EU-COMPASS FOR ACTION

ON MENTAL HEALTH AND WELLBEING

ANNUAL REPORT 2017

SUMMARY AND ANALYSIS OF KEY DEVELOPMENTS IN MEMBER STATES AND STAKEHOLDERS

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

This report represents the Deliverable D13b of the EU Compass consortium under the service contract 2014-7103 on "Further development and implementation of the 'EU Compass for Action on Mental Health and Well-being'. "The EU Compass is a tender commissioned by the European Commission and Consumers, Health, Agriculture and Food Executive Agency and is implemented by a consortium led by the Trimbos Institute in the Netherlands, together with the NOVA University of Lisbon, the Finish Association for Mental Health and EuroHealthNet under the supervision and in close cooperation with the "Group of Governmental Experts on Mental Health and Wellbeing".

Acknowledgments

This report was coordinated by the Mental Health Policy (MHPol) Consortium. Nigel Henderson and Chiara Samele provided important contributions in the elaboration of the report.

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

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1. EXECUTIVE SUMMARY

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

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

The areas in which more countries reported key activities were promotion and prevention initiatives and services organization and quality activities, while legislation and impact assessment are two areas in which key developments are still absent in more than 30% of the countries.

Activities in legislation were focused on the preparation/implementation of new mental health laws, and regulation of compulsory treatment, while new policy developments were centred on implementation of national mental health programmes and in the development of specific strategies (e.g. on child and adolescent care, and suicide prevention).

Several Member States reported additional State funding for mental health in 2016, confirming a tendency already observed in 2015. Some countries developed new services, for instance, for child mental health care, migrants, drug additions and mental health services in prisons, while others developed quality programmes.

All countries reported new developments in promotion and prevention plans and programmes. Many addressed the prevention of mental disorders in general as well as stigma against mental illness. Important advances took place on suicide prevention, work-based programmes, school-based programmes, depression prevention, drug abuse prevention, strengthening of parenthood and couple relationship, and promotion of children's rights, among others.

In most countries, cross-sectoral cooperation is now a common practice, and the involvement of patients, families and NGO´s in the development of mental health initiatives of different types is considered a mandatory requirement of Governments.

The large majority of Member States monitor the mental health status of the population through surveys and national register data, with interesting new activities having taken place in 2016 in the measurement of mental wellbeing at a national level (Norway), the situational analysis of child and adolescent mental health status, monitoring of programs for the prevention of suicide in prison, and monitoring of the health promotion and prevention activities. The impact of policies is still not assessed in a significant number of countries. However, some Member States reported important progress.

It should be stressed that 2016 reports show that Member States are increasingly adopting the Mental Health in All Policies (MHiAP) framework, and that several countries reported innovative activities in this area.

Overall, in 2016, some countries accomplished important steps in the implementation of comprehensive mental health strategies, involving innovative developments in policy, funding, reorganisation of services, promotion and prevention. This was particularly evident in the Nordic countries, the UK and the Netherlands. Most of the other countries continued important reforms previously initiated and/or started new key activities in specific areas (e.g., child and adolescent mental health care, promotion and prevention programmes, participation of consumers and families, mental health in all policies etc.). Unfortunately, there was not enough information for an assessment of the progress registered in a significant number of countries, namely in the Eastern European Region.

The analysis of the stakeholders reports show that the majority of them implemented activities related to mental health in the workplace, particularly activities associated to the reintegration/return to work of people who have experienced mental health difficulties and to the prevention of mental health problems.

Many stakeholders reported to have implemented recommendations related to mental health and schools, but with a lower level of implementation than in mental health in the workplace. Regarding the prevention of suicides, there was a high level of implementation both regarding primary prevention and secondary or tertiary prevention.

The findings reported in the EU Compass scientific paper on mental health in the workplace show there is now robust evidence on work-related risks that can negatively affect both mental and physical health. The critical analysis of the literature about mental health interventions at the workplaces indicates that a large number of interventions proved to be effective in the prevention of common mental ill health, as well as in facilitating the recovery of employees diagnosed with depression and/or anxiety. It also shows that the available studies on an economic perspective indicate a return on investment at the level of mental health promotion in the workplace. However, further research is necessary to examine interventions addressing risk factors in the work environment in combination with interventions at the individual level. More studies are also needed on the effectiveness of comprehensive programmes in medium sized companies.

Several important policy actions, described in the scientific paper, have already been taken both at EU level and in the Member States to promote mental health in the workplace in a coordinated manner. Examples of good practices in this field are also cited in the EU Compass position paper.

Based on the analysis of the advances registered in 2016 towards the objectives of the EU Joint Action on Mental Health and Wellbeing, and taking into consideration the difficulties and insufficiencies found in this process, new recommendations presented in this Report, which complement the recommendation of the Framework for Action, should be considered by Member States.

2. INTRODUCTION

This Report is the second annual activity report of the EU Compass for Action on Mental Health and Wellbeing. Based on the 2017 Activity Reports of Member States and Stakeholders, which can be seen in Annexes, and taking into consideration relevant information from other sources, the Report includes a summary of the mental health policy related key activities developed in the last year by Member States and Stakeholders, an analysis of the developments to tackle the priority areas selected this year – mental health in the workplace, mental health and schools and suicide prevention - implemented in 2016, as well as recommendations for the future.

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

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

3. METHODOLOGY

To assess the progress made across EU Member States in the last 12 months we analysed information, data and good practices that were collected/identified through the EU Compass survey and presented in the EU Compass scientific position on mental health in the workplace. We also took into consideration data and information presented in the Joint Action on Mental Health and Wellbeing publications and in WHO reports.

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

The Member States and stakeholders questionnaires used in the survey focus on basic and background information, updates of key activities on the main areas of mental health policy developed in the last year, and updates on three of the annually rotating themes (mental health in the workplace, mental health and schools, suicide prevention) in the same period. More detailed information on the development, structure and contents of the questionnaires can be seen in Annex 1 (Annual Activity Reports of Member States and Stakeholders 2017).

Data collection took place between January and April of 2017. Completed questionnaires were submitted by web-based survey tools and checked for any inconsistencies or missing data. The questionnaires were sent out to 28 Member States, as well as Norway, Iceland, and Turkey (a country that is regularly invited to EC activities), and to 620 non-governmental stakeholders in the realm of health, social affairs, education, workplaces, justice and civil society (see Annex 1, pp. 11-14, for more detailed information).

Out of the 28 Member State representatives, and 3 additional countries invited to respond to the Member State questionnaire, 20 have responded (Austria, Belgium, Bulgaria, Croatia, Cyprus, Denmark, Finland, Greece, Iceland, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Portugal, Romania, Spain, Sweden and United Kingdom). Out of the 620 stakeholders invited to fill in the survey, 47 responded.

Raw data from the respondents of the Member States' and Stakeholders' surveys were exported from Webropol to SPSS. All quantitative data analyses were performed using SPSS (Statistical Package for the Social Sciences), version 23. This package was used to carry out descriptive statistics (e.g. frequencies and cross-tabulations) on mainly binary and categorical data. Qualitative survey data from both surveys were cleaned, and the researchers read and re-read the written answers and prominent answers and concepts were identified as answer variables. The researchers checked if the new variables worked and independently coded the written answers according to them and carry out descriptive statistics using Statistical Package for Social Sciences (SPSS), version 23.4.

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

The percentages of the countries in which key developments took place in each of the areas of mental health activities are presented in Figure 1. Promotion and prevention initiatives is the only activity area in which all the countries reported developments in 2016, followed by Services organization development and /or quality, with 92.3%. These numbers show that the need to invest in prevention and promotion is now widely recognized in Europe, and that improvement of services continues to be a priority for almost all countries.

More than 80% of the countries report key developments in all other areas, with two exceptions: Mental health legislation (69.2%) and measuring the impact of policies and or emerging new needs (66.7%). According to these figures, a significant majority of the countries is developing at least some work in all areas of mental health activities, but legislation and impact assessment are two areas in which key developments are still absent in more than 30% of the countries.

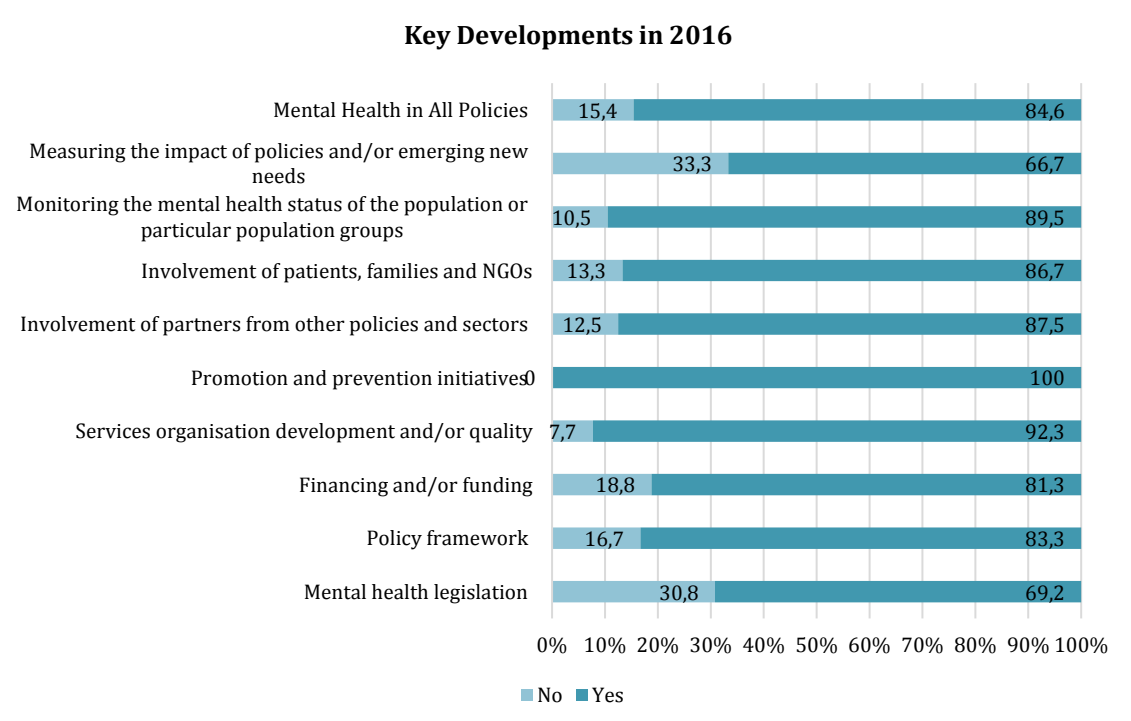

Figure 1 proportion of member states with key developments in activities on mental health and wellbeing in the last year

MENTAL HEALTH LEGISLATION

The developments reported in the legislation area focused mainly on two aspects: preparation or implementation of new mental health laws, and regulation of admission to treatment, problems related to compulsory treatment and security issues.

The Finnish Ministry of Social Affairs and Health, for instance, is in the process of preparing legislation on the right to self-determination and reforming the Mental Health Act. In Greece a draft of law focusing on the reorganization of mental health services aiming at the decentralization of decision-making, the enhancement of sectorization, and the protection of rights of people with mental disability has been developed. While in Lithuania, Norway and Romania activities were focused on the review or development of implementation rules of existing legislation.

Some countries revised the existing legislation or drafted new legislation in order to regulate admission to treatment, and to address problems related to compulsory treatment and security issues. Belgium approved a new act on the admission of persons with mental health problems, which became effective from 1 January 2016, and will optimize the reintegration of patients in society. The Netherlands is promoting changes in the Mandatory Mental Health Care Act that should replace the current Psychiatric Hospitals Compulsory Admissions Act. The proposal is much more focused on the prevention of compulsory treatment, aiming to make it less invasive if it is required, and includes the option to also enforce ambulatory treatment. In the UK, England proposed a change to English legislation so that people under 18 cannot be detained in a police cell under sections 135 or 136 the Mental Health Act 1983 (places of safety), and published the Prison Safety and Reform White Paper in November 2016 which set out a range of measures including improving mental health and suicide and self-harm prevention in prisons.

Given the importance of the incorporation of the principles established by the UN Convention on the Rights of Persons with Disabilities (CRPD) in the national legislations, and taking into consideration the challenges that this incorporation represent, we would expect to see a activities associated to this issue reported by

a significant number of Countries, This is not the case, a fact that shows that the importance of this debate has not yet been recognized in Europe.

POLICY

Several countries developed activities aiming at the preparation and implementation of national mental health programs. In Iceland a new Mental Health Policy and Action Plan until 2020 passed through congress in April 2016, and a Public Health Policy until 2020 with a special emphasis on children and adolescents until 18 years of age was issued in October 2016, while Portugal has extended the National Plan for Mental Health until 2020. The Swedish Government also adopted a national strategy for mental health for the period 2016-2020, which is based on five focus areas that have been identified as the main challenges in mental health and wellbeing. An interesting development took place in Italy, where the research programs have started to monitor the implementation of the most recent National Policies in the different Regions.

Some countries developed strategies in specific areas: Croatia implemented a strategic plan for child and adolescent psychiatry, Cyprus established a law that gives access of people with drug addictions to a program for detoxification and rehabilitation instead of being convicted, Luxembourg focused on a national suicide prevention plan, while in Austria an intersectional and multidisciplinary workgroup started working in the Austrian health target No.9 "to promote psychosocial health in all populations groups. In Denmark an agreement of new specialized social psychiatric departments was signed in order to make available a specialized service for a vulnerable target group with a severe mental disorder, externalizing behaviour, complex life circumstances and who are in need of a holistic and intensive treatment.

FINANCING AND FUNDING

The Report last year showed some encouraging signs of an increasing awareness of the need to ensure more State funding for mental health. These encouraging signs are confirmed and strengthened in this Report.

