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

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

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Abbreviations

ADHD – Attention deficit hyperactivity disorder

CBT – Cognitive behavioural therapy

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

CSDH - Commission on Social Determinants of Health

EAAD - European Alliance Against Depression

HCQI - Current health care quality indicators

IAPT - Improving access to psychological therapies

ECHI - European Commission Health Indicators

EHIS - European Health Interview Survey

GDP - Gross Domestic Product

MHEEN - Mental Health Economics European Network

MHP – Mental Health Promotion

NGO – Non-governmental organisation

OECD - Organisation for Economic Co-operation and Development

PMI – Prevention of mental illness

SME – Small and medium sized enterprise

WHO – World Health Organisation

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Executive summary

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

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

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

Status of mental health in the European Union

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

Organisation of mental health care in the EU

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

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

Prevention and promotion in the EU

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

Analysis of country profiles – key findings

- Eleven countries continue to provide long-stay hospital care, some of which are still in transition towards community based mental health services.
- The number of inpatient psychiatric care beds and admissions varies considerably between countries.
- Community mental health services in different forms were present in almost all countries. However, only eight countries had a comprehensive range of community-based services, including specialist services such as early intervention or assertive outreach.
- Variations and gaps in mental health services were found. The uneven distribution of services was a particular problem for several countries with relatively well-developed community based services. Other countries reported a lack of even basic community services such as outpatient clinics, and child and adolescent psychiatric services.
- All participating countries provided examples of prevention of mental illness and promotion of mental health initiatives; 381 initiatives were reported, 62.7% of which were prevention programmes mostly in schools (41.8%). There were relatively fewer mental health promotion activities (16.8%), of which 62.5% were also in schools. Work-based programmes mostly combined prevention and promotion (28.2% of 78 combined programmes). Only 6.6% of all reported initiatives targeted older people.

Strengthening systems to support prevention and promotion

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

[2] http://dataprevproject.net/

Feasible and practical indicators

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

Future plans for prevention and promotion activities

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

Conclusions

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

Key policy recommendations

Recommendations for Member States

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

Recommendations for the European Commission

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

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1. Introduction and Objectives

1.1 Introduction

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

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

1.2 Policy context

Burden and associated costs of mental illness

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

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

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

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

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

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

Social determinants of mental health

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

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

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

Mental health, well-being and happiness

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

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

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

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

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

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

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

Recovery, person-centred approaches, stigma and social inclusion

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

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

Prevention and promotion - definitions and interventions

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

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

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

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

The WHO defines mental well-being as:

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

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

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

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

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

1.3 European mental health policy - an overview

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

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

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

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

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

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

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

Economic crisis

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

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

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

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

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

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

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

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

Further developments at policy level

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

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

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

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

1.4 Objectives of the project

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

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

Other relevant questions were also explored. These included:

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

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2. Methods

2.1 Literature review

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

Inclusion criteria

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

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

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

Exclusion criteria

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

Search methods

The following eight bibliographic databases were searched:

