



European  
Commission

# Mental Health:

good practices and implementable  
research results

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# **Mental Health:** good practices and implementable research results



# Contents

- 06 *One of Us*
- 08 *SUPRA Suicide Prevention in Austria*
- 10 *Life Works*
- 12 *Joint Experiences and Local Mental Health Systems*
- 14 *Mental health care delivery system reform in Belgium*
- 16 *Flexible Assertive Community Treatment (F-ACT)*
- 18 *Individual Placement and Support for Employment (IPS)*
- 20 *European Alliance Against Depression (EAAD)*
- 22 *The Well-being Guild of Entrepreneurs*
- 24 *Multisystemic Therapy (MST)*
- 26 *Housing First Portugal*
- 28 *Stability training*
- 30 *The Professionally Guided Peer Support Groups for Bereaved by Suicide*
- 32 *Comparing policy framework, structure, effectiveness and cost-effectiveness of functional and integrated systems of mental health care - The COFI study*
- 34 *COPING: Children of Prisoners, Interventions and Mitigations to Strengthen Mental Health*
- 36 *Using the power of football to improve lifestyle & health in football fans (EuroFIT)*
- 38 *MasterMind*
- 40 *SPLENDID*

# Fighting Stigma at Work

**ONE OF US**

No more doubt, silence and taboo about mental illness!

ONE OF US – the national campaign for anti stigma in Denmark  
[www.one-of-us.nu](http://www.one-of-us.nu)

**Source reference:**  
EU Compass

## **Practice description:**

- ONE OF US was started in 2011, initiated by the health and social sectors.
- The labour market is one of the five target areas - implementation at national, regional and local level
- Based on social contact activities and printed and digital materials, including films
- Objectives:
  - Lived experience involvement and recognition
  - Knowledge of recovery
  - Timely help-seeking
  - Reflection on culture and language
  - Reduced self-stigma

## **Outcomes/Results:**

- Strategic partnerships with relevant organizations and materials relevant for use on multiple levels worked well with the implementation of the practice.
- Anti-stigma work is dependent on collaborators willing to “open the door” into their own organization and network and ambassadors willing to share their lived experience.
- Ambassadors experience significant improvement in personal recovery and empowerment.

This practice connects to the public health priority:  
Mental health at work

## Fighting Stigma at Work: One of Us

Location: [Danemark](#)

More information: <http://en-af-os.dk/english>

Fighting Stigma at Work: One of Us began September 2011; it was initiated by the health and social sector. The practice focuses on campaigns.

The objectives of the Fighting Stigma at Work: One of Us are:

- the increased recognition and involvement of service users' and relatives' knowledge and competence.
- increased knowledge of recovery.
- a call to seek timely help.
- increased reflection on culture and language.
- combating self-stigma, guilt and shame.

One of Us focuses all activities on methods that have been proven to be relevant for anti-stigma efforts to facilitate identification, empathy and reflection through:

- social contact activities where target groups can meet people with lived experience of mental illness for information and dialogues at schools, work places, health and social units, festivals, and conferences.
- films, pictures, TV, radio, and theater about and or with people with lived experience of mental illness.
- dialogue, information, knowledge via social media.
- challenging myths with facts.
- PR initiatives based on data from surveys that can promote more positive stories of mental illness and people affected hereby than the traditional media coverage based on dramatic incidents.

Fighting Stigma at Work: One of Us has been evaluated or assessed. Evidence shows that programme ambassadors experience a significant improvement in personal recovery and empowerment.

# Suicide Prevention Austria (SUPRA)



Federal Ministry  
Labour, Social Affairs, Health  
and Consumer Protection

Austrian Federal Ministry of Labour,  
Social Affairs, Health and Consumer  
Protection

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**Source reference:**  
EU Compass

SUPRA is a multilevel national suicide prevention programme with the main objectives to ensure support for risk groups, to restrict access to means of suicide, to raise awareness and develop media support for suicide prevention, to integrate suicide prevention programmes into other health promotion activities, and to support research on suicide.

- In 2012, the Austrian suicide prevention program SUPRA was published and the Austrian Ministry of Health established a „coordination centre“ at the GÖG (Austrian Public Health institute) to support the process of implementation.
- Goals and measures that were already ongoing (i.e. media guidelines) or easy to achieve were conducted immediately (i.e. annual national suicide reports and conferences, webpages, several regional initiatives and projects)
- Meanwhile, a structured concept for implementation, with 6 strategic, 18 operative goals and 70 measures (including target sizes, indicators and responsibilities), was developed with a panel of leading national experts.
- Finally, a suicide prevention starter package was defined with prioritisation of measures on regional and national levels that will be implemented within the next two years.

The multilevel approach and the measures associated with SUPRA are based on scientific evidence. The annual reports on suicide rates will be supplemented by programme updates and monitoring.

Awareness for mental health and suicide prevention have increased among policy makers in the last years. Several federal states have drawn on the SUPRA implementation concept for their own local suicide prevention programmes and a variety of national and regional suicide prevention projects are currently being funded. The major focuses correspond to the starter package: provision of a national 24 hour hotline, nationwide roll-out of train-the-trainer and gatekeeper-training programmes, implementation of suicide prevention programmes in schools, identification and management of suicide hotspots, dissemination of media guidelines and establishment of the Papageno-Media Award.

[https://www.sozialministerium.at/site/Gesundheit/Gesundheitsfoerderung/Psychische\\_Gesundheit/Suizid/](https://www.sozialministerium.at/site/Gesundheit/Gesundheitsfoerderung/Psychische_Gesundheit/Suizid/)

Public health priority: Preventing suicide



## Suicide Prevention Austria (SUPRA)

Location: [Austria](#)

More information: <https://www.bmgf.gv.at/home/suizid>

Suicide Prevention Austria began January 2017. The practice focuses on action programmes and policy.

The objectives of Suicide Prevention Austria were to coordinate suicide prevention in Austria at the national and regional levels, to ensure support for risk groups, to develop standards for access to means of suicide, to develop media support for suicide prevention, to integrate suicide prevention programmes into other health promotion activities, and to support research on suicide.

In 2012, the Austrian suicide prevention program SUPRA was published and the Gesundheit Österreich GmbH was assigned to support its implementation by the ministry of health. The program is a 70 page paper that was written by Austria's leading experts. It describes a broad range of possible measures. However, the paper does not go into details on prioritization of measures, responsibility for implementation, recommended target goals or outcome indicators. In order to convince decision makers to foster suicide prevention in a federally structured country like Austria, all of this information is crucial, especially in times of limited resources. A double strategy was chosen for the implementation of SUPRA. In close collaboration with a panel of leading experts, 6 strategic and 18 operative goals were identified and more than 70 measures, target sizes, indicators, and responsibilities were described.

Suicide Prevention Austria has been evaluated or assessed. The measures associated with Suicide Prevention Austria are based on scientific evidence; implementation of SUPRA in the region of Styria has partly been evaluated during the last two years but has not be published at this time.