In the Netherlands, the total available budget for curative mental health care in 2016 was increased by 1%, and the Government gave financial support for two foundations to combat the stigma on mental health.

In Finland, significant State funding was allocated for Government key projects, in areas such as "Health, wellbeing and inequalities". The government grants for projects related to mental health is about 3,1 M€. There are specific funds for a programme to address reform in child and family services, to a key project on "Career opportunities for people with partial work ability", and there are grants to projects and programmes, including mental health, and health promotion.

In the UK an additional £1bn investment will be made up to 2020 in England and Wales: £400m for crisis care services in the community; £290m to improve perinatal mental health; and £250m to implement mental health liaison teams in every general hospital by 2020. Also announced in 2015, an additional £250m each year up to 2020 to improve children and young people's mental health and £30m each year to improve services for eating disorders will be available. Finally, additional investment of £15m to improve the number of health based places of safety for people detained under the English mental health Act 1983.

In Sweden, through the 2016 Agreement on Support for Targeted Measures for Mental Health, the Government provided approximately 100 M Euros to support measures within local authorities and regions to promote mental health and mental well-being and to improve services for individuals suffering from mental health problems. It should be noted that the governmental action plan gives the regions/local authorities autonomy on how the money should be distributed in the regions but all work is based on five focus areas that the government has proposed.

In Denmark, the agreement for the new specialized social psychiatric departments (see Legislation) allocates 401 million DKK in the period 2017-2020 for this purpose. On the other hand, the special pool for the social area for 2015-2018 allocated 2.2 billion DKK to the area of psychiatry, while the Danish Regions and the Ministry of Health in 2014 made a partnership agreement which will allocate 50 million DKK each year until 2020 to reduce the amount of coercive measures used by half. The agreement also allocated 100 million DKK as a one- time expense

to the improvement of psychiatric ward facilities. Moreover, Iceland increased funding for psychological services in primary health care and multi-disciplinary teams that provide mental health and social services for people with mental disorders.

Other interesting developments reported in this area include a project aiming at developing an innovative financing model of mental health care in Portugal, and an initiative in Lithuania to regulate costs of primary health care services, including mental health services.

SERVICES ORGANIZATION, DEVELOPMENT AND QUALITY

Finland is preparing a massive reform of social welfare and health care, in order to reduce inequalities, and to manage costs. The responsibility for organising health care and social services will be transferred from municipalities to counties. An important reform of child and family services, including mental health, is also being implemented. Cyprus is also developing child mental health care, as well as services for drug addictions and mental health services in prisons. Luxembourg developed care services for migrants, and the Netherlands reported a significant decrease in the number of beds and an increase of patients in non-specialized mental health care, although there was a delay in the increase of ambulatory mental health care provisions.

Integration and continuity of care has been a special concern in some countries: Iceland established a legal requirement for improved integration and continuity of mental health services between the state and municipalities, while Portugal started the implementation of the "Integrated Continuous Care Project", a project involving the Ministry of Health and the Ministry of Social Security that promotes the creation of community-based networks of psychosocial rehabilitation facilities and programmes for adults and children.

Special attention was dedicated by several countries to the development of quality programmes: Belgium developed quality indicators projects, and in the UK the Care Quality Commission (English health and social care regulator) has developed a rigorous assessment regime to inspect all registered mental health providers.

PROMOTION AND PREVENTION INITIATIVES

As mentioned before, all countries reported developments in promotion and prevention activities. Suicide is undoubtedly the area in which most countries (Austria, Denmark, Finland, Latvia, Lithuania, Luxembourg, Netherlands, Portugal, Sweden, among others) developed prevention programmes in 2016. Several countries invested specifically in prevention and promotion programmes in schools, for example, in anti-bullying, suicide prevention, problem solving, and anti-stigma programmes (e.g. Finland, Iceland, Latvia and Portugal) or at the workplaces (e.g. Belgium and Denmark). Other countries invested particularly on anti-stigma programmes (e.g. Portugal and UK), prevention of depression and of deinstitutionalization of people with severe mental disorders (Greece).

Several countries initiated or continued comprehensive programmes on promotion and prevention. Norway, for instance, initiated a new 10 year mental health promotion and wellbeing strategy. Denmark developed prevention initiatives in areas such as vulnerable and marginalized children, young people and suicide, promoted programmes to increase the knowledge of the population about mental health, and to create a better understanding of mental illness in schools and workplaces. Luxembourg developed programmes on suicide prevention, violence, mobbing prevention, drugs and aids prevention, as well as initiatives in the school, social and health sectors, gender-intersex, human trafficking, abuse and maltreatment.

In Sweden, the Government provided financial support to local authorities and regions allocated to promote mental health and mental wellbeing, besides improving services for individuals suffering from mental health problems. On the other hand, Swedish Local Authorities and Regions also received a governmental commission concerning prevention efforts targeted at migrants. The National Board of Health and Welfare developed revised National Guidelines for Anxiety and Depression and National Guidelines for School Health Care (including a chapter on mental health). Furthermore, the Public Health Agency of Sweden has been assigned, in 2016, to build and develop work aiming to promote mental health and prevent mental ill-health among the entire population at a national level. Since May 2015, the Agency also has the Government's assignment to

coordinate national efforts to reduce suicides and the public health agency has also published an annual report following up the suicide prevention initiatives taken on the national level. A working group was also established aiming at developing and disseminating knowledge support to prevent mental ill among the elderly population.

In Finland, the government decided to finance grant projects with the following objectives: (1) to strengthen mental health skills in the population and among professionals in different fields (Mental Health First Aid) (2) to influence awareness about substance misuse among teenagers in vocational training and to strengthen their social skills and mental health (3) an early intervention programme for persons in the danger of completing suicide (ASSIST-method) and (4) to strengthen the suicide prevention skills of social and health service personnel. Grant projects were also funded to promote active participation and to prevent loneliness and to disseminate effective methods to quit smoking within mental health and substance abuse services. Promotion and prevention activities are also of high priority in mental health of child and family agenda, and include programmes on strengthening of parenthood and couple relationships, promotion of children's rights, and prevention of bullying in schools.

INVOLVEMENT OF PARTNERS FROM OTHER POLICIES AND SECTORS

A large number of mental health activities require the participation of different sectors. Thus, it is not surprising that most countries refer to this cross-sectoral cooperation as a common practice. However, some developments in this area deserve a special mention.

Croatia, for instance, reports the collaboration of social care, education and health care sectors in the implementation of TF Twinning project "Ensuring Optimal Health Care for People with Mental Health Disorders". Austria created a coordinating platform for psychosocial support of refugees and aid workers, which involves several ministries, the federal states, social insurance and NGOs. Norway created an Inter-ministerial Collaboration body on violence prevention, an Inter-ministerial cooperation system to promote school mental health and to prevent school dropout, an Inter-directorial working group on mental health in asylum

seekers and refugees. In Finland, the government's key projects are multi-sectoral, and for example the Ministry of Social Affairs and Health and the Ministry of Education steer the programme for child and family services in partnership. In Greece, a cross-sectional deinstitutionalization strategy will be developed with the Ministry of Employment & Social Welfare for the enhancement of community integration for people with disabilities and other vulnerable groups. In Portugal, cooperation was established between the Ministry of Health and the Ministry of Internal Administration to develop suicide prevention programmes in the security forces. In the UK, the Cross-Government National Suicide Prevention Strategy has been reviewed to strengthen delivery in partnership with Department of Health, Department for Education, Department for Work and Pensions, Department for Transport, and non-government organisations.

INVOLVEMENT OF PATIENTS, FAMILIES AND NGO´S

The involvement of patients, families and NGO´s in the development of the mental health strategies, at the national, regional and local levels, as well as in mental health initiatives of different types, is now considered a mandatory requirement of Governments in most countries, and some countries report interesting innovative initiatives in this field, as we can see the in the examples described below.

Austria has established, in the Framework of health-target No.9, an Exchange-platform for patients. Norway created clinical guidelines on the involvement of users and families in mental health issues. Belgium developed different tools to support patient and family organizations in order to increase their involvement and empowerment. In Denmark, a psychiatric committee was established to ensure a broad discussion of mental health issues by relevant authorities, professionals and NGO's. A user driven beds project was also created, through which selected psychiatric patients are being offered a contract that gives them the right to decide when they will like to be hospitalized. The project has shown good results, and will continue in 2017. In Luxembourg a new NGO was created by families and friends of persons with severe mental disorders. The Portuguese Government supported the creation and activities of the National Federation of Associations of Families of People with Mental Illness Experience, as well as the continuation of the activity of the Consultative Commission for the Participation of

Users and Caregivers in the National Mental Health Strategy. In Sweden, the Government supported the work of NGOs in the area of mental health, through a whole range of initiatives, and allocated approximately 7 M Euros to support the work of NGOs in the area of mental health and suicide prevention. In Finland, NGOs are essential partners in all Government key projects. Strengthening the involvement of patients and families is also part of most key projects. Greece decided to include users and families in the bodies established in the context of the imminent administrative reorganization of mental health services. In the Netherlands, the umbrella organization for family and patient organizations for people with mental health care (LPGGz) received financial support from the ministry of Health, Welfare and Sport. In the UK, the development of the Five Year Forward View for Mental Health in England to transform mental health services was led by an independent non-government organisation and a taskforce made up of wide range of NGOs and charitable and voluntary sector organisations and experts by experience. The Forward View was tested vigorously with a wide range of public stakeholders including service users and their families and carers.

MONITORING THE MENTAL HEALTH STATUS OF THE POPULATION OR PARTICULAR POPULATION GROUPS

Almost all countries monitor the mental health status of the population through surveys and national register data. In some cases (e.g. Belgium, Denmark, Iceland, Sweden), countries collected information from national health surveys that include a mental health component. Other countries used information from mental health specific surveys of the general population (e.g. Finland, Latvia) or addressed specific issues.

Interesting activities took place in 2016. Norway measured mental wellbeing at a national level. Croatia developed a situational analysis of child and adolescent mental health status. Bulgaria developed an on-line portal to collect and process data about suicide attempts, while Italy monitored programs for the prevention of suicide in prison, and Austria produced Annual suicide and Annual drug reports. Portugal produced the annual edition of "Portugal: Mental Health in Numbers", a publication monitoring epidemiological indicators on mental health and suicide.

Spain collected information related to the mental health strategy by sex, including special groups such as children, adolescents, seniors, and prison population. These data refer to the state and perception of mental health, self-harm, suicide rates, alcohol and other drugs, hospital and community resources, rehabilitation, residential (beds, rooms, etc.), prevalence of certain diseases, medical discharge, readmission, existence of programmes, employment supports and others.

In Finland, the National Institute for Health and Welfare, besides monitoring the mental health status of the population through population based survey, is also monitoring the health promotion and prevention activities of municipalities, while the Statistics Finland is providing data on suicide.

The Netherlands continued the Netherlands Mental Health Survey and Incidence Study (NEMESIS), a psychiatric epidemiological longitudinal study in the general population aged 18 to 64, as well as an annual monitoring of suicide.

Sweden monitored changes in mental health through national surveys and national register data. The National Board of Health and Welfare administers a number of registers to be able to analyse and monitor trends in health care and social services. In 2016 it also analysed trends in particular population groups, such as mental health of migrants coming to Sweden, and mental ill-health among individuals in same-sex marriages.

In the UK the seventh yearly National Adult Psychiatric Morbidity Study for England was published in 2016, and a new National Children and Young People's Mental Health Survey for England, to be published next year, was commissioned. Other publications presented suicide registrations for the UK, public health profiles for every local area in England which includes mental health indicators, as well as a wide range of data on mental health and disabilities and detentions under the Mental Health Act 1983 in England.

MEASURING THE IMPACT OF POLICIES OR EMERGING NEW NEEDS

In order to measure the impact of policies, Austria monitored Health Targets and the Health Promotion strategy. In Finland the Health 2015 programme was evaluated, and the impacts of the Government's key projects will be evaluated by using a set of pre-established indicators and external evaluators. In the

Netherlands, both monitoring of the use of Youth care and Youth mental health care and monitoring of the transition of intramural mental health care to ambulatory health care were continued. On the other hand, the Dutch Healthcare Authority has measured the waiting lists in mental health care. In Sweden, a decision-support system for medical insurance was produced in cooperation with the Swedish Social Insurance Agency. Doctors can use this system as a guide when prescribing sick leave for persons with mental illness.

The UK established a new mental health data strategy and Mental Health Data Board, which sets the strategy for collecting data on mental health to progress and measure impact of policies. The national MyNHS website (which publishes public ratings and experiences of local mental health services), as well as Five Year Forward View Mental Health Dashboard (which publishes a wide range of performance indicators on meeting the recommendations of the Forward View) were launched. A Clinical Commissioning Group Improvement and Assessment Framework which published a wide range of health indicators, including mental health, to measure the performance of local health services was launched, and the National Mental Health Crisis Care Concordat website published a map and ratings of local mental health crisis care action plans.

