals;
- Develop facilities and programmes that have so far been underdeveloped in many EU countries, such as integrated programmes with case management, community rehabilitation services for complex cases, outreach or mobile mental health teams, e-Health, self-help, and users and carer groups;

- Develop structured cooperation between mental health services, social services and employment services, to ensure that community-based residential facilities, vocational programmes, and other psychosocial rehabilitation interventions are available;
- Promote the use of the opportunities provided by the EU 2020 Strategy on research and development to improve the monitoring and evaluation of policies addressing the social exclusion of people suffering from mental disorders.

#### 7.4. INTEGRATED GOVERNANCE/MENTAL HEALTH IN ALL POLICIES

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