# Lifeworks Psychotherapy



Intapsych

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**Source reference:**  
EU Compass

## **Practice description:**

- Lifeworks is located in London, but can be replicated in any city; it is a specialised open access psychotherapy service for homeless people and rough sleepers. It:
- Provides access to psychotherapy in hostels, day centres, places where rough sleepers and homeless people are
- Provides high quality psychotherapy to people with complex presentations including personality disorders, psychosis, drug and alcohol dependency, histories of compound trauma, and who are otherwise excluded

## **Outcomes/Results:**

Over 75% improvement in wellbeing scores  
Reduction in use of emergency medical services  
Increase in take-up of other services (e.g. health, resettlement, training/employment)  
High attendance (>75%) and engagement (>70%)  
Improved housing and resettlement outcomes

**Better access to mental health**

- PREVENTION OF DEPRESSION AND PROMOTION OF RESILIENCE
- PROVISION OF COMMUNITY-BASED MENTAL HEALTH SERVICES
- PROVISION OF MORE ACCESSIBLE MENTAL HEALTH SERVICES
- SUICIDE PREVENTION

## Lifeworks

Location: [United Kingdom](#)

More information: <https://www.mungos.org/wp-content/uploads/2017/07/LifeWorks-Recovery-Results-Briefing.pdf?x74044>

Lifeworks started in 2008 and is still ongoing. The program was initiated by the voluntary sector and is a service-delivery approach/method. The objective of Lifeworks is to improve mental health and resilience of socially excluded people, including those who are homeless and rough sleepers. Activities focus on individual psychotherapy in accessible places such as hostels, day centers, and other community settings. Concrete results of Lifeworks include:

- 70% engagement from rough sleepers and homeless people and >75% attendance;
- >75% positive outcomes, as measured by the South London and Maudsley evidence-based Well-being Measure; and
- an increase in social functioning across all measures of Outcomes Star (for example 44% of people were in training or work placement after six months, compared to 20% of those who were not in the service).

**Italian Association for Mental health, Tuscany Health Agency, Tuscany Network of Mental health Associations, Tuscany Network of Mental Health Users**

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**Joint Experiences and Local Mental Health Systems**

**Source reference:**  
EU Compass

**Background/Introduction**

The Joint Experiences and Local Mental Health Systems project (JE&LMHS) is the continuation of psychiatry led self-help oriented endeavours which began in Florence and Prato (Italy) in the 80's.

- Currently in its 3rd phase, the project began in Prato at the beginning of 2000, through collaboration between various agencies at both Italian and European level.
- In the 1<sup>st</sup> and 2<sup>nd</sup> phases of the project (2001 - 2005 and 2009 - 2012) three main elements and their interactions were particularly studied, at theoretical and practical levels : (1) the Joint Experience (collaboration) (2) the Intermediate Area - area between the services and the community (3) the Local Mental Health System - comprising the local community and the services.
- The 3<sup>rd</sup> phase of the project started in 2014. A steering group composed of the Tuscany Agency for Health (ARS), the Italian Association for Mental Health (AISMe), the Tuscany Network of Mental Health Associations, and the Tuscany Network of Mental Health Users, jointly worked on developing an instrument to obtain an up-to-date map of the Tuscany projects; associations collaborated with services and local governments in peer relationship (Joint Experiences). Two questionnaires have been produced, one relating to the Joint Experiences, and the other to the associations.
- The key requisites of the project are : (1) services allowing professionals to spend part of their working time outside therapy/rehabilitation settings (2) users wanting to take responsibility for their wellbeing (3) local governments wanting an active role in mental health.

**Aim of the Project**

The project is founded in the awareness that good mental health cannot be attained through special services alone; the involvement of local communities is important. Thus the aim of the project is to develop a variety of collaborative activities in peer relationship (joint experiences) amongst services, associations (especially service user and carer associations) and local governments.

**Outcomes**

The possibility of knowing each other more closely in a positive and transparent way, through a jointly made instrument like the questionnaire, was recognised as very important for the different projects and associations. Some suspicions of inappropriate competition, clientelism and conflicts of interest could diminish significantly / disappear.

It was decided to proceed further with the mapping of the joint experiences and exploring the experiences in more depth.

Associations and local governments in Tuscany are becoming more active, working for action/research projects together with services and other organizations. The newly established recovery centre led by AISMe in Florence (Casa della Cultura) is closely implementing the project.

A JE&LMHS project was started in Watford (Hertfordshire, UK) in the second half of 2018, from within the local mental health service (HPFT), with some service users involved from virtually the start.

Mention the public health priority that this practice connects to. Better access to mental health

## Joint Experiences and Local Mental Health Systems, third edition 2014-2017

Location: [Italy](#)

More information: <http://aisme.info/en/2015/06>

The Joint Experiences and Local Mental Health Systems program was started in 2014 and was initiated by the cultural sector, the social sector, and the health and social sector. Joint Experiences focuses on action and research. The objectives of Joint Experiences and Local Mental Health Systems include:

- to develop local knowledge in mental health by activating social and cultural elements in order to better balance the current predominance of the therapeutic approach of services based on global and mainly bio-medical knowledge;
- to develop different initiatives at local level through peer to peer collaboration among users, carers, local governments, and services (Joint Experiences);
- to permanently monitor both the state of each Joint Experience and the relationships among users, carers, local governments and services; and
- to establish an intermediate area between the service and the community as support to the Joint Experiences, which is led democratically by user organizations, relative organizations, services, and local governments.

Activities of Joint Experiences and Local Mental Health Systems focus on a questionnaire for mapping the Joint Experiences in Tuscany, data collection, data processing and discussion with the core group, and production of a web profile for each Joint Experience. Furthermore, meetings are held with all stakeholders for revision of the questionnaire and the project; a conference is held to launch a permanent online mechanism to update the Joint Experiences regarding both their internal functioning and the relationship with their local mental health system. Concrete results (outputs and outcomes) of the practice include the direct involvement of user and carer organizations in the field of action-research and the development of local knowledge beyond the biomedical knowledge.

# Mental health care delivery system reform in Belgium



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**Source reference:**  
 EU Compass  
 Providing community based mental health services.

## 1. Introduction

- Approximately 25% of the Belgians are experiencing some sort of psychological distress.
- Until 2010, the national Belgian mental health care strongly remained a hospital-based system. With more than 150 beds per 100.000 inhabitants, Belgium ranks itself in the global top 3.
- Belgium's mental health care reform is based on a comprehensive and integrated approach, with the construction of a network around the user, enabling resources to be used efficiently in line with the needs and with a recovery oriented vision.
- Since 2011, creation of networks covering each Belgian municipality since mid 2016
- **The reform targets any adult with mental health issues.**



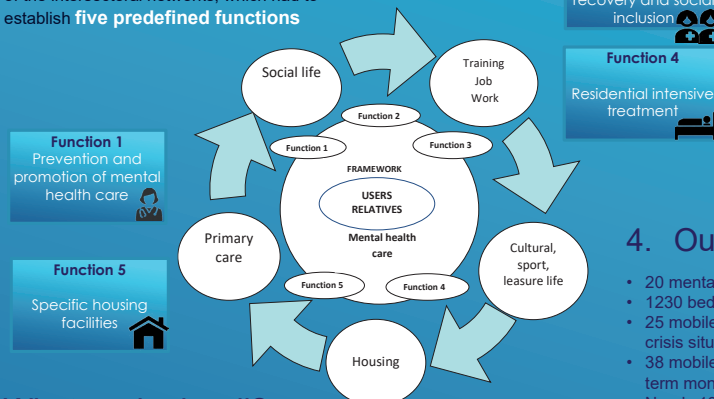
## 2. Main aims

- Improve quality of care.
- Improve quality of life.
- Costs - Efficiency.
- Better working environment for mental health workers
- The reform implicates bed reduction, to be accomplished by a reallocation of the bed-based financial means to new mobile treatment teams or hospital care intensification.