MENTAL HEALTH IN ALL POLICIES

The Mental Health in All Policies (MHiAP) framework was particularly valued in some countries. For instance, in Iceland the new Public Health Policy was formed within this framework. In Austria, MHiAP played an important role for the Elaboration of Health Targets No. 9 "To promote psychosocial health in all population Groups", Safety and Health at Work Act is an important step to promotion of mental health and prevention of mental disorders in the workplace, and a Coordinating platform for psychosocial support of refugees and aiders was created. Croatia implemented the TF Twinning project "Ensuring Optimal Health Care for People with Mental Health Disorders" within health, education and social care sectors. In Portugal, the National Mental Health Program coordinated efforts with the National School Health and Child and Youth Health Programs, involving teaching teams from public schools and primary health professionals, in the scope of promoting child and youth mental health. In Sweden, the National Coordinator

for Mental Health initiatives mandate involves supporting the work carried out by national agencies, municipalities, county councils and organizations within the sector, and ensuring that all initiatives in the area of mental health are coordinated at a national/ governmental level. One of the key issues for the coordinator is to make sure that a MHiAP perspective is present in all initiatives at a governmental level and that the key actors work together within different policy areas. In Finland, one of the examples of MHiAP projects is the Government's key project Career paths for persons with partial work ability. This project will build flexible and suitable approaches and co-operation practices between health and social services, rehabilitation, insurance institutions, education, employment office and voluntary services for those unemployed and workers whose ability to work is affected by their disability . Finland has also worked actively on the reduction of psychosocial risks and psychosocial strain in workplaces. In the UK the Five Year Forward View for Mental Health made a wide range of recommendations for the NHS and across Government. The establishment of the first Inter-Ministerial Group on Mental Health across all Government Departments to oversee delivery of the cross-Government recommendations for mental health was one of the measures taken in this area.

5. MEMBER STATES IMPLEMENTATION STRATEGIES IN PRIORITY AREAS

This year, the EU Compass survey specially focused on three EU Compass annual themes: 1) *mental health in the workplace;* 2) *mental health and schools;* and 3) *suicide prevention.* Key activities developed by Member States in these areas, in 2016, were described in the MS reports (see Annex 1), and were briefly summarized in the previous Section of this Report. The following sections show an analysis of how Member States have addressed the challenges in these areas in the past year, with a special focus on the level of priority attributed to each theme, the existence or not of national programmes/strategies, and the level of implementation of the EU Framework for Action recommendations.

5.1. MENTAL HEALTH IN THE WORKPLACE

Priority Level

Regarding the priority level of addressing mental health in the workplace in the policy or strategy documents in their country (Fig. 2), 70% of the Member States considered this area as a priority.

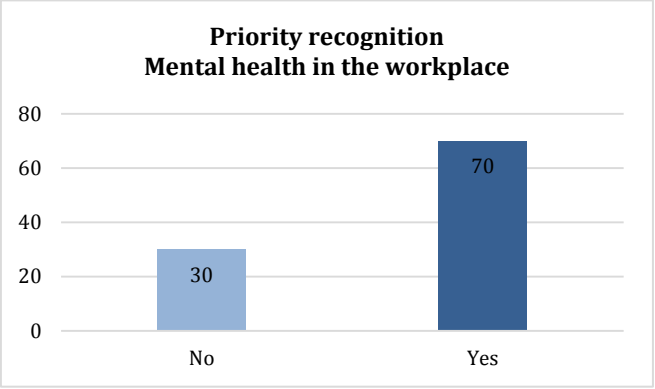

Figure 2 Member States Priority recognition of Mental health in the workplace

Existence of National Programmes/Strategies

The analysis of the information reported by Member States regarding the existence of national programmes/strategies for mental health in the workplace show that half of the countries have implemented programmes/strategies to address this issue (Fig. 3).

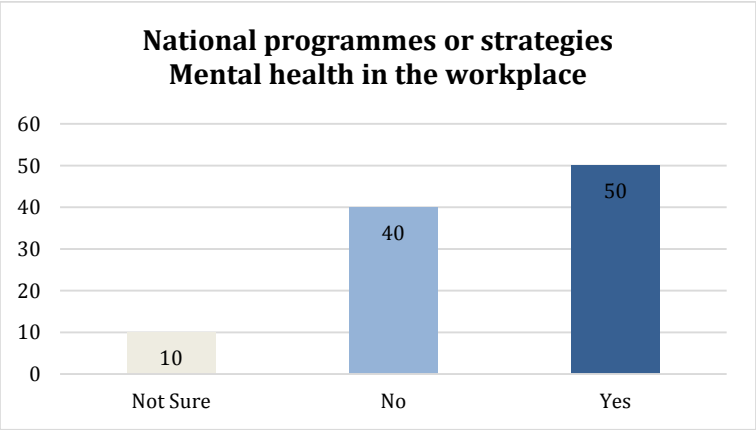

Figure 3 Existence of national Programmes/strategies Addressing Mental health in the workplace

Level of implementation of recommendations in 2016

Several recommendations were developed to take further action on mental health in the workplace.

a) Build effective cross-sector partnership and cooperation between the health policy and labour policy sectors to improve mental health and wellbeing in the workplace

The most widely implemented recommendations under the topic of building effective cross-sector partnership and cooperation were: "measures and strategies that promote open communication in the workplace and reduce the stigma of mental health problems", with 80% of the Member States referencing that they have fully or to some extent implemented this action; and "Informal (e.g. working groups who exchange experiences) cooperation and approaches for key social security stakeholders in both policy fields to be permanently involved", with 70% of the Member States stating implementation either as: to some extent or fully implemented. The recommendations with the lowest levels of implementation were "Health policy development to legally anchor structures for inter-sector

cooperation" (45 % stated not at all implemented), "development of platforms to facilitated structured exchange of experience for social health insurance institutions and government health agencies" (40% stated not at all implemented) and "Health policy sector working together with OSH stakeholders to make it easier for SMEs to access support" (40% stated not at all implemented) (Fig. 4).

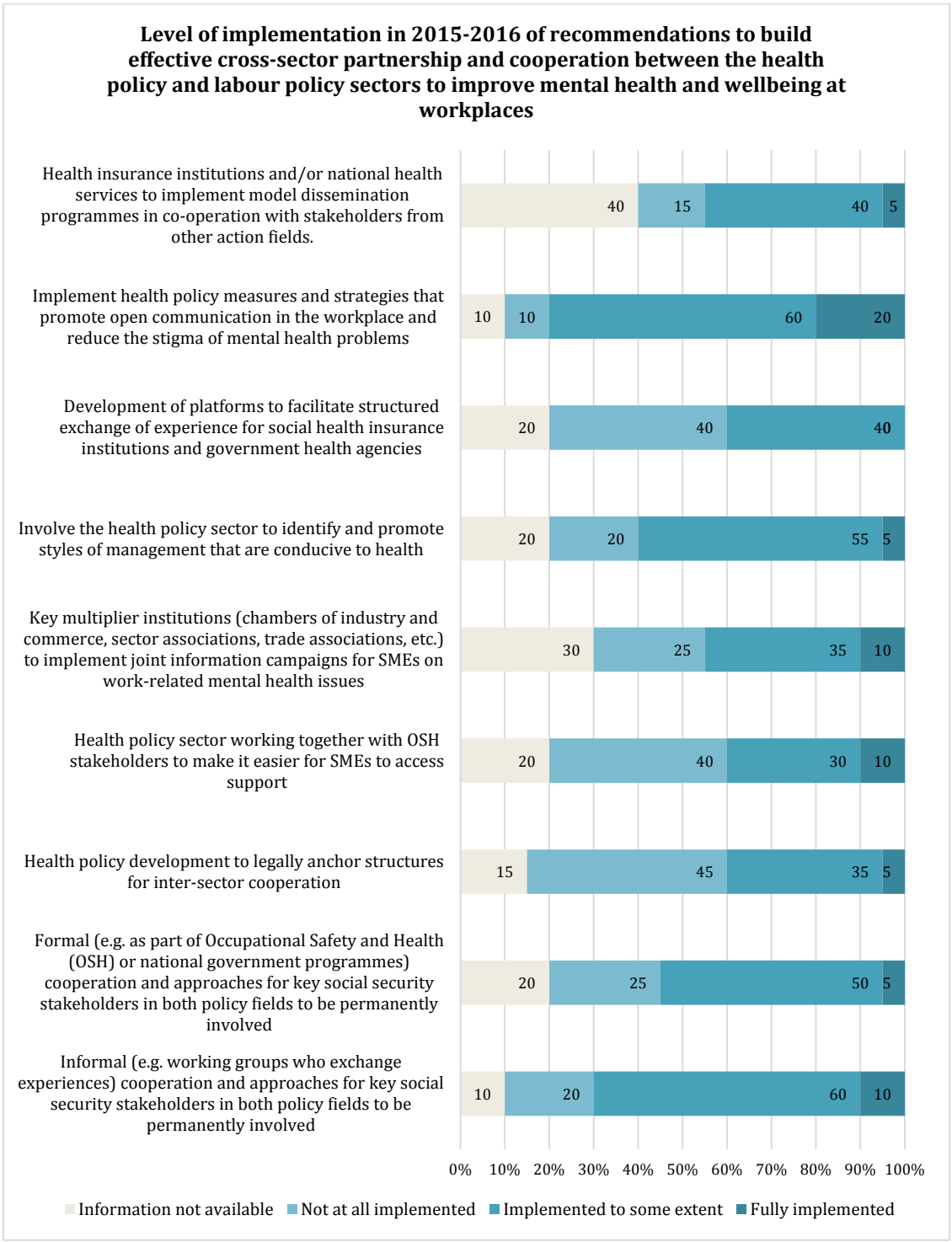

Figure 4 Level of implementation of Recommendations to build effective cross-sector partnership and cooperation

b) Prevent mental health problems in the workplace

The most widely implemented recommendations under the topic of prevention of mental health problems in the workplace were "develop and disseminate easy-to-understand tools and instruments for employers" and "recognise that small and medium-sized enterprises (SMEs) need a tailored approach and support to tackle psychosocial risk factors", both with around 60% of the Member States referencing to some extent up to fully implemented. The recommendation with the lowest levels of implementation were "Examine how national health service and statutory health insurance institutions can provide support to workplaces on mental health" (52.6% of not at all implemented), and "Develop coordinated national and regional goals for OSH and workplace health promotion and translate them into general psychosocial recommendations" (47.4% of not at all implemented) (Fig. 5).

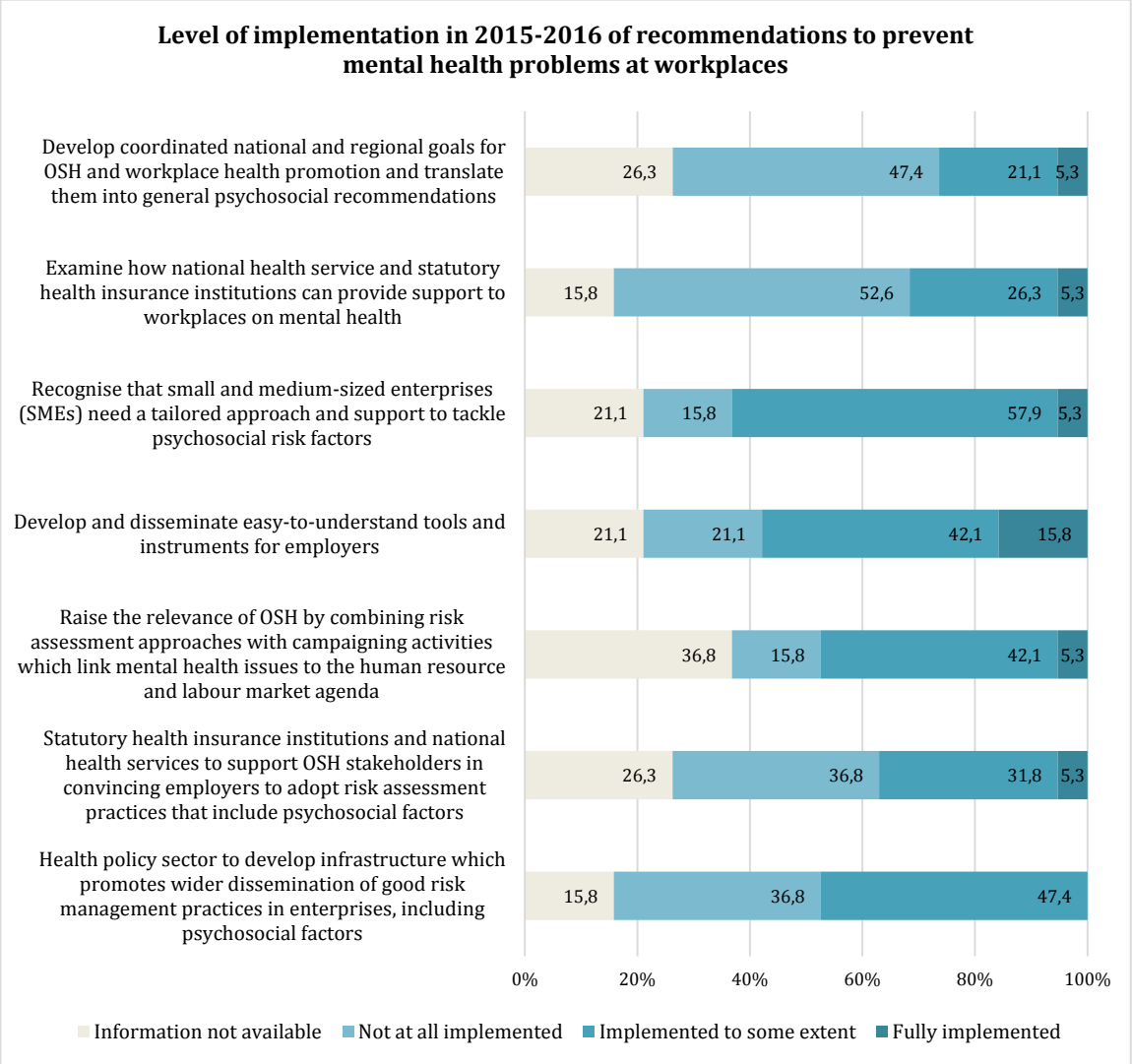

Figure 5 Level of Implementation of Recommendations addressing Prevention

c) Promote mental health and wellbeing in the workplace

In terms of promoting mental health and wellbeing at workplaces, the most frequently implemented strategy was "approaches combining life style improvements with working condition focused approaches (more than 70% of the Member States referencing to some extent up to fully implementation). The strategies "support from the health policy sector in the dissemination of good practices in the promotion of mental health at workplace in all institutions of the health care system" and "engagement of key external stakeholders (social partners, regulatory system, social insurance, health care etc.) to both with adopt a supportive role for enterprises in the field of workplace health promotion (WHP)", were both to some extent or fully implemented by 50% of the countries. The least implemented recommendation reported by Member States were "health policy sector examines and modifies existing rules and regulations, including the tax system, to encourage enterprises to invest in measures for workplace mental health promotion" and "health policy sector promoting good working organization and leadership practices as drivers for business excellence and competitiveness", both with 50% or more not at all implemented (Fig. 6).