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

Search terms

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

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

Grey literature

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

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

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

Selection of studies

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

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

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

Search results

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

First screening

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

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

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

Second screening

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

Third screening

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

Grey Literature

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

2.2 Selection of country collaborators

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

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

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

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

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

2.3 Data collection from country collaborators

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

Data template for collaborators

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

Table 2.1: Collaborators' data collection tasks

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

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

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

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

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

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

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

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

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

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

Definitions of mental health services

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

Collaborators' data sources

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

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

Preparation and validation of country profiles

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

2.4 Survey of key experts

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

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

Questionnaire development

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

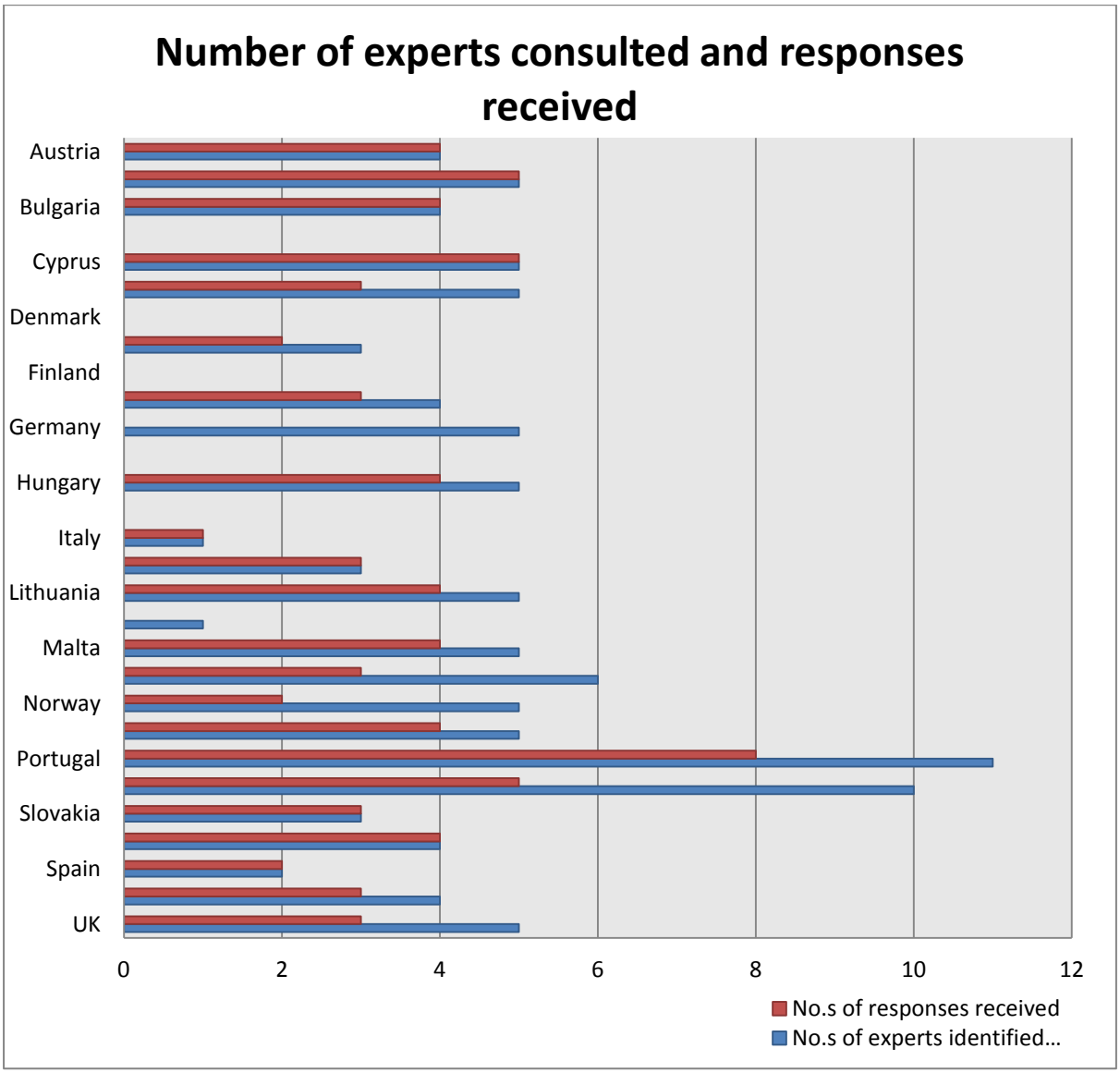
The questionnaire was written in English and piloted in three countries – Bulgaria, England and Norway. Amendments to the questionnaire were made accordingly which included rewording questions to elicit appropriate responses.