## 3. Objectives

- **De-institutionalization:** limiting residential treatment in health care facilities to those who really need it.
- **Inclusion:** readaptation and rehabilitation in the context of an indispensable collaboration with the sectors of education, culture, work, social housing ...
- **De-categorization:** establishment of an intersectoral collaboration, through circuits and networks of care. All the stakeholders work together around the user.
- **Intensification:** intensification of care within hospitals, corresponding to shorter hospital stays and treatments with intensive care programs.
- **Consolidation:** regularization of the various pilot projects involved, at the federal, community and regional levels, within the concept of globalization of mental health care. This goal is not reached yet.

A network coordinator is financed for each pilot project to facilitate the creation of the intersectoral networks, which had to establish **five predefined functions**



## 4. Outcomes and results

- 20 mental health care networks.
- 1230 beds used for 548 FTE mobile care.
- 25 mobile or ambulatory of intensive treatment teams for crisis situations.
- 38 mobile or ambulatory teams for people who require long-term monitoring.
- Nearly 13.000 users followed by mobile teams on annual basis.

## 5. What worked well?

- The local implementation, taking into account the opinion of the different actors in the field.
- The development of the model of care based on the concept of Network on the basis of a global and integrated offer.
- The network coordinator for the coherence of resources and the formalization of procedures
- The involvement of users / relatives at all decision levels.



- The model is based on the community approach with a vision oriented towards recovery.
- Interest was shown by the WHO for the reform that our authorities wished to take into consideration by carrying out, in partnership, the manual of innovative practices.

## 6. Recommendations

- It is helpful to **include** all relevant authorities, all stakeholders, professionals, users, and relatives in a **bottom-up** movement.
- It is important to include **users and relatives**: "Nothing about us without us".
- Having a **clear strategic plan** is recommended.
- It is necessary to develop a global training program for all stakeholders.



Contribute to innovative, efficient and sustainable health systems



- PROVISION OF COMMUNITY-BASED MENTAL HEALTH SERVICES
- PROVISION OF MORE ACCESSIBLE MENTAL HEALTH SERVICES
- INTEGRATED APPROACHES TO GOVERNANCE
- MENTAL HEALTH IN THE WORKPLACE
- MENTAL HEALTH IN ALL POLICIES

## Mental health care delivery system reform in Belgium

Location: [Belgium](#)

More information: <http://www.psy107.be>

Until 2010, Belgian mental health care strongly remained a hospital-based system. Although the late eighties and nineties gave rise to new housing initiatives nationwide, such as sheltered living and psychiatric nursing homes, this was only a first step in a further evolution towards a community-based approach. A transformation of supply-driven residential mental healthcare towards a more differentiated demand-driven care was needed. The Joint Declaration of all ministers responsible for public health in 2002 on the future mental health policy stated that future acute and chronic care had to be organised through collaborating networks and circuits for three target groups (children and adolescents, adults and the elderly), bringing mental healthcare as close as possible to the needs and demands of people with mental health problems. In May 2010, public health authorities launched the 'Guide towards a better mental health care', thereby setting in motion the reform for adults. The Guide described a programme and an organisational network model. A network coordinator was financed for each pilot project to facilitate the creation of the intersectoral networks, which had to establish five predefined functions:

- prevention and promotion of mental health care, early detection, screening and diagnostic activities;
- ambulatory teams offering intensive treatment;
- rehabilitation team focusing on recovery and social inclusion;
- residential intensive treatment; and
- specific housing facilities for both acute and chronic mental health problems.

Belgian mental healthcare has undergone profound changes in an ongoing transformation process towards a community-based mental health care. Inter-organisational networks and a recovery-oriented practice can be considered key aspects therein. The aim now is to broaden and deepen the reform over the next years for all regions and target groups. The professional sector, the authorities, the patient, and family federations have undertaken this journey side by side.



Source reference:  
EU Compass

# Flexible Assertive Community Treatment (F-ACT)

integrated care for persons with Severe and persistent Mental health Issues (SMI)

**Size of problem in Europe:** SMI affect about 2% of population but cause highest costs of health systems. Mental disorders rank 1<sup>st</sup> cause of Years Lost due to Disability (YLDs).

**Added value:**

Traditional/usual care	F-ACT model
Hinders recovery & participation in society, frequent acute crisis & hospital admissions, revolving door syndrome, police presence, family alienation & social exclusion. Inequities in housing, finance, work, social contacts, etc	Evidence-based service delivery model of care focused on symptomatic & personal recovery by providing flexible, assertive community mental health care, and integrating medical & social interventions.

**Key features:**

1. F-ACT team operates in a defined catchment area;
2. It focuses on crisis prevention and management at home, targeting all people with SMI, including those hard to engage;
3. F-ACT teams collaborate with local stakeholders, pooling resources of the clients and community;
4. Individual case management with support of a multidisciplinary team;
5. Team includes people with lived experience as peer experts;
6. Care is scaled up and down as needed, based on daily reviews during F-ACT team board meetings;
7. Intensive team care provides daily assertive outreach to 10-20% of clients with high need of care, using a whole team approach.
8. Services include: assertive outreach, home visits, supported employment.

**Outcomes/Results:**

**Continuity of care,  
Remission in symptomatic and personal recovery,  
Outcome (Quality of Life)**

**Drop Out < 2%  
Admission Rates < 10-30%  
Costs per patient**

**Transferability to other settings**

- Well described model with a model fidelity scale;
- The ability to adapt the model to different contexts.
- Broad implementation and adaptation in several countries; > 300 certified F-ACT teams in The Netherlands, in regions in the British Isles, the Nordic countries, Central and Eastern Europe, Canada, Hong Kong and Australia



## Providing community based mental health services

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## Flexible Assertive Community Treatment (F-ACT)

Location: [The Netherlands](#)

More information: <https://www.f-actnederland.nl/>

A Dutch version of Assertive Community Treatment (ACT) is the Flexible Assertive Community Treatment (F-ACT). The multidisciplinary F-ACT team works in a defined catchment area for all people with severe mental illness and can operate in two different ways, namely:

- Individual case management by a member of the team, where other disciplines can be involved based upon the needs of the patient; and
- Intensive (ACT) team care, which involves the clients having contact with several team members; these clients are listed on the Community Treatment board and the team discusses them daily to decide which form of care should be provided and by which team members.