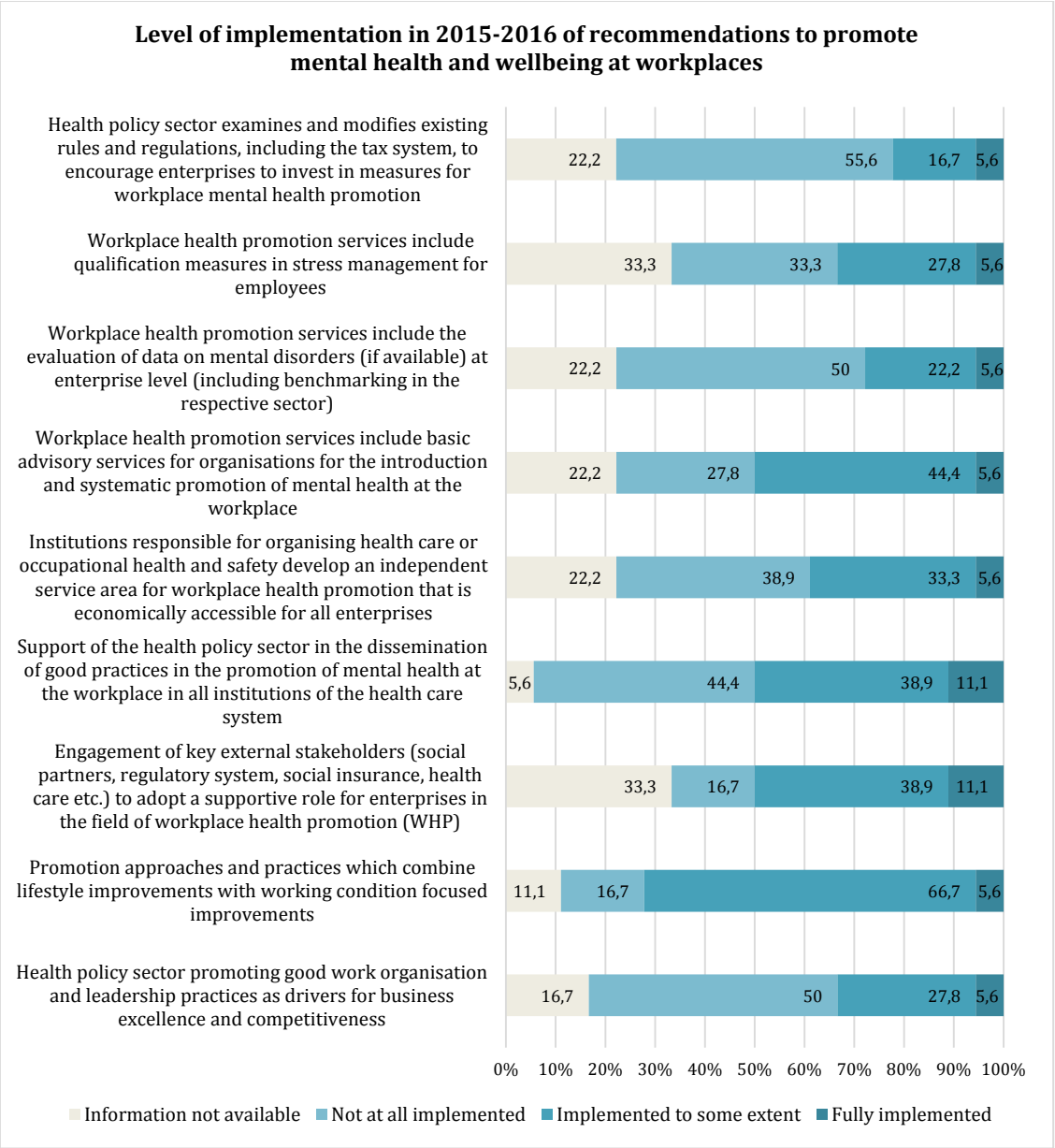

Figure 6 Level of Implementation of Recommendations addressing Promotion

d) Support the reintegration/return to work of people who have experienced mental health difficulties

The most popular recommendations regarding the reintegration/return to work of people with mental health difficulties are "support is available for persons with partial work capacity to participate in the labour market", and "focus on early identification of the need for care" implemented by more than 80% of the member states. The least implemented recommendations was "health policy sector ensures and improves access to care for mentally-ill employees" with nearly 18% of the

Member states stating that this recommendation was not at all implemented (Fig.7).

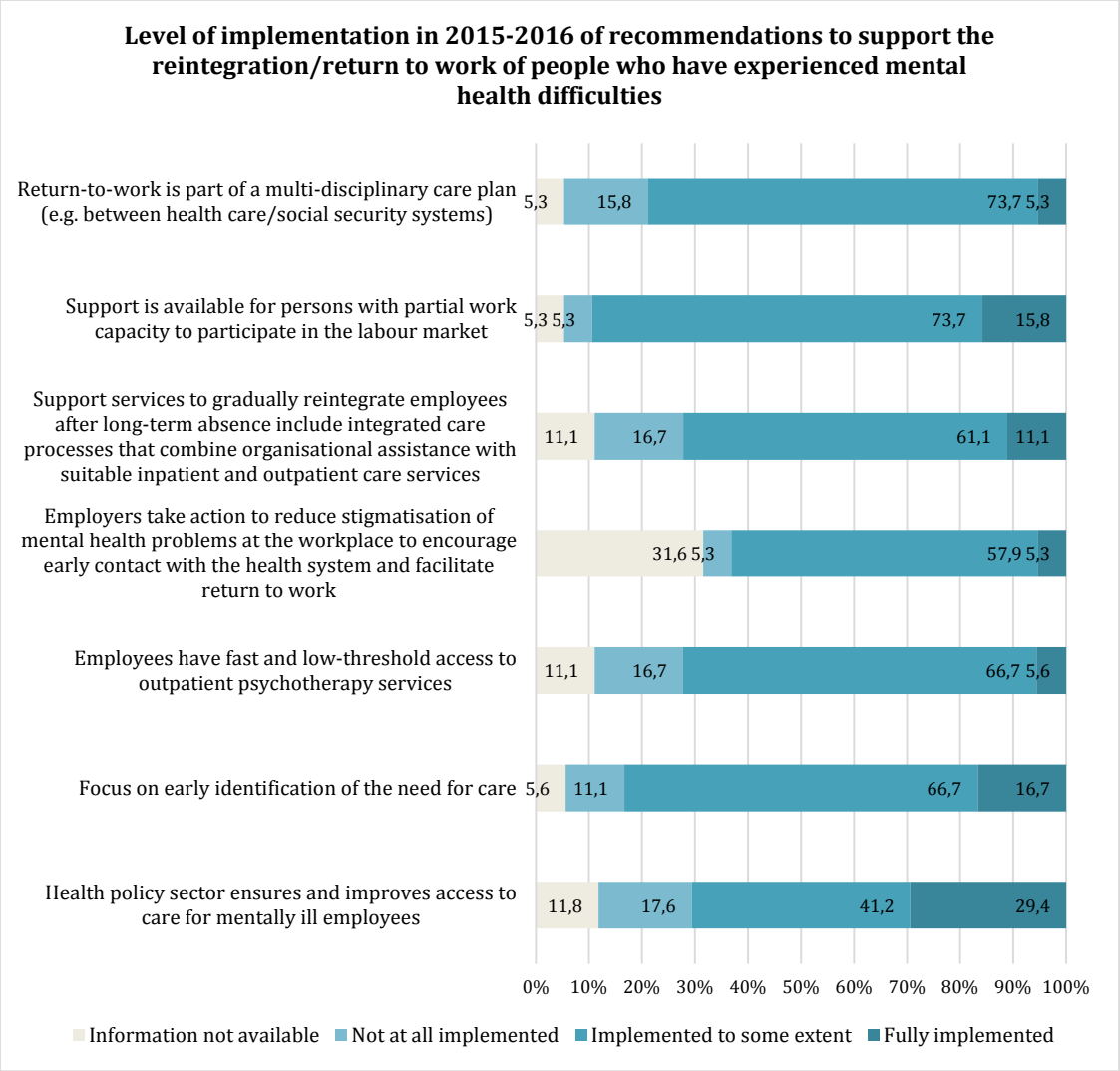

Figure 7 Level of Implementation of Recommendations to Support Reintegration/Return to Work

5.2. MENTAL HEALTH AND SCHOOLS

Investing in mental health and wellbeing during childhood and adolescence has a broad range of positive outcomes throughout the life-course, such as the prevention of mental disorders, as well as promoting children and adolescents' potential to live fulfilling and productive lives.

Priority Level

The present analysis (Fig. 8) indicates that mental health and schools is recognized as a priority by the large majority of Member States (94,7%).

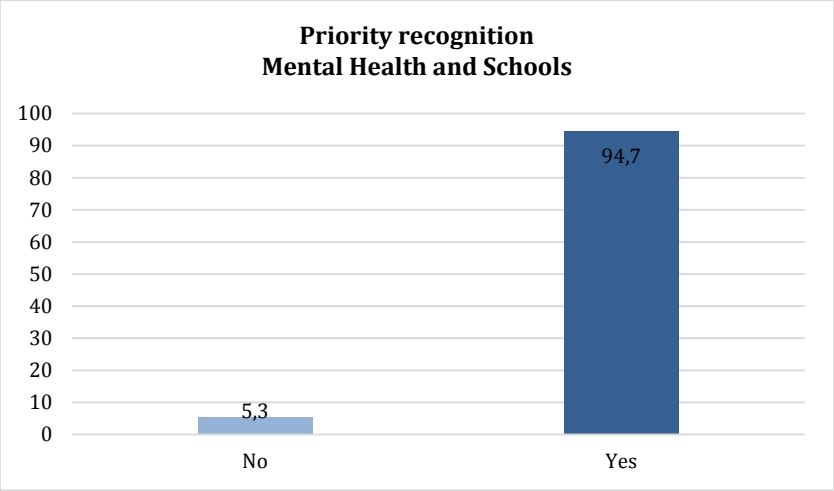

Figure 8 Member States Priority recognition of Mental Health and Schools

Existence of National Programmes/Strategies

The existence of national programmes or strategies concerning mental health and schools was reported by 58% of Member States (Fig 9).

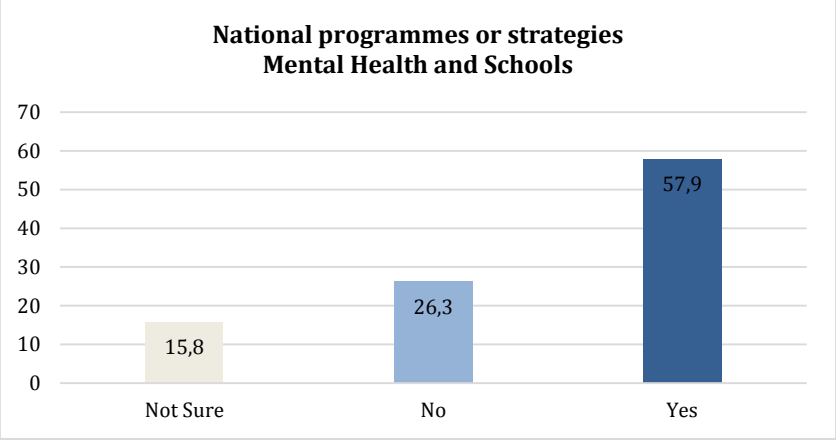

Figure 9 Existence of national Programmes/Strategies addressing Mental Health and Schools

Level of implementation in 2015-2016 of recommendations

Member States developed several of the recommendations to improve action on mental health and schools.

a) Strengthen information and research on mental health and well-being among children and adolescents

The analysis of the level of implementation of recommendations focused on strengthening the information and research of children and adolescents' mental health indicates that "establish a solid information base to have a detailed epidemiological framework of children and adolescent mental health and evidence on interventions" was the most frequently implemented recommendation (more than 60% of the countries). The recommendations "examine the potential to increase access to promotion information and to prevention services through the use of web-based technologies (e-mental health)" and "provide information on coverage and outcomes of interventions, provide information on coverage and outcomes interventions" were implemented by almost 60% of the countries. The least frequently implemented was "carry out a mapping and analysis of existing screening tools for early identification of mental disorders in children and school population" (Fig. 10).