Identification of experts and questionnaire distribution

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

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

Figure 2.1: Experts approached and questionnaires completed



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

2.5 Databases and web sources

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

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

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

2.6 Analysis

Literature review

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

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

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

Matrix for collaborators' data

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

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

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

Responses from the consultation exercise with experts

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

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3. Review of the literature

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

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

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

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

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

3.1 Mental Health status in the European Union

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

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

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

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

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

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

Groups at risk and protective factors

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

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

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

Table 3.1 Risk and protective factors by groups and diagnosis

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

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

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

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

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

Stigma and discrimination

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

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

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

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

Consequences of mental illness

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

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

3.2 Organisation of mental health care in the EU

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

De-institutionalisation and implementing community-based care

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

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

- access to mental health care for people with long-term mental health conditions is better with community-based services rather than traditional psychiatric hospitals;

- community-based services better protect the human rights of people with mental disorders and prevent stigmatisation of those people;

- studies comparing community-based services with other models of care consistently show significant better outcomes on adherence to treatment, clinical symptoms, quality of life, housing stability, and vocational rehabilitation;

- studies suggest that care in the community for acute psychoses is generally more cost effective than care in a hospital, although it is important to note that

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

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

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

Implementing community-based care

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

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

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

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

Recent developments in mental health care

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

Recovery and person-centred approaches

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

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

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

Early intervention for psychosis

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

Wider access to psychological therapies

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

Financing mental health systems and promoting efficiency

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

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

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

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

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

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

3.3 Mental health promotion and prevention of mental illness

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

EU funded projects on mental health promotion and mental illness prevention

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

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

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

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

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

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

MHP and PMI – current and emerging evidence-base

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

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

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

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

School-based interventions

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

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

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

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

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

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

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

Workplace interventions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Good practice examples and effective approaches

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

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

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

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

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

Interventions for older people

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

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

Depression and suicide prevention

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

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

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

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

Recent developments and the current EU policy context

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

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

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

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

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

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

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

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

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

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

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

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

Implications of the evidence base for policy and practice

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

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

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

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

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

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

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

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

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

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

The Way Forward?

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

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

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

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4. Country Profiles

4.1 Austria

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Summary

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

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

Background information

Population (1 January 2011)	8,404,252
Population density Inhabitants per km^2 (2009)	101.5
Women per 100 men (2011)	105.2
GDP PPP 2010 EU27 = 1	1.1
Psychiatric care beds in hospitals per 100,000 inhabitants (2009)	36.5
Standardised Suicide rate by 100,000 inhabitants (2011)	15.3
Gallup Wellbeing index (2010)*	
Thriving	57%
Struggling	40%

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

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

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

Mental health policy and inclusion of prevention and promotion

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

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

Access and usage

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

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

Variation and gaps

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

Financing

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

Mental health workforce

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

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

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

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

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

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

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

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

Mental health status

Prevalence of mental health in the population

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

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

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

Incidence

Not reported.

Protective and risk factors

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

Prevention and promotion programmes /activities

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

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

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

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

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

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

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

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

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

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

Financial responsibility for prevention and promotion activities

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

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

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

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

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

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

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

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

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4.2 Belgium

Authors

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Summary

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

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

Completed and Validated 2012

Background information

Population (1 January 2011)	10,951,665
(July 2012 population estimate)	(10,438,353)
Population density Inhabitants per km^2 (2009)	356
Women per 100 men (2010)	104.1
GDP PPP (2010)	1.1
Psychiatric care beds in hospitals per 100,000 inhabitants (2012)	179.2
Standardised Suicide rate by 100,000 inhabitants	17.6
Gallup Wellbeing index (2010)*	
Thriving	56
Struggling	41
Suffering	3

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

Mental health policy and inclusion of prevention and promotion

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

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

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

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

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

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

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

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

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

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

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

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

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

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

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

Access and usage

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

Variation and gaps

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

Financing

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

Mental Health Workforce

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

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

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

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

Mental health status

Prevalence of mental health in the population

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

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

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

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

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

Incidence

Not reported.

Protective factors

Social support, higher education.