The flexible switching of care within a team between levels is the quintessence of F-ACT. For most clients, individual supervision suffices. However, if psychosis recurs (or threatens to recur), if hospitalisation is imminent, or if an individual needs extra care for other reasons, care is stepped up. This is a fluctuating group of 10-20% of the clients in the team's total caseload. For clients requiring more care, the team provides team care according to the ACT principle of 'shared caseload'. This means that all members of the team have been informed about the client and that he or she is monitored and counselled by several care workers in the team. As a result, the client can receive care every day or even several times a day.

To ensure good coordination of the care workers' activities, there are daily meetings to discuss clients who are listed on the Community Treatment board. If individual supervision is not enough, the client's name is listed on the board during the team's meeting. The clients on this board are discussed every day. This group consists of clients with psychotic disorders, usually combined with addiction problems (dual diagnosis). Many of them had been in hospital (sometimes for a long time) and were caught in the 'revolving door' between the hospital and the community.

## Individual Placement and Support (IPS) for Employment



Mental Health Europe  
(MHE)  
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**Source reference:**  
EU Compass  
2016 booklet on  
good practices

### **Practice description:**

The objective of IPS is to enable people with severe and/or chronic mental ill health to enter and/or remain in the competitive labor market. The method works by placing someone in employment and then supporting and training them in an inclusive work environment.

IPS is based on eight basic principles:

1. It aims to get people into competitive employment;
2. It is open to all those who want to work;
3. It tries to find jobs consistent with people's preferences;
4. It works quickly;
5. It brings employment specialists into clinical teams;
6. Employment specialists develop relationships with employers based upon a person's work preferences;
7. It provides time unlimited, individualized support for the person and their employer; and
8. Benefits counseling is included.

### **Outcomes/Results:**

Numerous randomized controlled trials (RCTs) have shown that IPS gets up to twice as many people into competitive employment as other traditional vocational services. It is the most researched employment intervention worldwide providing a unique evidence base for its effectiveness. This method has been increasingly used throughout the world and in Europe including in the UK, the Netherlands, Spain and Italy.

Providing community based mental health services and developing integrated governance approaches.

- PROVISION OF COMMUNITY-BASED MENTAL HEALTH SERVICES
- PROVISION OF MORE ACCESSIBLE MENTAL HEALTH SERVICES
- MENTAL HEALTH IN THE WORKPLACE
- LABOR MARKET INTEGRATION

## Individual Placement and Support for Employment (IPS)

Location: [United Kingdom](#)

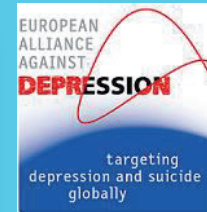
More information: <https://www.centreformentalhealth.org.uk/what-individual-placement-and-support>

Individual Placement and Support (IPS) first started in the UK in 1995 at South West London and St George's Mental Health NHS Trust. It has now spread across the UK and is still ongoing. The practice was initiated by the health and social sector and is categorized as a campaign and service delivery method. It focuses on both action and research. The objective of IPS is to enable people with severe and/or chronic mental ill health to enter and/or remain in the competitive labor market. IPS has been shown to be more effective the more closely it follows these eight principles:

- 1) it aims to get people into competitive employment;
- 2) it is open to all those who want to work;
- 3) it tries to find jobs consistent with people's preferences;
- 4) it works quickly;
- 5) it brings employment specialists into clinical teams;
- 6) employment specialists develop relationships with employers based upon a person's work preferences;
- 7) it provides time unlimited, individualized support for the person and their employer; and
- 8) benefits counseling is included.

The concrete results of IPS show that more than twice the number of people joined paid employment than with any other methodology, as has been confirmed by numerous randomized control trials.

# European Alliance Against Depression (EAAD)



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Juliane Hug, Pia Drießen, the EAAD  
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**Source reference:**  
EU Compass

## Practice description:

- Start in 2004 as an EU-funded project, registered non-profit association since 2008, with partners in 22 countries globally
- **Main aims** are i) to improve care and optimise treatment for patients with depressive disorders and ii) to prevent suicidal behaviour
- To achieve these aims, EAAD implements and promotes its community-based **4-level programme**: (1) Cooperation with primary and mental health care; (2) Public awareness campaigns; (3) Cooperation with community facilitators; (4) Support of high risk groups and their relatives
- EAAD supports other regions and countries with initiating this 4-level programme
- The **iFightDepression®** tool is disseminated: a guided, non-profit self-management tool developed by EAAD for patients with milder forms of depression (available in 12 different languages including an Arabic version)
- The [ifightdepression.com](http://ifightdepression.com) website provides evidence-based info on depression in 15 different languages



## Outcomes/Results:

- The 4-level intervention has already been implemented in over **110 regions from 20 countries**. Broad experience has accumulated on how to implement the 4-level intervention in different countries and health care systems.
- Evidence for **effects of this 4-level intervention** concerning the prevention of suicidal behavior has been provided not only by the model project in Germany, the Nuremberg Alliance against Depression (Hegerl et al. 2006, 2010), but also from another city in Germany (Regensburg, Hübner-Liebermann et al. 2010), a controlled study in Hungary (intervention region, Szolnok, control region Szeged, Szekely et al. 2014) and a controlled study from Portugal (intervention region Amadora, control region Almada, OSPI-study).
- iFightDepression® tool has an increasing number of registered patients in Germany and across Europe (> 1200 users by January 2019)
- [ifightdepression.com](http://ifightdepression.com) website has > 60.000 monthly visitors

**Priority:**  
Preventing depression and promoting resilience.

- PREVENTION OF DEPRESSION AND PROMOTION OF RESILIENCE
- PROVISION OF COMMUNITY-BASED MENTAL HEALTH SERVICES
- PROVISION OF MORE ACCESSIBLE MENTAL HEALTH SERVICES
- SUICIDE PREVENTION

## European Alliance Against Depression (EAAD)

Location: [Germany](#)

More information: <http://www.eaad.net>

The European Alliance Against Depression began January 2004; it was initiated by the health sector and the health and social sector. The practice focuses on action programs, campaigns, e-mental health, mental health in all policies, policy work, research, service delivery approaches, tools/instruments, and training. While based in Germany, the European Alliance Against Depression is active at the European level.

The objective of the European Alliance Against Depression is a community-based 4-level intervention programme promoted by EAAD operates at four levels of intervention. These levels of intervention include:

- cooperation with primary and mental health care, focusing on training general practitioners.
- public awareness campaigns.
- cooperation with community facilitators and stakeholders.
- support for people at high risk, and their relatives.

The objectives of the EAAD have been reached, in part, by actions to improve the care for patients affected by depression and prevent suicides, raising public awareness of the occurrence and impact of depression and suicidal tendency, and dissemination of EAAD results at regional, national, and European levels, and supporting young researchers.

Various aspects of the European Alliance Against Depression have been evaluated or assessed. Evidence shows that the community-based intervention programme was effective in reducing suicides and in improving the care of depressed patients.

# The Well-being Guild of Entrepreneurs



The Finnish Association for Mental Health (FAMH)  
Tiina Lumijärvi

**Source reference:**  
EU Compass

## **Practice description:**

- The Guild model supports mental well-being of SMEs, ensuring they are equipped to react early in case of mental health problems.
- The core activities are:
  - two-day course on mental well-being
  - peer group activities to develop participants' self-knowledge, stress management skills, and ability to handle loneliness
- The Guild project operated from 2008 to 2016. It was initiated by health and labour sectors. The Guild model was developed by FAMH, which continues to operate it as a core activity.