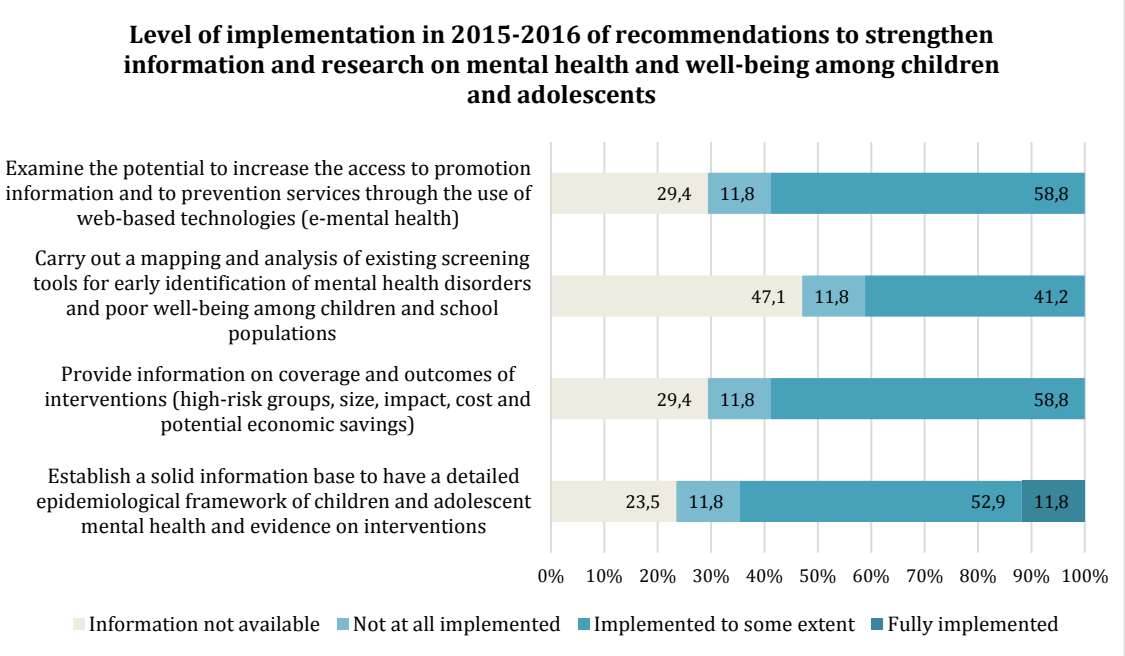

Figure 10 Level of Implementation of Recommendations to Strengthen Information and Research

b) Establishing schools as settings for mental health promotion and prevention of mental disorders

The analysis of the set of recommendations to establish schools as a setting for promotion of mental health and prevention of mental disorders show that almost 90% of the countries, reported to have to some extent or fully implemented the recommendation "recognise the role of early childhood education, school and peer education in creating opportunities for collaboration" and almost 80% did the same regarding the recommendation "mandate school administrations to develop and formalise the promotion of mental health and address risk factors such as bullying and cyber-bullying". The least frequently implemented recommendation was "put in place evidence based interventions to combat early school leaving" (Fig. 11).

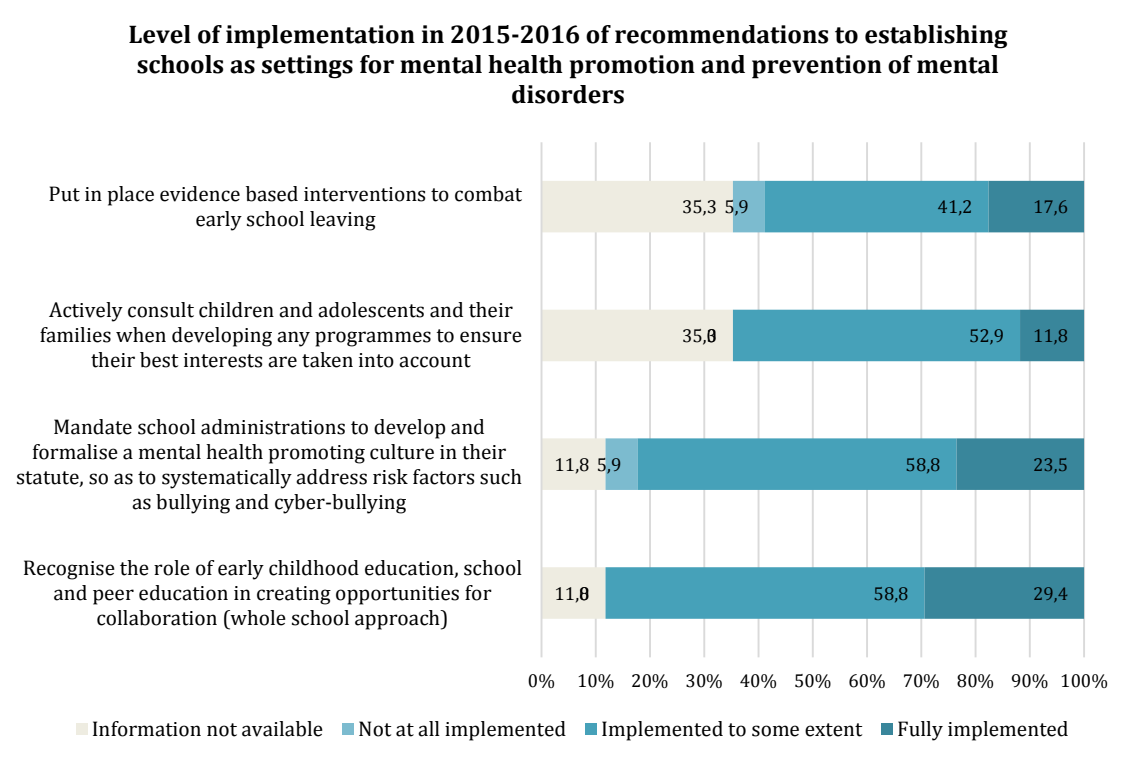

Figure 11 Level of Implementation of Recommendations to Establish Schools as Settings for Mental Health Promotion and Prevention

c) Enhance training for all school staff on mental health

Considering the level of recommendations to enhance training for all school staff on mental health (Fig. 12), there is a low level of full implementation among Member States. The recommendation more often reported by Member States to be fully implemented concerned the preparation and sharing of relevant guidelines for mental health and wellbeing promotion in schools, in collaboration with other sectors under the coordination of the education sector (17.6%). Most recommendations were implemented to some extent by Member States. The recommendation to draw particular attention to positive mental health and wellbeing of teachers and school staff through continuous support and mentoring was reported to be implemented to some extent by 56%. Regarding the recommendations to ensure that training is made available to families and caregivers, following a community level approach, as well as the recommendation to involve other sectors such as social, criminal justice and youth organization, the unavailability of information was reported by half of the Member States (50.0% and 47.1%, respectively).

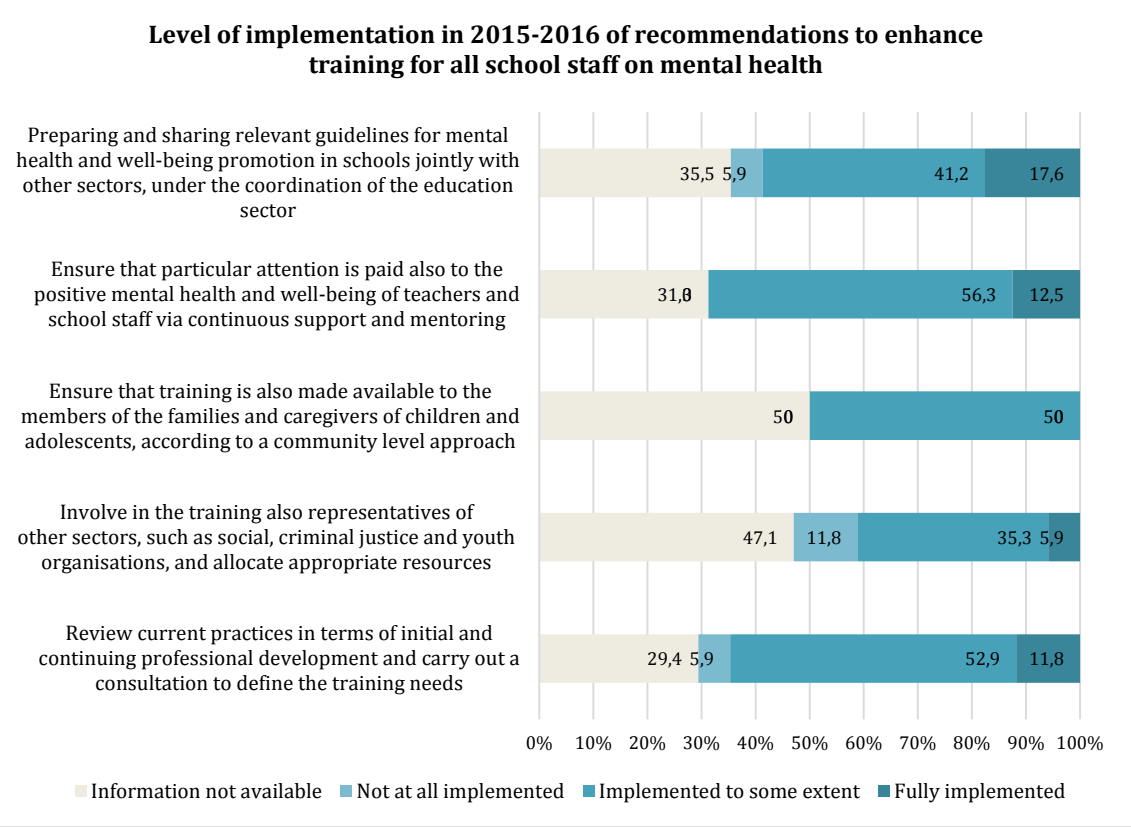

Figure 12 Level of Implementation of Recommendations to Enhance Training

d) Link schools with other community stakeholders involved in mental health of children and adolescents

Regarding the set of recommendations to link schools with other community stakeholders involved in mental health of children and adolescents (Fig. 13), two of the recommendations were not fully implemented in any of the Member States: "evaluate the effectiveness of school based interventions" and to "estimate data on the workforce and financing specifically dedicated to the mental health of children and adolescents". National or regional legislation to consolidate, legitimate and regulate terms of cooperation between sectors was fully implemented in 17.6% of Member States. The recommendation to ensure that mental health and wellbeing of children and adolescents is considered when defining and implementing policy in different sectors was reported to be implemented to some extent by 64.7% of the Member States.

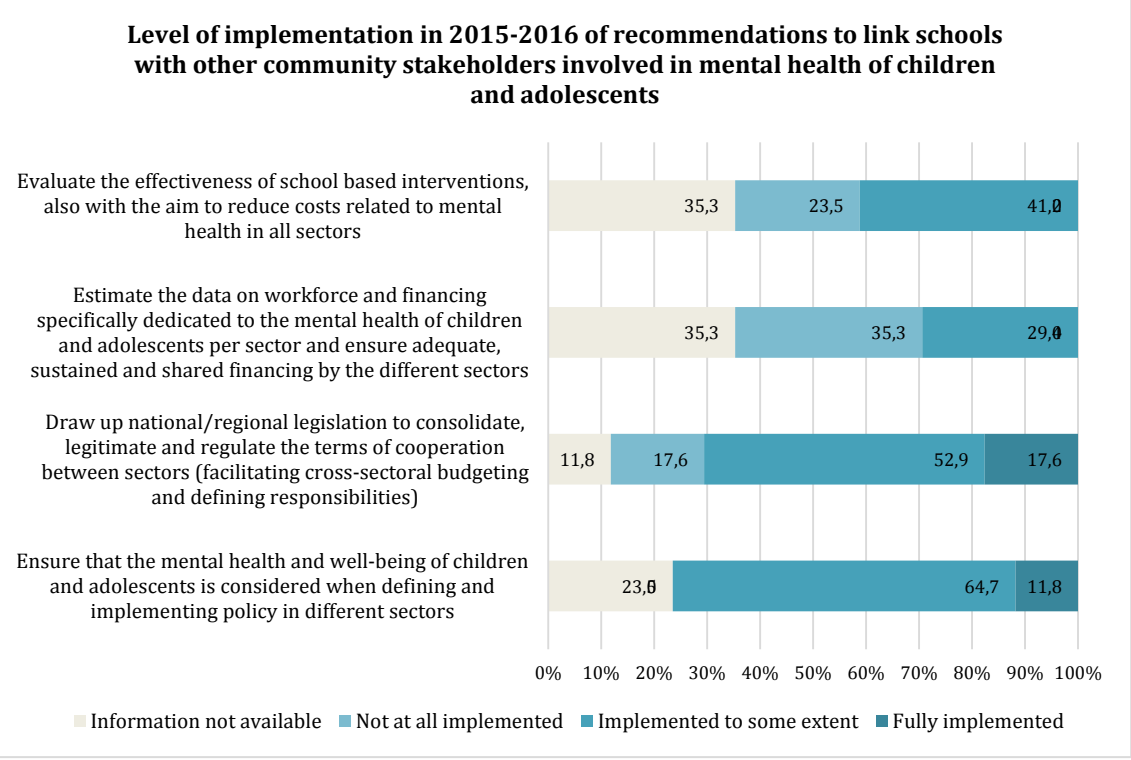

Figure 13 Level of Implementation of Recommendations to Link Schools with Other Community Stakeholders

5.3. SUICIDE PREVENTION

Suicidality is one of the most important public health challenges in Europe. It causes not only the individual loss but also creates significant distress for family and significant others. Both suicides and suicide attempts are preventable. Thus, reducing the rate of suicide should be a high priority of the European public health agenda. The importance of supporting Member States to develop or strengthen awareness and comprehensive suicide prevention strategies is well established.

The following sections show an analysis of the current situation regarding how Member States are addressing suicide prevention.

Priority Level

Most of the Member States (85%) stated that their countries recognize Suicide Prevention to be of high priority, while 15% did not (Fig. 14).