Risk factors

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

Prevention and Promotion programmes /activities

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

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

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

Financial responsibility for prevention and promotion

(see below)

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

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

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

Benefits to be expected

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

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

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

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4.3 Bulgaria

Authors and validation

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Summary

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

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

Completed and Validated 2012

Background information

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

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

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

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

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

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

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

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

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

Mental health policy and inclusion of prevention and promotion

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

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

Mental health services

Organisation and functioning of mental health systems

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

Mental health inpatient services include:

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

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

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

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

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

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

Access and usage

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

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

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

Variation and gaps in services

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

Financing

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

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

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

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

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

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

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

Mental health workforce

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

6.75	psychiatrists
431.01	nurses
0.91	psychologists
0.36	social workers

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

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

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

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

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

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

Mental health status

Prevalence of mental health in the population

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

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

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

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

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

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

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

Incidence

No data reported

Protective and risk factors

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

Prevention and promotion programmes /activities

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

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

Financial responsibility for prevention and promotion

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

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

None identified.

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

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

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

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

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4.4 Croatia

Authors and validation

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Summary

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

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

Background information

Population (1 January 2011)	4,290,612
Population density Inhabitants per km^2 (2010)	78.1
Women per 100 men (2011)	107.2
GDP per capita (2010)	5.1 (10.394€)
Psychiatric care beds in hospitals per 100 000 inhabitants (2010)	96.6
Standardised Suicide rate by 100 000 inhabitants (2010)	14.7

Gallup Wellbeing index (2010)
Not available

Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

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

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

Mental health policy and inclusion of prevention and promotion

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

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

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

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

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

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

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

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

Access and usage

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

Variation and gaps

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

Financing

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

Mental health workforce

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

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

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

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

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

Mental health status

Prevalence of mental health in the population

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

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

Incidence

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

Protective and risk factors

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

Prevention and promotion programmes/activities

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

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

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

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

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

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

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

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

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

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4.5 Cyprus

Authors

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Summary

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

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

Completed and validated 2012.

Background information

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

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

Mental health policy and inclusion of prevention and promotion

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

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

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

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

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

Access and usage

Information on usage included above.

Variation and gaps

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

Financing

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

Mental Health workforce

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

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

The total number of other staff includes:

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

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

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

Mental health status

Prevalence of mental health in the population

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

Incidence

No available data

Protective and risk factors

Not reported

Prevention and promotion programmes /activities

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

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

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

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

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

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

Initiatives to strengthen MH systems in relation to MHP and PMI

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

Data sources

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4.6 Czech Republic

Authors

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

Summary

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

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

Background information

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

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

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

Mental health policy and inclusion of prevention and promotion

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

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

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

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

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

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

Access and usage

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

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

Variation and gaps

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

Financing

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

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

Workforce

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

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

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

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

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

Mental health status

Prevalence of mental health in the population

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

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

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

Incidence

See above.

Risk factors

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

Prevention and promotion programmes /activities

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

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

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

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

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

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

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

Financial responsibility for prevention and promotion

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

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

Not reported.

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

None reported.

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4.7 Denmark

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Summary

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

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

Background information

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

*Reprinted with permission of Gallup, Inc

Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

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

Mental health policy and inclusion of prevention and promotion

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

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

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

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

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

Access and usage

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

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

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

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

Variation and gaps

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

Financing

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

Workforce

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

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

There is a lack of psychiatrists and specialised trained nurses.

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

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

Mental health status

Prevalence of mental health in the population

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

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

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

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

Incidence

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

Protective and risk factors

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

Prevention and promotion programs/activities

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

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

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

Examples of prevention and promotion of mental health initiatives include:

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

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

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

Financial responsibility for prevention and promotion activities

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

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

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

Initiatives to strengthen MH systems in relation to MHP and PMI

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

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4.8 Estonia

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Summary

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

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

Completed and validated 2012.