## **Outcomes/Results:**

- By the end of 2018 over 1000 entrepreneurs have taken part in the Well-being Guild of Entrepreneurs.
- Peer group discussions have helped entrepreneurs to balance their everyday life and work better.
- Most participants' say that their coping skills have improved and their own mental well-being has increased.

Mental health in the workplace

- PREVENTION OF DEPRESSION AND PROMOTION OF RESILIENCE
- PEER SUPPORT, MENTAL HEALTH FIRST AID
- MENTAL HEALTH IN THE WORKPLACE
- SUICIDE PREVENTION

## The Well-being Guild of Entrepreneurs

Location: [Finland](#)

The Guild project was carried out between 2008 and 2010, which led to the development of the Guild model. The dissemination of the Guild model in Finland commenced in 2012 and finished in 2016. The Guild project was initiated by the health sector and the labor sector; the model was developed by an NGO. The Guild project focuses on the tool/instrument, action, training, and dissemination of the Guild model.

The main objective of the Guild project is 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. In line with the model, veteran entrepreneurs and well-being experts advise entrepreneurs in small and medium-sized companies on sustainable well-being. The core activities are two-fold:

- a two-day course on welfare (applied mental health first aid); and
- the guild's peer group activities, in which expert and peer support were used to develop participants' self-knowledge, stress management skills, and ability to handle loneliness.

There have been over six hundred entrepreneurs who have taken part in the Well-being Guild of entrepreneurs. Two thirds of participants were women and over ninety percent of the participants recommend Guild activities to their colleagues. Peer group discussions focused on coping and on problems related to everyday life and work. This has helped entrepreneurs understand their own coping and identify risks related to mental well-being.



## Multisystemic Therapy (MST)



MST-Nederland/Belgie  
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info@mst-nederland.nl

**Source reference:**  
EU Compass

Multisystemic Therapy (MST) is an intensive family- and community-based treatment program that focuses on addressing all environmental systems that impact chronic and violent juvenile offenders — their homes and families, schools and teachers, neighbourhoods and friends. Multisystemic Therapy recognizes that each system plays a critical role in a youth's world and each system requires attention when effective change is needed to improve the quality of life for youth and their families. MST works with the toughest offenders ages 12 through 17 who have a very long history of arrests. The MST clinician goes to where the child is and the teams are on call 24 hours a day, seven days a week.. The therapist works intensively with the caregivers to keep the adolescent focused on school and gaining job skills.

Multisystemic Therapy is an evidence-based approach which has been proven to produce positive results in troubled youth. It blends the best clinical treatments—cognitive behavioural therapy, behaviour management training, family therapies, and community psychology— to reach this population. MST has a very strong and supportive quality assurance and improvement system in place. Multisystemic Therapy has been implemented by several organizations in the Netherlands since 2005, and in Belgium since 2011. Since 2008, the implementation of MST in the Netherlands and Belgium is supported by MST-Netherlands/Belgium.

### Outcomes/Results:

After 30 years of research and 18 studies, MST has repeatedly been shown to achieve its objectives. These objectives are to:

- Keep kids in their home and reduce out-of-home placements;
- Keep kids in school;
- Keep kids out of trouble and reduce re-arrest rates;
- Improve family relations and functioning;
- Decrease adolescent psychiatric symptoms
- Decrease adolescent drug and alcohol use.

In 2017, MST in the Netherlands achieved:

Youth living at home: 96%  
In school / working: 85%  
No new arrests: 97%

Providing community based mental health services.  
Prevention of out of home placement of young persons.



## Multisystemic Therapy (MST)

Location: [The Netherlands](#)

More information: [http:// www.mstservices.com](http://www.mstservices.com)

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- Improve family relations and functioning;
- Decrease adolescent psychiatric symptoms; and
- Decrease adolescent drug and alcohol use.

# Housing First Portugal (Casas Primeiro Portugal)



AEIPS  
[www.aeips.pt](http://www.aeips.pt)  
+ 351 218 453 580

**Source reference:**  
EU Compass

## Practice description:

- Casas Primeiro – The first HF Program implemented in Portugal (2009)
- Provide housing and support to long term homeless people with severe mental illness
- Individualized, permanent and scattered site housing in mainstream neighborhoods
- Mobile team (1 professional to 10 participants, including 1 peer provider)
- Support services are provided in the participant household and community contexts
- Support services oriented to promote recovery and people's access to community services and resources (e.g. health, mental health social welfare, education, employment)
- To foster social inclusion and citizenship.

## Outcomes/Results:

- Housing retention of 85 – 90%
- Better quality of life in terms of: personal safety (98%), nutrition (80%) and sleeping habits (80%), health and mental health (78%), social life (52%).
- Decrease of the number of psychiatric admissions and emergency services (90%)
- Satisfaction with the program and house/neighbourhood (93%)
- Participants reported a large sense of freedom and hope and 30% become involved in education, employment and other significant community activities

Providing community based mental health services

- PROVISION OF MORE ACCESSIBLE MENTAL HEALTH SERVICES
- HOUSING AND COMMUNITY SUPPORT FOR HOMELESS PEOPLE WITH SEVERE MENTAL ILLNESS

## **Housing First Portugal (Casas Primeiro Portugal)**

Location: [Portugal](#)

More information: <http://www.aeips.pt/>

Housing First was started in 2009 and was initiated by the health and social sector. Housing First is a service delivery approach or method.

The objective of Housing First is to provide integrated housing in the community for long-term homeless people with severe mental illness, in some cases combined with substance abuse.

Activities of Housing First include intensive and direct support to the person in the household and the integration in local services in all areas, such as health, mental health, social welfare, and judicial services (if applicable). A concrete result of Housing First is that 89% of the people involved retain their housing option.

# Stability Training

The Finnish Association for Mental Health (FAMH)  
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**Source reference:**  
EU Compass

## **Practice description:**

- Stability Training model was developed as a project 2012-2014. Stability Training is a group model for immigrants suffering from traumatic experiences.
- The objective is to educate immigrants suffering from traumatic experiences to learn understand, recognize, and cope PTSD and its symptoms.
- The use of the Stability Training model has been teach in national level to psychologist, psychiatric nurses and social workers working with immigrants and refugees.

## **Outcomes/Results:**

More awareness and coping skills of the PTSD symptoms for professionals and immigrants themselves.

The effects of practice through feedback of the group participants have been for example better understanding towards own symptoms, better coping abilities and decrease of suicidal thoughts.

Mental Health of immigrants and refugees

## Stability training (Tasapainoalmennus)

Location: Finland

More information: <http://www.mielenterveysseura.fi/en/support-and-help/support-and-help-foreigners>

The Stability Training model was developed as a project in 2012-2014 by the Finnish Association for Mental Health and is now part of rehabilitation services of the SOS- Crisis Centre at the Finnish Association for Mental Health. Stability Training addresses a service delivery method.