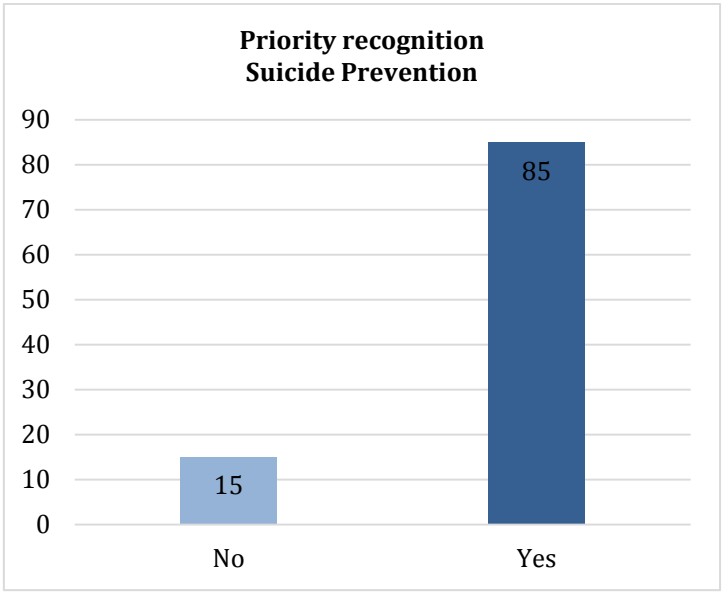

Figure 14 Figure 8 Member States Priority recognition of the need of Suicide Prevention

Existence of National Programmes/Strategies

In terms of policy, 65% of Member States reported to have national suicide prevention programmes or strategies, while 35% are still in need of developing a national response (Fig. 15).

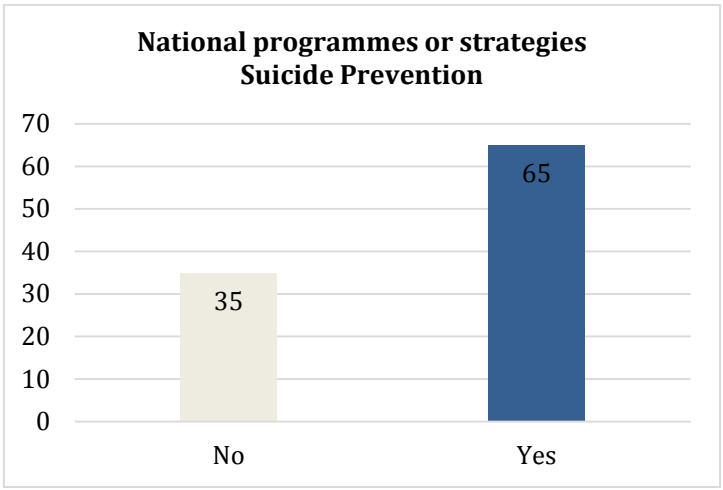

Figure 15 Existence of national Programmes/Strategies addressing Suicide Prevention

Level of implementation in 2015-2016 of recommendations

Member states were asked to evaluate the level of implementation of the recommendations to better take action on suicide prevention as stated in the European Framework for Action on Mental Health and Wellbeing.

a) Policy and legislation for suicide prevention

Regarding policy and legislation (Fig. 16), the most fully implemented recommendations stated by 33% of the Member States were: "develop a national strategy to prevent suicide (or implement it if one already exists) with a clear action plan and measurable targets" and "reduce the package size of potentially lethal medicines and/or restrict their availability". The least implemented recommendation reported by 72% of the Member States was "revise legislation to include protections for persons who have attempted suicide to return back to work."

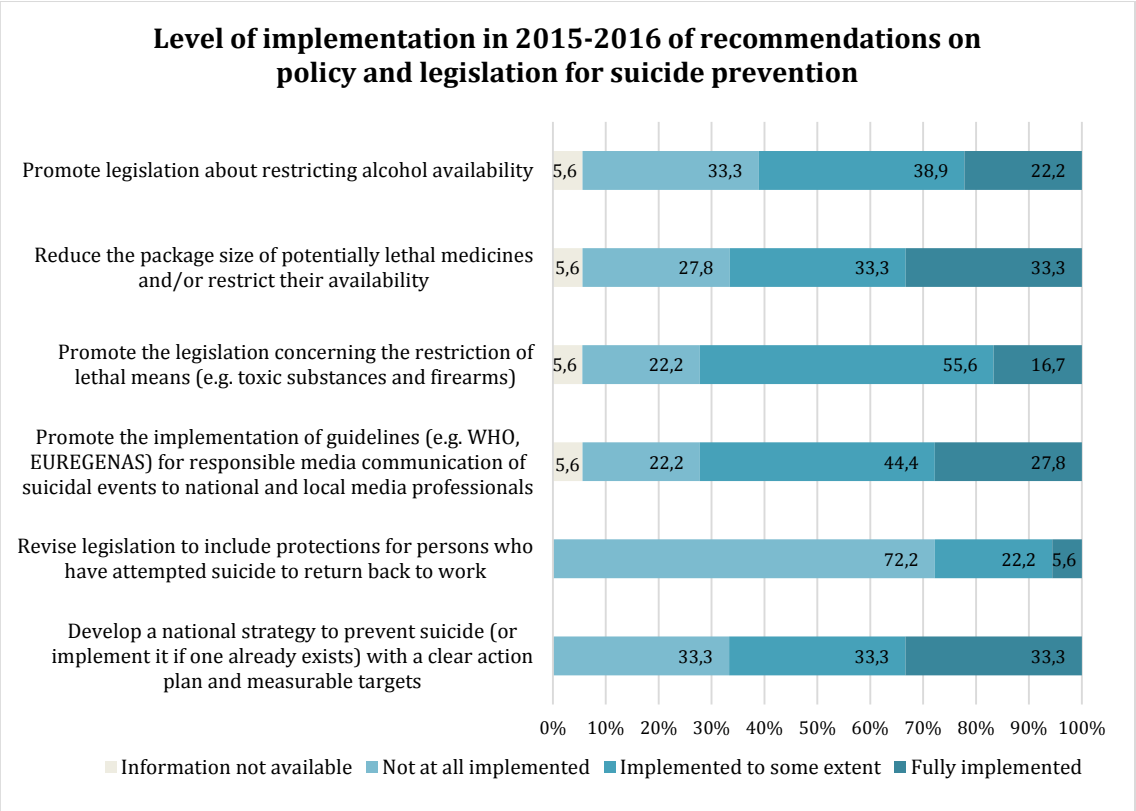

Figure 16 Level of Implementation of Recommendation on Policy and Legislation

b) Primary suicide prevention

In terms of the level of implementation of the recommendation on primary suicide prevention (Fig. 17), the most fully implemented actions implemented by 20% and 15% of the Member States were: "promote and implement programmes which lead to increased knowledge and decreased stigmatization of depression and other mental health problems in the general public"; "ensure support is available for people bereaved by suicide"; and "provide training to specific professional target groups to identify and make contact with suicidal persons". There are at least three recommendations that no Member State reported to have fully implemented: "develop age-specific IT tools for the electronic delivery of mental health promotion and suicide prevention programmes to the general population"; "educate the public about suicide and increase the public awareness concerning the signs of crisis"; and "implement mental health first aid programmes in communities to detect distress, signs and symptoms". Nonetheless, the last two

recommendations were partially implemented respectively by 80% and 68% of the Member States.

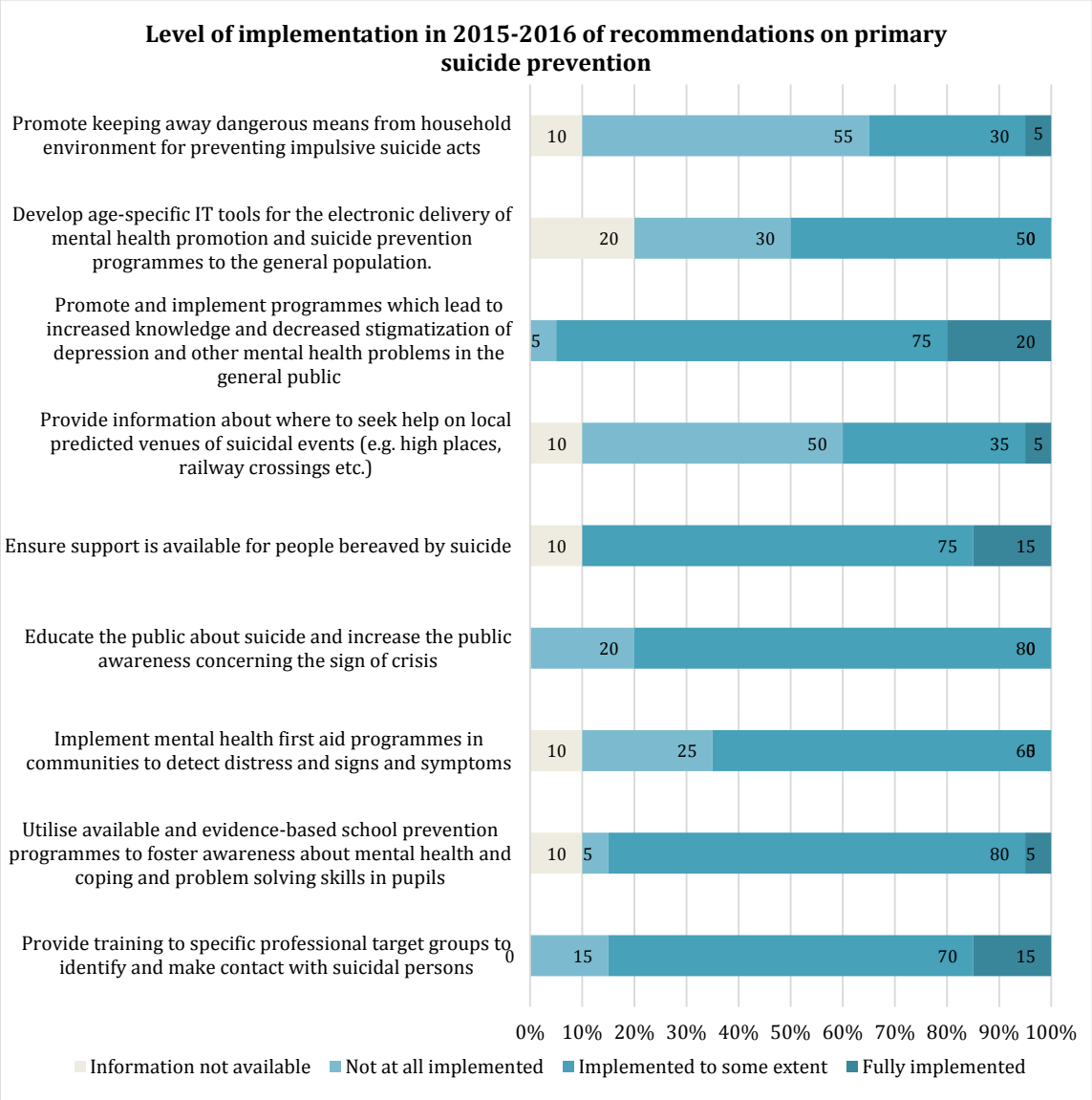

Figure 17 Level of Implementation of Recommendation on Primary Prevention

c) Secondary and tertiary suicide prevention

The most fully implemented recommendations under the topic of secondary and tertiary suicide prevention (Fig. 18) reported by nearly 32% and 16% Member States respectively were "increase the availability of telephone hotline services and utilise the methods and practice of European best practice telephone services" and "increase the availability of web-based crisis intervention services."

The recommendation to "incorporate brief intervention into emergency treatment to provide information about local, available resources for crisis management, mental and social care and suicide prevention e-health tools" was the least implemented; none of the countries implemented it to full extent and 37% of the Member States mentioned it was not at all implemented.

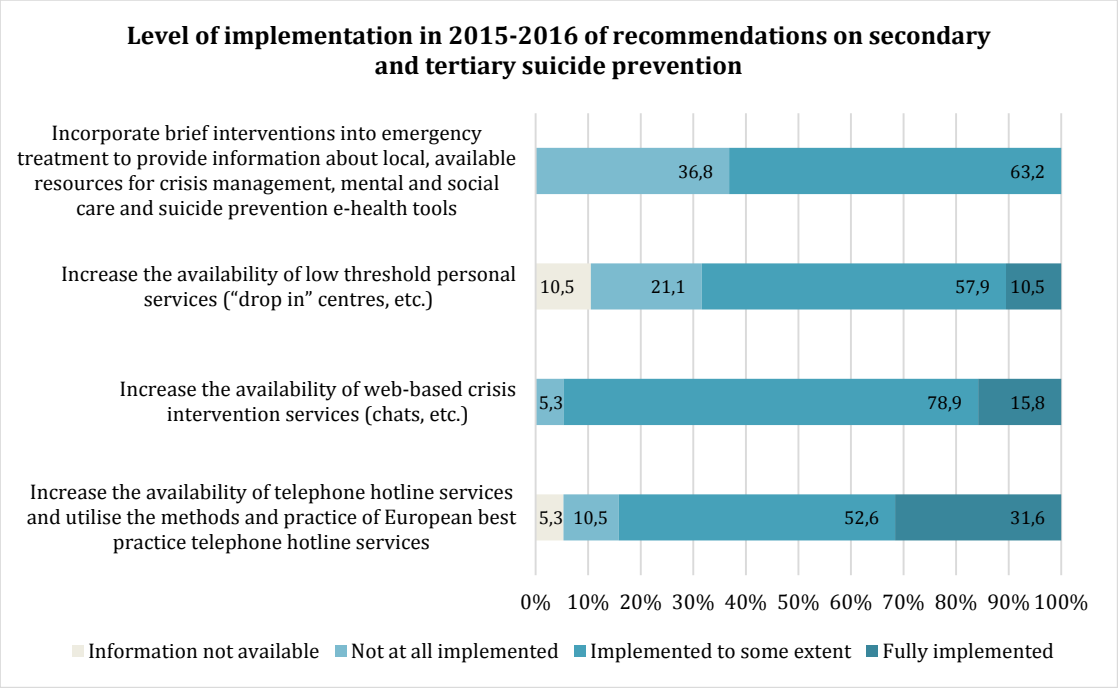

Figure 18 Figure 16 Level of Implementation of Recommendation on Secondary and Tertiary Prevention

d) Capacity building and inter-sectoral collaboration for suicide prevention

Regarding capacity building and inter-sectoral collaboration (Fig. 19), the most cited fully implemented recommendations were: "support the establishment and operation of National Centres for Suicide Research and Prevention" and "establish a national data register about suicide and attempted suicide in order to analyse the characteristics of completed suicides for the better identification of high risk groups". The recommendation that were least implemented were: "encourage the IT sector and governmental actors to develop a sustainable business model to implement further evidence-based e-mental health tools" and "systematically monitor national and regional risk-factors for suicide and suicide attempts."