Background information

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

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

Mental health policy and inclusion of prevention and promotion

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

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

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

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

The number of services that currently hold licences include:

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

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

Other mental health services include the:

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

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

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

Access and usage

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

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

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

Source: Estonian Health Insurance Fund

Variation and gaps

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

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

Financing

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

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

Workforce

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

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

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

Mental health status

Prevalence of mental health in the population

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

Incidence of mental illness

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

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

Protective and risk factors

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

Prevention and promotion programs/activities

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

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

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

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

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

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

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

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

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

Financial responsibility for prevention and promotion activities

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

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

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

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

Not reported

Data sources

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4.9 Finland

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Summary

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

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

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

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

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

Background information

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

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MH Legislation and Policy

Current update and reference to prevention and promotion

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

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

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

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

Mental health policy and inclusion of prevention and promotion

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

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

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

Mental health services include:

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

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

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

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

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

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

Access and usage

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

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

Variation and gaps

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

Financing

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

Workforce

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

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

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

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

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

Mental health status

Prevalence of mental health in the population

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

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

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

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

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

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

Incidence

Not reported

Protective factors

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

Risk factors

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

Prevention and promotion programs/activities

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

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

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

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

Financial responsibility for prevention and promotion activities

Not reported.

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

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

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

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

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4.10 France

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Summary

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

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

Completed 2012, but not validated.

Background information

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

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

Mental health policy and inclusion of prevention and promotion

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

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

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

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

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

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

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

Source: World Health Organization (2011)

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

Access and use

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

Variation and gaps

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

Financing

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

Workforce

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

Psychiatrists	22.3
Nurses	86.2
Psychologists	47.9
Social workers	3.8

Source: World Health Organization (2011)

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

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

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

Mental health status

Prevalence of mental health in the population

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

Incidence

Not reported.

Protective factor

Good parenting.

Risk factors

Separation or divorce; being unemployed.

Prevention and promotion programs/activities

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

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

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

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

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

Financial responsibility for prevention and promotion activities

Not reported.

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

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

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

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

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

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4.11 Germany

Authors

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Summary

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

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

Background information

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

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

Mental health policy and inclusion of prevention and promotion

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

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

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

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

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

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

Access and usage of services

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

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

Gaps and variations in services

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

Financing

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

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

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

Mental health workforce

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

15.23	Psychiatrists
56.06	Nurses

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

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

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

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

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

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

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

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

Mental health status

Prevalence of mental illness in the population

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

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

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

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

Incidence

See above

Protective and risk factors

Not reported.

Prevention and promotion program/activities

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

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

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

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

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

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

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

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

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

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

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

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

Financial responsibility for prevention and promotion activities

See above.

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

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

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

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

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4.12 Greece

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Summary

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

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

Background information

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

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

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

Mental health policy and inclusion of prevention and promotion

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

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

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

Among the 13 regions of Greece there are:

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

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

Access and usage

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

Variation and gaps

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

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

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

Financing

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

Workforce

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

12.9	psychiatrists
26.8	psychologists

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

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

Mental health status

Prevalence of mental health in the population

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

Protective and risk factors

Not reported

Prevention and promotion programs/activities

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

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

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

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

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

Not reported

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

See above.

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4.13 Hungary

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Summary

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

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

Background information

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

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

Mental health policy and inclusion of prevention and promotion

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

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

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

Mental health services

Organisation and functioning of mental health systems

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

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

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

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

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

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

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

Access and usage

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

Variation and gaps

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

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

Financing

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

Workforce

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

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

(World Health Organization, 2011)

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

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

Mental health status

Prevalence of mental health in the population

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

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

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

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

Incidence

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

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

Protective and risk factors

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

Prevention and promotion programmes/activities

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

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

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

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

Financial responsibility for prevention and promotion activities

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

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

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

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

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

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4.14 Republic of Ireland

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Summary

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

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

Background information

Population (1 January 2011)	4,480,858
Population density Inhabitants per km^2 (2009)	65.2
Women per 100 men (2011)	101.8
GDP PPP (2010)	1.1
Acute Public Psychiatric beds per 100,000 inhabitants end (2011)	25.4
Standardised Suicide rate by 100,000 inhabitants (2011)	1.4
Gallup Wellbeing index (2010)*	
Thriving	49
Struggling	49

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Mental Health Legislation and Policy

Current update and reference to prevention and promotion

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

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

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

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

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

Mental health policy and inclusion of prevention and promotion

'A Vision for Change' the Report of the Expert Group on Mental Health Policy, was launched in 2006 and accepted by Government as the basis for developing mental health services in Ireland. The Report proposes a holistic view of mental illness recommending an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. It recommends a person centred treatment approach to addresses each of these through an integrated care plan, reflecting best practice, evolved and agreed with service users and their carers. Interventions should be aimed at maximising recovery from mental illness, and build on the resources in service users and their immediate social networks, to allow them to achieve meaningful integration and participation in community life.