The objective of Stability Training is to educate immigrants suffering from traumatic experiences to learn understand, recognize, and manage PTSD and its symptoms. Stability Training is designed to consist of eight meetings. A shorter model, Stability Training Info, was developed for immigrants who suffer from changes caused by immigration processes and cultural changes rather than from trauma. This model focuses on the immigration and integration process and consists of one to four groups meetings, which give information and tools to understand and support well-being in difficult life situations.

Participants learn about tools to deal with symptoms through better understanding and body awareness. Out of the total of eight meetings, four meetings focus on psychoeducation, two on practical training with physiotherapist, and one is a lesson given by a physician about medication and open questions around the topic. The short Stability Training Info-sessions aim to teach basic knowledge about mental health and well-being through psychoeducation and (educational) materials translated in the language of the participants.

## The Professionally Guided Peer Support Groups for Bereaved by Suicide

The Finnish Association for Mental Health (FAMH)  
SOS Crisis Centre, Helsinki, Finland  
reija.tuomisalo@famh.fi

**Source reference:**  
EU Compass

### Practice description:

- Professionally guided peer support groups have been part of national crisis work for bereaved by suicide in FAMH since 1995.
- The objectives of the group model: to strengthen the group members' resilience, to learn different ways to cope in difficult life situations, to strengthen social well-being and to prevent suicide attempts among this high risk group.
- Groups are arranged as intensive courses around Finland (3-5 days) or as weekly meetings (15 sessions).
- The main method is thematic discussion guided by the professionals. The sessions form a continuum processing the loss experiences, dealing with various feelings and to strengthen resilience and coping. There is a manual (2017) of this method: *On the Path to Recovery – a Group Model for Bereaved by Suicide*

### Outcomes/Results:

The participants evaluate the content, functionality and the professional leaders of the group. Results have been excellent for many years also 3 months later when they evaluate the group again. The mean of Likert Scale answers has been more than 4 of 5. The participants report the raise of hopefulness and the decline of suicidal thoughts.

**Priority Areas:** Suicide Prevention, Prevention of Depression and Promotion of Resilience

## **The Professionally Guided Peer Support Groups for Bereaved by Suicide (Ammatillisesti Ohjatut Vertaistukiryhmät Läheisensä Menettäneille)**

Location: [Finland](#)

More information: <http://www.mielenterveysseura.fi/fi/tukea-ja-apua/vertaistukiryhm%C3%A4t>

The Professionally Guided Peer Support Groups were started in 1995. The Peer Support Groups were initiated by the health and social sector and are a tool/instrument, training method, and service delivery approach/method. The objective of the Peer Support Groups is to strengthen the group members' resilience and teach different ways to cope in difficult life situations. Other objectives of the program are to strengthen social well-being and to prevent suicide attempts among this high risk group.

The main methods used in the groups are thematic discussions guided by professionals. These thematic discussions form a continuum from processing the experiences of participants, dealing with the various feelings caused by the life situation, to strengthening resilience and coping. The groups are arranged as intensive courses around Finland (three to five days) or as weekly meetings (fifteen meetings) in the crisis center in Helsinki or in other cities.

During the last group session and three months later, participants are asked to evaluate the content and functionality of the support group and the professional leaders. Results have been excellent for years; the mean of Likert scale answers is continuously more than 4 out of 5. Participants indicate that most positive changes during their process were due to peer support in the group.

**Introduction**

- A core question in the debate about how to organise mental healthcare is whether in- and out-patient treatment should be provided by the same (personal continuity) or different psychiatrists (specialisation).
- The existing evidence is based on small and low-quality studies which tend to favour whatever is the novel or experimental system of organising care.
- Definitions, characteristics and pros of personal continuity and specialisation are summarised in the following Table.

**Personal continuity**

**Specialisation**

The same psychiatrist across inpatient and outpatient settings.      Different psychiatrists across inpatient and outpatient settings

Also known as 'integrated'

Also known as 'functional split'

Old system traditionally used in the NHS.

NHS Trusts are moving towards this model, whilst other countries are moving towards continuity.

Pros: better therapeutic relationships, better coordination between settings, reduced need for referrals.

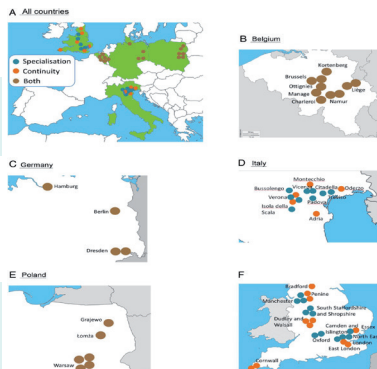
Pros: quicker clinical decision-making, highly specialised clinicians and services.

**Methods**

- We carried out a prospective natural experiment in Belgium, England, Germany, Italy and Poland.
- Patients admitted for psychiatric in-patient treatment were eligible if aged over 18 years, and clinically diagnosed with a psychotic, mood or anxiety/somatisation disorder.
- Our primary outcome was readmission to hospital within one year.
- We included 57 hospitals, whose geographic location is shown below.

**Results**

- 7302 patients were consecutively recruited; 6369 (87.2%) were followed-up.
- When assessing inpatient satisfaction – patients preferred personal continuity.
- No statistically significant differences were found in re-hospitalisation, neither overall (adjusted percentages: 38.9% in personal continuity, 37.1% in specialisation; odds ratio=1.08; CI: 0.94-1.25; p= 0.28)
- There was no substantial difference on relapse and re-hospitalisation over a one-year period.



No difference in re-hospitalisation rates between personal continuity and specialisation overall and within:

- Each country
- Each diagnostic group
- People who were admitted to hospital for the first time
- People who had previous hospital admissions

**Impact summary**

- This study provides a clear answer to a much debated care organisation problem.
- Not finding a difference between the two alternative models suggests that policy makers should stop spending money on care organisation and focus on more influential aspects to improving patient care.
- Patients maybe more satisfied when there is personal continuity
- We disseminated these findings to policy makers and service users in different European countries.





## Comparing policy framework, structure, effectiveness and cost-effectiveness of functional and integrated systems of mental health care - The COFI study

Location: [United Kingdom](#)

More information: <http://cofi.qmul.ac.uk/>

Mental disorders are a leading cause of disability in Europe and determine high health-care costs and loss of productivity. Effective service organisation is required to maximise the effects of care and reduce this burden. A highly debated question in mental health care is whether to privilege personal continuity of care or specialisation of services. In COFI, we addressed this question by comparing two alternative systems of mental health care:

1) Functional systems: different primary clinicians are responsible for the treatment of a patient, depending on whether the patient is in inpatient or outpatient care. In these systems the focus is on specialisation of care.

2) Integrated systems: the same primary clinician is responsible for both the inpatient and outpatient care of a patient. These systems privilege personal continuity of care.

COFI was conducted using in five countries - Belgium, Italy, Germany Poland and the UK, where the two systems are both available in routine mental health care. This meant that we did not change or allocate patients to a care system but studied these systems in a natural experiment, so the results are immediately transferable to policy and practice. Patients with a diagnosis of psychotic, affective or neurotic / somatoform disorders (F2-F4) admitted to a psychiatric hospital over the 14-month study period were included. Overall, 57 hospitals and 7,302 patients participated, of which 6369 (87.1%) were followed up at one year.