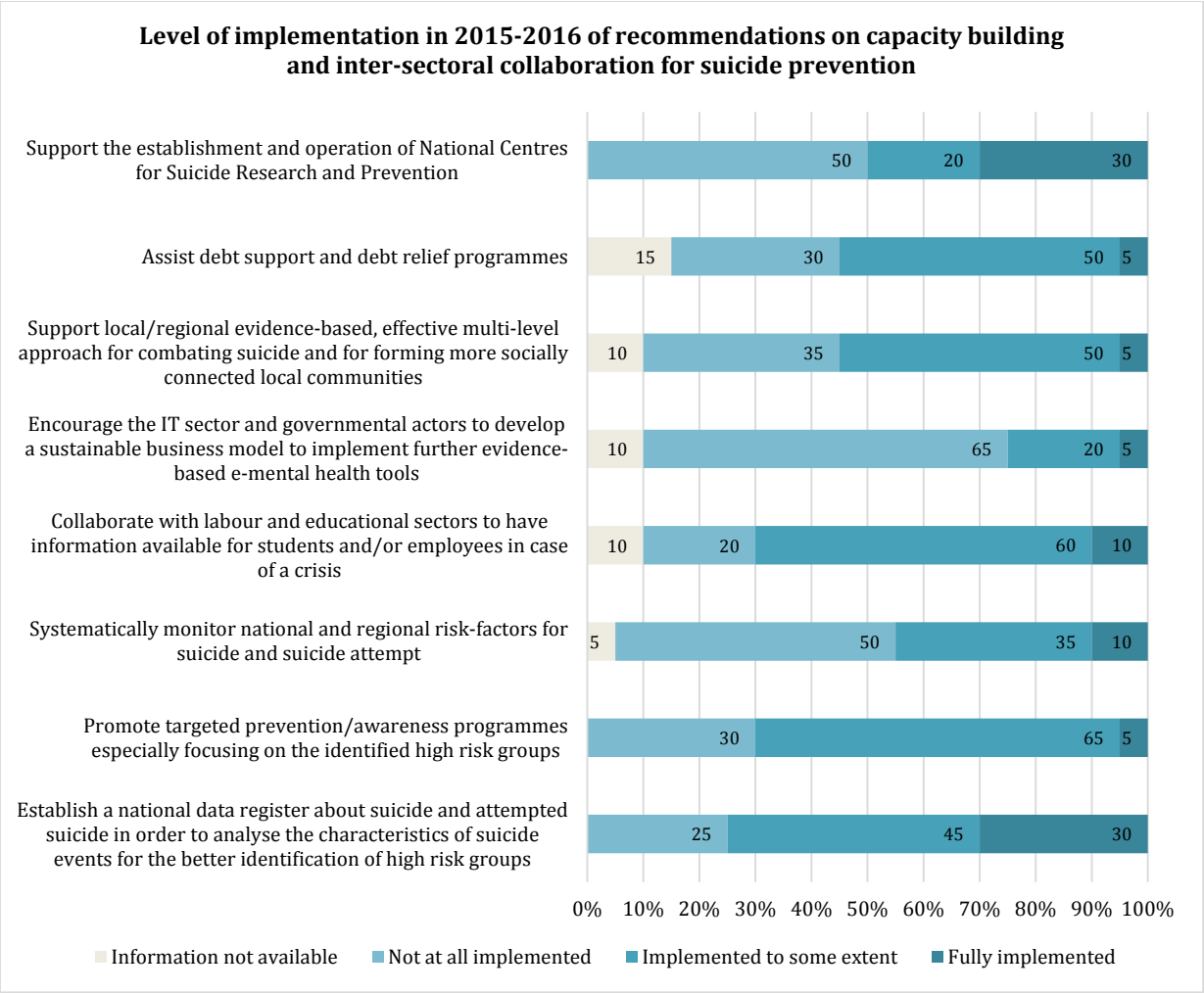

Figure 19 Figure 16 Level of Implementation of Recommendation on Capacity Building and Inter-Sectoral Collaboration

6. KEY DEVELOPMENTS IN ACTIVITIES ON MENTAL HEALTH AND WELLBEING BY STAKEHOLDERS OVER THE PAST YEAR

An analysis of the reports made by stakeholders show their action status and sector and also the level of implementation of the recommendations regarding mental health in the workplace, mental health and schools and suicide prevention.

Status and Sector of the Organization

The majority of the stakeholders reported their status (Fig. 20) to be non-governmental (third sector) and their action sector (Fig. 21) to be an integration of health and social care services.

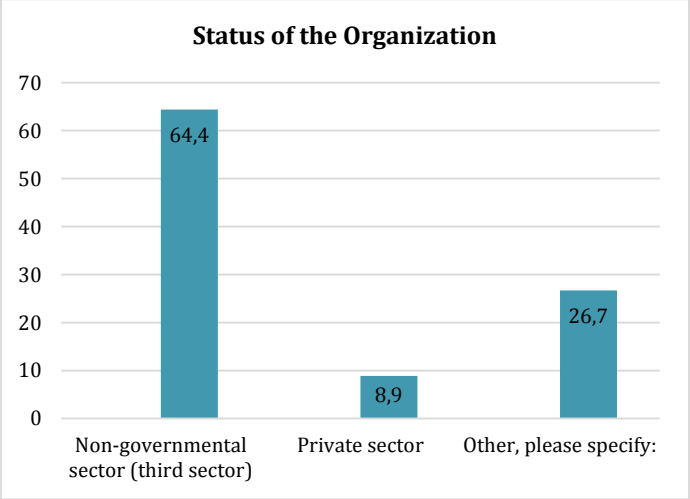

Figure 20. Status of the Stakeholders' Organizations

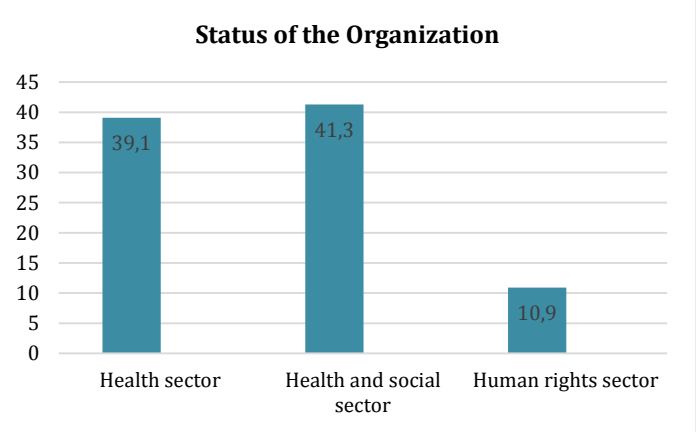

Figure 21. Sector of the Stakeholders' Organizations

Level of implementation of recommendations

Stakeholders were asked to evaluate the level of implementation of the recommendations to improve action on Mental health in the workplace, Mental Health and Schools and Suicide prevention stated in the European Framework for Action on Mental Health and Wellbeing.

a) Activities regarding mental health in the workplace

The majority of the stakeholders reported to have implemented some and up to extensively a number of activities related to mental health in the workplace (Fig. 22). The most common extensively implemented activities with rates of nearly 36% and 31% respectively were "support the reintegration/return to work of people who have experienced mental health difficulties" and "prevent mental health problems". The recommendation with the highest rate of non-implementation (29%) was "build effective cross-sector partnership and cooperation between the health policy and labour policy sectors to improve mental health and wellbeing".

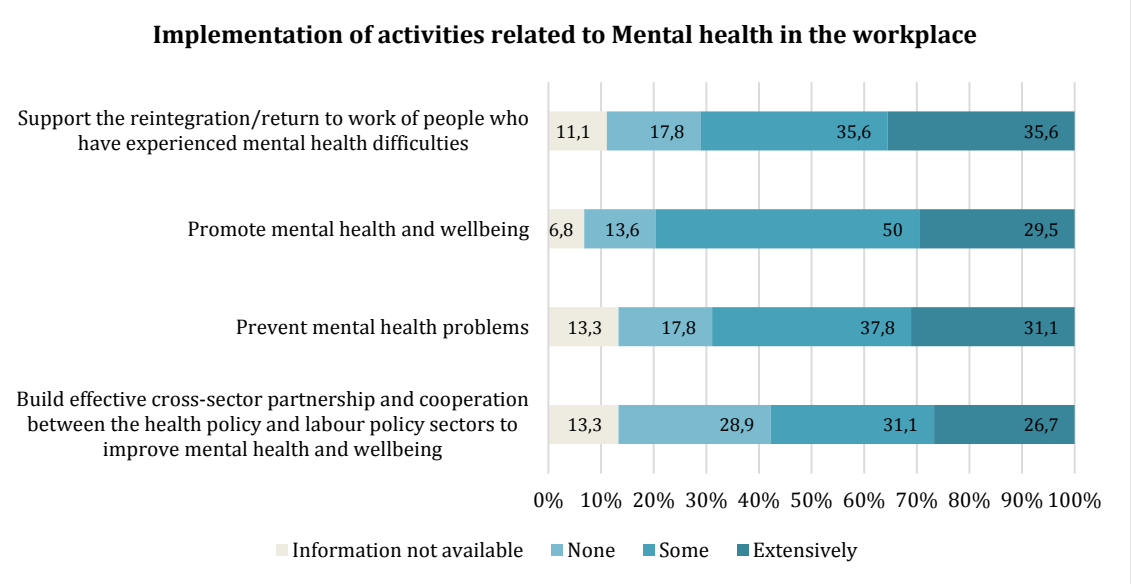

Figure 22 Level of Implementation of Activities related to Mental health in the workplace

b) Activities regarding mental health and schools

Many stakeholders reported having implemented recommendations related to mental health and schools (Fig. 23). Nevertheless, the level of extensive implementation was lesser in comparison to the recommendations' relating to mental health in the workplace and there are many stakeholders who reported none implementation in most of the activities.

The most common actions with extensive implementation included "strengthen information and research on mental health and well-being among children and adolescents" and "link schools with other community stakeholders involved in mental health of children and adolescents". Nearly half of the stakeholders reported to have not implemented "enhance training for all school staff on mental health".

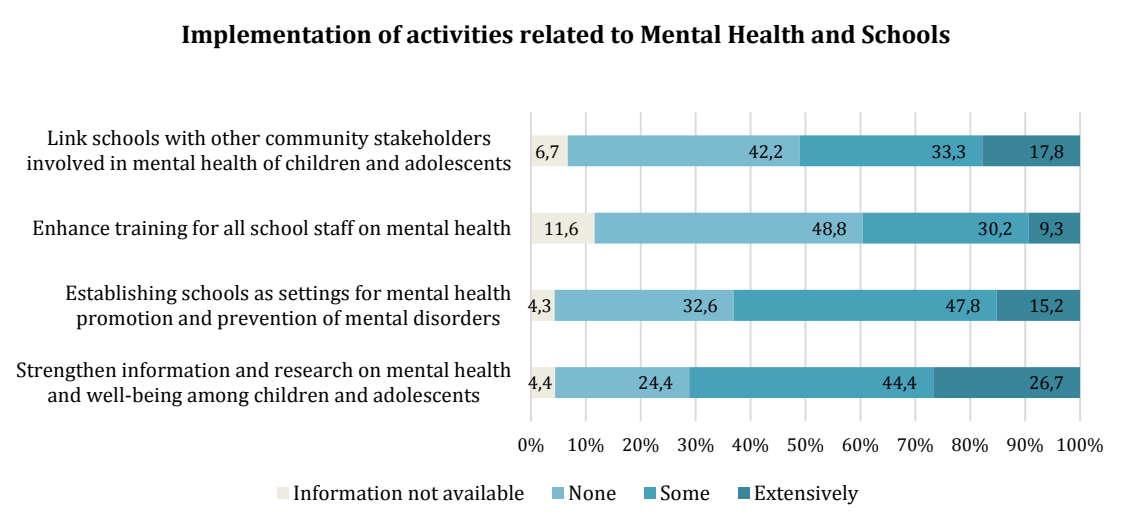

Figure 23 Level of Implementation of Activities related to Mental Health and Schools

c) Activities regarding prevention of suicides

Regarding the prevention of suicides (Fig. 24), the most common recommendations implemented extensively by the stakeholders were "primary prevention of suicides" and "secondary or tertiary prevention of suicide". The activity that most of the stakeholders reported to have not implemented was "policy and legislation to prevent suicides".