The Report outlines a comprehensive mental health policy framework that seeks to address the mental health needs of the whole Irish population. The policy embraces the wider health and social importance of mental health and makes recommendations for improving population mental health and well-being across the lifespan and improving the spectrum of services. Recommendations are made for fostering well-being and promoting positive mental health, preventing mental health problems and improving the functioning and social inclusion of people experiencing mental health problems.

In relation to the promotion of positive mental health *'A Vision for Change'* focuses on four key issues;

1. Promoting positive mental health and well being
2. Raising awareness of the importance of mental health

3. Enhancing the capacity of service providers and the general community to promote positive mental health
4. Suicide prevention

The Report proposes the adoption of a lifespan approach to mental health promotion, supported by a national research, evaluation and monitoring programme. In order to increase protective factors and decrease the risk of mental illness, mental health promotion programmes should be integrated into all levels of mental health services. It is recommended that designated health promotion officers should have responsibility for mental health promotion and work in co-operation with local voluntary and community groups and with formal links to the mental health services. The report adds that training and education programmes should be put in place for the development of capacity and expertise in evidence-based prevention and promotion campaigns.

'Reach Out' the National Strategy for Action on Suicide Prevention sets out a series of specific actions and calls for a multi-sectoral approach to preventing suicidal behaviour to foster cooperation between health, education, community, voluntary and private sector agencies. The National Office for Suicide Prevention is implementing the *Reach Out* Actions in a four way strategy - delivering a general population approach to mental health promotion and suicide prevention; using targeted programmes for people at high risk of suicide; delivering services to individuals who have engaged in self-harm and providing support to families and communities bereaved by suicide.

Mental health services

Organisation and functioning of mental health systems

Considerable changes to mental health services have taken place in Ireland over the past forty years with the closure, or closure to acute admissions, of a number of large mental hospitals and the development of community based services. The number of patients resident in Irish psychiatric units and hospitals over the last 47 years has fallen from 19,801 in 1963 to 2,812 in 2010. This represents a reduction of 86% in in-patient numbers since 1963 and a reduction of 17% since 2006.

The HSE has developed a strategy for the phased closure of the remaining old psychiatric hospitals. Closures will take place on a phased basis with wards closing sequentially; hospitals will only close when the needs of the remaining patients have been addressed in more appropriate settings such as community residences, day hospitals and day centres.

Community services: A comprehensive range of secondary care community-based mental health services are available, delivered by multidisciplinary teams; currently (October 2012) there are 124 adult and 61 child and adolescent multidisciplinary teams. While the composition and skill mix of each team should be appropriate to the needs and social circumstances of its sector population, each multidisciplinary team should include the core skills of psychiatry, nursing, social work, clinical psychology and occupational therapy. Community based mental health services are provided by the HSE and voluntary sector partners in a number of different settings including the service users' own home, community mental health centres, outpatient clinics, day hospitals, and day centres. Residential hostel accommodation at high, medium and low support are also provided, however current policy is to discontinue the direct management and staffing of low and medium support accommodation. Specialist community mental health services are also available such as outreach services and crisis interventions.

Acute Inpatient Care: There are currently (September 2012) 63 approved centres for the care and treatment of persons suffering from mental illness with a total number of 25.4 public beds per 100,000 at end 2011. Approximately 800 other centres provide community based services. Acute Psychiatric in-patient units, primarily attached to general hospitals, provide short term inpatient acute care. Bespoke acute inpatient provision is also available for children and adolescents in age appropriate facilities. Specific psychiatry of old age services are also available including acute inpatient provision and continuing care options for older people with mental illness. There are also specialist community mental health teams for old age psychiatry. However this provision is not universal as yet.