The main findings of the study informed us to develop the following recommendations:

- If the aim is to improve long-term outcomes for patients, costly reorganisations of mental health care systems should not focus on changing from integrated to functional care or vice versa.
- If the aim is to improve patients' experience of in-patient treatment, integrated care may be seen as preferable.
- Both approaches have strengths and weaknesses – organisational considerations in the local context and preferences of patients and clinicians may favour one of the two approaches.
- Patient preferences are particularly important when there is a choice between the two systems in the same service. Potential advantages and disadvantages of each system should be considered when making the choice.
- Mental health services should consider ways to address the discrimination that psychiatric patients anticipate and experience, including patients with anxiety and somatoform disorders.
- Research and policy may focus less on the organisation of care at a system level, but instead aim to improve the actual treatment within any given organisational system.

Changing mental health care organisation on a system level is expensive. Our findings show that re-organisations of care from integrated to functional systems, or vice-versa, are unlikely to have a significant impact on clinical outcomes justifying the expense. This knowledge has the potential to save substantial amount of resources for European Union Member States, which can instead be used for more influential changes in mental health care provision.



## **COPING** **Children of Prisoners:** ***Interventions and Mitigations to Strengthen Mental Health***

Using a **child-centred positive-psychology** methodology, COPING investigated the wellbeing, vulnerability to mental health problems and resilience of children who are impacted by parental imprisonment. The first and only Pan-European study of its kind, COPING involved a survey of over 1000 children of prisoners (CoP) and interviews with over 300 CoP, caregivers, and parents in the UK, Germany, Romania and Sweden. A mapping of available services across the four countries was also carried out. These different countries reflect diverse incarceration levels, welfare policies and mental health interventions.

Research shows that CoP experience:

- Feelings of shame and stigma
- Anti-social/delinquent behaviour
- Low self-esteem
- Mental ill health
- Poverty
- Intergenerational criminal behaviour
- Weakened family relationships
- Poor school performance

### **We explored:**

- ← Resilience and coping strategies
- ← Family strengths and limitations
- ← Children's views
- ← Networks of support
- ← Shame and stigma
- ← Role of schools
- ← Availability of appropriate services
- ← What works

*Public health priorities COPING addresses:*

- *preventing child depression and promoting resilience*
- *improving access to mental health services*
- *mental health in schools.*
- *providing community based mental health services.*
- *developing integrated governance approaches.*

*Project led by Professor Adele Jones, School of Human and Health Sciences, The University of Huddersfield and involved a consortium of 10 partner agencies from 6 countries*

<http://coping-project.hud.ac.uk/>



The COPING project has received funding from the European Community's Seventh Framework Programme (FP7/2007-2013) under Grant Agreement no 241988

- PREVENTION OF DEPRESSION AND PROMOTION OF RESILIENCE
- PROVISION OF COMMUNITY-BASED MENTAL HEALTH SERVICES
- INTEGRATED APPROACHES TO GOVERNANCE
- MENTAL HEALTH IN SCHOOLS

## **COPING: Children of Prisoners, Interventions and Mitigations to Strengthen Mental Health**

Location: [Germany, Romania, Sweden, United Kingdom](#)

More information: <http://coping-project.hud.ac.uk/>

COPING was a child-centred research project funded under FP7 which aimed to investigate the characteristics of children with imprisoned parents, their resilience, and their vulnerability to mental health problems. This group of children is exposed to triple jeopardy through break-up of the family, financial hardship, and extremes of stigma and secrecy, often leading to adverse social, educational and psychological repercussions. The first study of its kind, the project also mapped available mental health services for this population across the study countries and identified examples of good practice.

COPING's mixed methods research involving approximately 1,500 children, caregivers and stakeholders showed that children of parents who are in prison are a vulnerable group for increased mental health problems - 25% were at high risk of mental health problems, rising to near 50% children in Romania. The support of care giving parent and extended family were found to be central to good mental health and resilience while schools were identified as also playing a key role as they function as a major source of stability at a time of upheaval and disruption. Parental imprisonment affected children in myriad ways depending upon: the nature of the offence, the extent of support for the child, the age and gender of the child, the gender of the imprisoned parent, the relationship the child had with the imprisoned parent, open communication about what happened, opportunities for contact and visiting, the attitude of the non-imprisoned parent, the extent of stigma and, the ways in which the criminal justice system operates. For instance, many children were initially traumatised at the point of parental arrest as this often involved invasion of the home and generated a high level of stress and anxiety. With few exceptions, children did better overall if they were able to maintain good quality contact with the imprisoned parent. Appropriately equipped child-centred visiting and regular, easily accessed contact which facilitated continuance of child-parent relationship was essential for children's well-being. Most agency support was provided via NGOs and some excellent models of practice were found. However, access to specialist services was ad hoc and within Romania was non-existent. Mainstream child and adolescent mental health services had little understanding of the needs of children of prisoners and they were largely invisible. Recommendations centred on five areas:

1. Child-friendly Criminal Justice Systems
2. Maintaining relationship with parent in prison
3. Improved access to services and support for children of prisoners and families
4. The role of the school
5. Public awareness and policy recognition

Key among the recommendations was the requirement for mental health and social welfare professionals to be made aware of the needs and vulnerabilities of children of prisoners and to provide appropriate support to them and their caregivers at several points: parental arrest, remand, conviction, imprisonment and release – all of these are major points of stress for children. Another area for improvement concerns the criminal justice system with the requirement that security should not inhibit a child's ability to interact with an imprisoned parent, visits should be a child's right not an earned privilege for prisoners and that prisons should provide age-appropriate activities for children to encourage positive parent/child interaction.

EuroFIT – improving lifestyle, mental and physical health in male football fans



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**Source reference:**  
RTD  
**Type:** Promising  
Research Results

**Practice description:**

- EuroFIT is an EU-funded healthy lifestyle program for overweight and obese male football fans aged 30-65 years
- EuroFIT aims to improve lifestyle (physical activity, sedentary behavior and diet), in order to improve health and wellbeing
- Participants followed a 12-week group based behavioural change program at their football club under supervision of club coaches
- It was tested in 15 football clubs in England, Netherlands, Norway and Portugal (n=1113)

EuroFIT webpage: <http://eurofitfp7.eu/>

**Outcomes/Results:**

- EuroFIT participants had improved physical activity, diet, body weight, blood profiles, wellbeing, vitality and self esteem one year after the start of the intervention program
- EuroFIT was cost-effective in the long term
- EuroFIT licensing model for implementation in European clubs is expected in spring 2019

Publication: PLoS Med 2019 16(2):e1002736

Public health priority: Providing community based mental health services

## Using the power of football to improve lifestyle & health in football fans (EuroFIT)

Location: [The Netherlands, Norway, Portugal, United Kingdom](#)

More information: <http://eurofitfp7.eu/>

The European Fans in Training (EuroFIT) program is a lifestyle program for male overweight or obese football fans aged 30-65, which builds on the Scottish Football Fans in Training program (FFIT). EuroFIT harnesses the intense loyalty that many football fans have for their club, using this to attract them to a lifestyle change programme at club facilities.