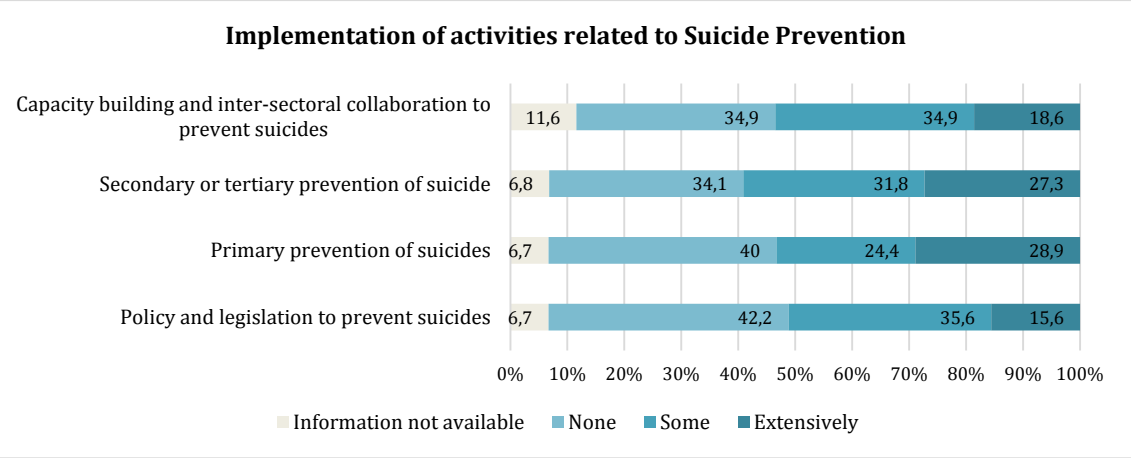

Figure 24 Level of Implementation of Activities related to Suicide Prevention

7. FINDINGS AND BEST PRACTICES IN MENTAL HEALTH IN THE WORKPLACE

As the EU Compass scientific position paper on mental health in the workplace largely shows, there is now robust evidence on work-related risks that can negatively affect both mental and physical wellbeing. A growing incidence of work-related mental ill-health, as well as increased absence from work and early retirement due to mental illness, have also been observed in most European countries (European Framework for Action on Mental Health and Wellbeing, 2016).

For these reasons, it is now widely recognized that promoting mental health and preventing mental ill-health in the workplace should be a priority in public mental health.

The critical analysis of the literature presented in the EU Compass scientific paper demonstrates that a large number of interventions in the workplace proved to be effective in the prevention of common mental ill health, as well as in facilitating the recovery of employees diagnosed with depression and/or anxiety. It also shows that the available studies on an economic perspective indicate a positive return on investment at the level of mental health promotion in the workplace. However, further research is necessary to examine interventions addressing risk factors in the work environment in combination with interventions at the individual level. More studies are also needed on the effectiveness of comprehensive programmes in medium sized companies.

The interventions that should be used range from the introduction of statutory regulation to voluntary workplace health promotion measures aiming at prevention, treatment and rehabilitation, including occupational integration (European Commission, 2016).

Several important policy actions, described in the scientific paper, have already been taken both at EU level and in the Member States to promote mental health in the workplace in a coordinated manner.

The thematic report on mental health in the workplace produced by the EU Joint Action for Mental Health and Wellbeing includes a comprehensive situation analysis in Europe, provides several examples on good practices in mental health

and well-being in the workplace and offers recommendations that were included in the EU Framework for Action on Mental Health and Wellbeing.

Examples of these good practices include, among others:

- the *Well-being Guild of Entrepreneurs*, developed in Finland, whose main objective was to support the mental well-being of small and medium-sized entrepreneurs and ensure that they have the skills and resources to take early action in case of onset of mental health problems.
- the project "*Mental Health in the World of Work*" (psyGA - Psychische Gesundheit in der Arbeitswelt), promoted by the German Federal Ministry of Labour and Social Affairs, and managed by the Federal Association of Company Health Insurance Funds (BKK Bundesverband), aims to reduce mental stress and to promote mental health in the workplace.
- the *SP@W: Stress Prevention at Work Project*, from The Netherlands, uses a strategic approach to workplace stress which is practical, integrated and customized.
- the *Individual Placement and Support (IPS),* implemented in the UK in 1995, supports people with severe and/or chronic mental health problems into and/or retain paid competitive employment.

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

The analysis of activities developed by Member States and stakeholders shows that significant progress was made in 2016 towards some of the objectives of the European Pact and the Framework for Action.

One limitation of this analysis concerns the lack of information on relevant activities in mental health developed over the past year for ten EU countries. This limitation is particularly important regarding the Eastern European countries as five of the countries from which it was not possible to obtain information on the activities developed in 2016 belong to this Region. Possible explanations for the modest rate of response to the surveys may be related to the complexity and number of questions of the questionnaires, the time available for the collection of the requested information and insufficiencies of mental health information systems at the national level.

The areas in which more countries reported key activities were promotion and prevention initiatives, service (re)organization and service quality activities; whereas, legislation and impact assessment are two areas in which key developments were still absent in more than 30% of the countries.

Overall, in 2016, some countries accomplished important steps in the implementation of comprehensive mental health strategies, involving innovative developments in policy, financing and funding, reorganisation of services, promotion and prevention. This was particularly evident in the Nordic countries, the UK and the Netherlands. Most of the other countries continued reforms previously initiated and/or started new key activities in specific areas (e.g., child and adolescent mental health care, promotion and prevention programmes, participation of consumers and families, mental health in all policies, etc.). Unfortunately, an assessment of the progress and difficulties registered in a significant number of countries could not be done due to the lack of information.

Activities in legislation were focused on two main aspects: preparation or implementation of new mental health laws and regulation of admission to treatment and problems related to compulsory treatment. As previously noted,

references to activities related to the incorporation of CRPD in the national legislations were scarce.

New policy developments were centred on the preparation and implementation of national mental health programs (e.g. Iceland, Portugal and Sweden), and in the development of specific strategies, such as child and adolescent care (Croatia), suicide prevention (Luxembourg), and specialized care for people with severe mental disorders (Denmark).

Confirming the encouraging signs found in 2015 in the financing of mental health, several Member States (e.g. Denmark, Finland, Iceland, Netherlands, Sweden and UK), reported additional State funding for mental health in 2016, with some of them specifying the amounts allocated to the selected objectives and programmes. The areas receiving additional funds include children and young people's mental health, suicide prevention, crisis care services in the community, perinatal mental health, and mental health liaison teams in general hospitals, eating disorders, improvement of psychiatric ward facilities, psychological services in primary health care and multi-disciplinary teams that provide mental health and social services for people with severe mental disorders.

A large reform of social welfare and health care, in order to reduce health and social inequalities, and to manage costs is going to be developed by Finland, while Portugal and Spain are updating their mental health strategies. New services were developed for child mental health care (e.g. Croatia, Cyprus, and Finland), migrants (Luxembourg), drug additions and mental health services in prisons (Cyprus).

Integration and continuity of care has been a special concern in some countries (e.g. Iceland and Portugal), while several countries developed service quality programmes (e.g. Belgium and the UK)

All countries reported new developments in promotion and prevention plans and programmes. Many addressed the prevention of mental disorders in general as well as activities tackling the stigma and discrimination of mental illness. Important advances took place on suicide prevention, work-based programmes, school-based programmes, depression prevention, drug abuse prevention, strengthening of parenthood and couple relationships, promotion of children's rights, among others.

Most countries reported cross-sectoral cooperation as a common practice. Several created new coordinating platforms for the implementation of projects involving different sectors (e.g. Austria for psychosocial support of refugees and aid workers, Norway for violence prevention, preventing school dropout and mental health in asylum seekers and refugees, Greece for a deinstitutionalization strategy, the UK for a Cross-Government National Suicide Prevention Strategy).

The involvement of patients, families and NGO´s in the development of mental health initiatives of different types is now considered a mandatory requirement of Governments in most countries. Some countries (e.g. Austria, Belgium, Denmark, Finland, Luxembourg, Norway, Portugal, Sweden and UK) reported interesting innovative initiatives in this field.

The large majority of Member States monitor the mental health status of the population through surveys and national register data. Interesting new activities took place in 2016 in the measurement of mental wellbeing at a national level (Norway), the situational analysis of child and adolescent mental health status (Croatia), monitoring of programmes for the prevention of suicide in prison (Italy), and monitoring of the health promotion and prevention activities of municipalities (Finland). The Netherlands continued a psychiatric epidemiological longitudinal study in the general population aged 18 to 64, as well as an annual monitoring of suicide, while the UK published the seventh yearly National Adult Psychiatric Morbidity Study for England.

The impact of policies is still not assessed in a significant number of countries. However, important progress was reported by some Member States in the monitoring of mental health targets and mental health promotion (e.g. Austria and Finland), in the use of Youth mental health care and the monitoring of the transition of intramural mental health care to ambulatory health care in Netherlands. The UK established a new mental health data strategy and Mental Health Data Board, which sets the strategy for collecting data on mental health to progress and measure the impact of policies.

The 2016 reports show that Member States are increasingly adopting the Mental Health in All Policies (MHiAP) framework. For instance, Iceland developed a new Public Health Policy based on this framework, in Austria MHiAP played an

important role in the creation of a coordinating platform for psychosocial support of refugees and aid workers. In Sweden, one of the key issues for the National Mental Health Coordinator is to make sure that a MHiAP perspective is present in all initiatives at a governmental level and that the key actors work together within different policy areas. In Finland, all important mental health programmes are based on a MHiAP approach.

The analysis of the stakeholders reports show that the majority of them implemented activities related to mental health in the workplace, particularly activities associated to the reintegration/return to work of people who have experienced mental health difficulties and to the prevention of mental health problems.

Many stakeholders reported having implemented recommendations related to mental health and schools (Fig. 23). Nevertheless, the level of extensive implementation was lesser in comparison to the recommendations implemented relating to mental health in the workplace and there are many stakeholders who reported no implementation in most of the activities.

Regarding the prevention of suicides, the most common recommended activities implemented extensively by the stakeholders were “primary prevention of suicides” and “secondary or tertiary prevention of suicide”. The activity that most of the stakeholders reported to have not implemented was “policy and legislation to prevent suicides”.

9. RECOMMENDATIONS

Based on the analysis of the advances registered in 2016 towards the objectives of the EU Joint Action on Mental Health and Wellbeing, and taking into consideration the information described in this Report on the difficulties and insufficiencies found in the implementation of mental health policy in Europe during the past year, new recommendations, that complement the existing recommendations of the Framework for Action, can be formulated in the following areas:

Information systems and sharing of information

- Develop mental health indictors and improve collection of data that measure performance of mental health services and the impact of mental health policies
- Improve capacity of Member States to share information on mental health policy monitoring

Legislation and policy

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

Financial resources

- Recommend to all countries that they increase the financial resources allocated to mental health to the level registered in several EU countries in the last years, in order to reduce disparity and inequalities
- Ensure additional funding to areas that have been often neglected, such as child and adolescent mental health care, psychological services in primary health care and multi-disciplinary teams that provide mental health and

social services for people with severe mental disorders, mental health promotion and prevention programmes

Services Organization, development and quality

- Continue implementation of the reforms and redesign of mental health services aimed at improving the transition to comprehensive and socially inclusive community-based mental health care
- Develop programmes contributing to the improved quality of mental health services

Mental health in the workplace

- Establish a European Platform to promote cooperation among key stakeholders in the fields of healthcare, occupational health and safety and support for the unemployed building on existing structures and experiences.
- Develop coordinated strategies for occupational health and safety and workplace health promotion at EU and national level, translated into joint general guidance and recommendations.
- Improve the interface within healthcare and social security systems to accelerate the re-integration of employees into the workforce with appropriate support.
- Disseminate good risk management practices in enterprises, including psychosocial risk management.
- Promote systematic comprehensive multi-modal approaches and practices which combine improvements in working conditions and lifestyle factors that are evidence based.
- Strengthen the evidence base by investing in the implementation and evaluation of organisational level interventions; studies in small and medium-sized organisations; studies examining positive mental health and wellbeing and associated outcomes; and policy evaluation studies.
- Address the specific needs of micro, small and medium sized enterprises in relation to the adoption and implementation of good workplace mental health promotion practices, tools and guidelines, through coordinated action of key stakeholders.

- Promote the interpretative document of Council Directive 89/391/EEC to clarify legal requirements for employers and other key stakeholders in Europe.
- Strengthen existing monitoring systems in the EU (such as the European Working Conditions Survey, the European Survey of Enterprises on New & Emerging Risks, DG Sante monitoring surveys) to allow better monitoring and benchmarking across members states.
- Showcase further the positive benefits of a healthy work environment for business and societal sustainability, raising awareness on the positive impact of good mental health and the need for fighting stigmatization.

Mental health and schools

- Carry out a mapping and analysis of existing screening tools for early identification of mental health disorders and poor well-being among children and school populations
- Increase the access to promotion information and to prevention services through the use of web based technologies (e-mental health)
- Establish a solid information base to have a detailed epidemiological frame of child and adolescent mental health and evidence on interventions
- Put in place evidence based interventions to combat early school leaving/drop out
- Actively consult children and adolescents and their families when developing any programmes to ensure their best interests are taken into account
- Involve representatives of other sectors, such as social, criminal justice and youth organisations, and allocate appropriate resources in the training for all school staff
- Ensure that training is also made available to the members of the families and caregivers of children and adolescents, based on a community level approach

- Estimate the data on workforce and financing specifically dedicated to the mental health of children and adolescents per sector and ensure adequate, sustained and shared financing by the different sectors
- Evaluate the effectiveness of school based interventions, also with the aim to reduce costs incurred by mental ill-health in all sectors

Suicide Prevention

- Take measures to ensure that the Member States that still haven't a national strategy to prevent suicide will have one and that all Member States will have a clear action plan and measurable targets
- Promote revision of legislation to include protections for persons who have attempted suicide to return back to work
- Promote actions to reduce the means in the domestic environment that prevent impulsive suicide acts
- Provide information and signage about where to seek help at local predicted venues of suicidal events (e.g. high places, railway crossings etc.)
- Develop age-specific IT tools for the electronic delivery of mental health promotion and suicide prevention programmes to the general population.
- Incorporate brief interventions into emergency treatment to provide information about locally available resources for crisis management, mental health and social care and suicide prevention eHealth tools
- Encourage the IT sector and governments to develop a sustainable business model to implement further evidence-based e-mental health tools
- Support the establishment and operation of National Centres for Suicide Research and Prevention
- Systematically monitor national and regional risk-factors for suicide and suicide attempts.

REFERENCES

European Commission (2008). European Pact for Mental Health and Wellbeing. Available at: http://ec.europa.eu/health/mental_health/policy/index_en.htm

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