Using cutting-edge behavioural science, EuroFIT adds novel technologies in a bid to prevent, rather than treat, chronic illnesses associated with inactivity and poor diet, such as type 2 diabetes and cardiovascular disease. EuroFIT is delivered by club community coaches in football club stadia in 12 weekly, 90-minute group sessions which are aimed at increasing physical activity, reducing time spent sitting and improving diet in a way that maintains change over the long term.

EuroFIT was developed and evaluated in large EU-FP7-funded multi-country project. During the project a randomised controlled trial of 1113 men was carried out across 15 professional football clubs. The clubs involved were Arsenal, Everton, Newcastle, Manchester City, Stoke (England); ADO Den Haag, FC Groningen, PSV, Vitesse (the Netherlands); Rosenborg, Strømsgodset, Vålerenga (Norway); and SL Benfica, FC Porto, Sporting CP (Portugal).

The study showed that participants were doing more physical activity and eating healthier diets directly after the program but also still a year after the start of the program. Sitting time was only reduced directly after the program. The study also showed that these healthier lifestyles resulted in reductions in body weight, healthier blood profiles, and improvements in wellbeing, self-esteem and vitality, which were all still present one year after the start of the program. A long term economic evaluation model shows EuroFIT is cost effective.

After the randomized controlled trial the EuroFIT program was successfully implemented and tested by additional pilot clubs in England, the Netherlands, Norway and Portugal. A not-for-profit licensing system to roll out EuroFIT across European clubs is expected to be available in spring/summer 2019.

# MasterMind

www.mastermind-project.eu



MasterMind

**Project Coordinator**  
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**Source reference:**  
RTD  
**Type:** Promising  
Research Results

## Practice description:

- Providing computerised Cognitive Behavioural Therapy (cCBT) and Videoconference for Collaborative care and treatment (ccVC) to adults suffering from mild, medium, or severe depression including inpatients and outpatients at an international level
- MasterMind aimed to:
  - Upscale the ICT-based mental health care services
  - Trigger the uptake of the services
  - Demonstrate clinical outcomes and economic effectiveness
  - Optimise the organisation of mental health services
  - Increase the equal access to mental health care
  - Ensure that the services are safe for patients and do not increase the incidence of adverse events

## Outcomes/Results:

### Overall level:

- Both services are clinically and organisationally effective
- Cross-border collaboration is an efficient way to upscale services
- MasterMind influenced the market to develop and improve innovative mental health solutions

### Country level:

- Denmark: The regional solution "Internetpsykiatrien" has been upscaled to a national service.
- Scotland: Full national rollout of cCBT was completed in July 2018.
- Turkey: Top Sende was successful as a pilot application. Service continues in a new research project.
- Basque Country: cCBT and ccVC is to be included in Osakidetza's services
- Wales: The service is currently being upscaled across Powys Teaching Health Board
- Catalonia: Service has been running since 2018 in Badalona, including more than 300 professionals
- Aragon: Running in daily operation, new version just implemented
- Germany: Running as a daily service in Schön Clinic and included in the reimbursement system
- Italy: Running in daily operation in ALSTO3 provide through a GP network.

Better access to mental health



## MasterMind

Location: Denmark, Estonia, Germany, Italy, Netherlands, Norway, Spain, Turkey, United Kingdom

More information: <http://mastermind-project.eu>

The MasterMind project aimed to make high quality treatment for depression more widely available for adults suffering from the illness by the use of ICT. Depression is a heavy burden and increasing worldwide, causing much individual suffering and social cost. There is a proven clinical effectiveness of ICT in Cognitive Behavioural Therapy. The overall goal was to pave the way for equal access to quality mental health care across Europe, specifically to assess through implementation at scale (more than 5.000 patient overall) the impact of cCBT (computerised Cognitive Behavioural Therapy) and video conference for collaborative care and treatment for depression across 10 EU and Associated Countries.

The results showed that both services were clinically and organisationally effective and that cross-border collaboration is an efficient way to upscale services. MasterMind also influenced the market to develop and improve innovative mental health solutions.

The project identified barriers and success factors to implementing the two services at a large scale in different political, social, economic and technical health care contexts and from the perspective of different stakeholders such as patients, professionals and health insurances.

Policy recommendations from the project highlight a diverse range of factors influencing the success of eMental health service implementation.

## Early behavioural detection of eating disorders in a school setting - the SPLENDID project

**SPLENDID**  
Personalised Guide for Eating and Activity Behaviour  
for the Prevention of Obesity and Eating Disorders



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**Source reference:**  
RTD  
**Type: Promising  
Research Results**

### Practice description:

- Behavioural screening in a Swedish high school (2014-2015) during school lunches
- Objective 1: The detection of in-meal behaviours pointing towards “eating styles” characterising eating disorder patients
- Objective 2: The development of a personalised guidance platform for promoting healthy eating patterns
- Collection of continuous eating data from 200+ students using personal plate-scales during school lunches
- Follow-up collection of behavioural measurements from students during their everyday life

### Outcomes/Results:

- Automated analysis of in-meal behaviours (eg, portion size, eating speed), using sensor-based measurements
- Detailed description of the eating behaviour of student populations during school lunches
- Machine learning based identification of “borderline” behaviours similar to those observed in eating disorder patient groups
- Association of the relationship between school-meal behaviours and behaviours observed in everyday student life

Mental health in schools



## SPLENDID

Location: [Greece](#), [The Netherlands](#), [Spain](#), [Sweden](#), [Switzerland](#)

More information: <https://splendid-program.eu>

SPLENDID's central assumption is that obesity and eating disorders are at the opposite ends on the same behavioural spectrum, and that both problems arise from long term behavioural disturbances in eating and physical activity. In the past, trials training patients to eat and move in a non-pathological way have been demonstrated as effective in individuals with both obesity and eating disorders. The project developed novel sensor technology and algorithms that, combined with clinical experience, will be used to correct eating and physical activity behaviors in an earlier stage of the development of the problems, preventing them from progressing.

SPLENDID emphasis is on behaviours measured in real-life settings rather than in controlled laboratory environments. This yields the automatic evaluation of how close the subjects are to behavioural patterns that indicate high Obesity or Eating Disorders risk making SPLENDID a novel screening tool.

The same technologies support personalized normalization interventions. The prevention of obesity and eating disorders requires retraining of eating and physical activity. While the behavioural goals are still defined by health professionals, the progress of the individual toward these goals will be automatically monitored by the SPLENDID system.

In order to support the aforementioned functionalities, three types of sensors have been integrated in the SPLENDID system, namely, the Mandometer® for recording eating behaviour, a chewing sensor for recording chewing and swallowing and an accelerometer for recording physical activity. A smartphone application is also used for interaction with the user and for communicating the collected data to the SPLENDID central server.

SPLENDID was the outcome of multidisciplinary research focusing to:

- Behavioural aspects of subjects with eating disorders & obesity
- Modelling eating & activity behaviour
- Sensors for eating patterns & activity
- Processing of eating & physical activity related signals
- Assessment of risk for developing obesity or eating disorders
- Goal description, setting and monitoring
- Personalised health systems

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