The National Forensic Mental Health Service is based at the Central Mental Hospital (CMH), Dublin. The CMH admits patients from the criminal justice system and from the psychiatric services and provides psychiatric treatment in conditions of maximum and medium security.

A number of prominent NGOs provide a wide range of activities on behalf of the HSE (including mental health promotion and anti-stigma campaigns) and support for people with mental health problems. These include: Mental Health Ireland which is represented by 106 local mental health associations, Young Mental Health Ireland, Headstrong, Shine, Console, Bodywhys, Glen, BeLong and AWARE.

Access and usage

Access to mental health services is normally through the GP or Primary Care team. For adults, the waiting time for a routine referral from primary care is approximately 6 weeks although an emergency assessment can usually be offered with 24 hours. Whilst the preferred route to treatment is via a closed Primary Care referral pathway, many

individuals present in crisis via the Emergency Department in a local hospital. Research suggests that over 12,000 cases of self- harm present to Emergency Departments each year in Ireland; it has been estimated that a further 60,000 self-harm cases go untreated.

According to statistics produced by the Health Research Board (HRB 2010), in 2010, there were 19,619 admissions to Irish psychiatric units and hospitals (462.7 per 100,000 population). First admissions increased from 140.9 per 100,000 in 2009 to 147.8 in 2010. Readmissions dropped slightly from 14,223 in 2009 to 13,353 in 2010. The number of involuntary admissions has also declined by 27% from 2,830 in 2005 to 2,057 in 2011.

In 2010 the average length of stay for under-18s admitted and discharged was 33.2 days (median 23.5 days), with discharges from specialist child and adolescent units having the longest average length of stay, at 47.1 days (median 41 days), followed by private hospitals, at 27.9 days (median 25 days), psychiatric hospitals, at 7.4 days (median 5 days), and general hospital psychiatric units, at 11.4 days (median 4 days) (HBR 2010).

The number of patients resident in Irish psychiatric units and hospitals on 31 March 2010 totalled 2,812, representing a hospitalisation rate of 66.3 per 100,000 total population. This is a reduction of 577 in the number resident in units and hospitals since the last psychiatric in-patient census in 2006 (3,389) and also a reduction in the rate of hospitalisation in the 2006 census, at 80.0 per 100,000.

Variation and gaps

Approved Centre (public) bed capacity in the West and South is greater and varies from 28.3 beds per 100,000 population in the South, to 20.6 in Dublin Mid-Leinster. First admission rates for adults vary from 31.9 per 100,000 in the South to 22.1 in Dublin Mid-Leinster, whilst involuntary admission rates vary from 10 in the West to 6.6 in Dublin Mid-Leinster. There are similar variations in relation to staffing with 136.82 mental health nurses per 100,000 in the South compared to 76.93 in Dublin Mid-Leinster, whilst there are 23.99 Allied Mental Health Professionals per 100,000 in the West and only 12.97 in Dublin North East.

A key recommendation of *A Vision for Change* is to develop a population based resource allocation model. In this regard, the HSE has established a Resource Utilisation and Resource Access in Mental Health Working Group to further develop a population-based resource allocation model. Its objective is to maximise equal access to mental health resources across the country by applying an equitable model of resource utilisation.

Financing

In 2012, 5.3% (€707 million) of the Health Service Executive Budget will be spent on specialist mental health services. This is a lower percentage than in previous years as prior to 2012, the figures in the Revised Estimates for Public Services for Health Care Group Areas such as Mental Health included an allocated share in relation to both

pension and corporate costs; these costs are now shown separately. It should also be noted that approximately 35% of people who attend primary care have a mental health problem and expenditure on these services is not captured in this percentage.

The National Service Plan 2012 published on 16th January 2012, set out the type and volume of health and social care services that the HSE will provide both directly and indirectly, through a range of funded agencies and organisations, within its allocated budget of €13.317bn. A total cost reduction of €750m is required of the HSE in 2012. This follows substantial budget reductions of €1.75bn in the past two years and a reduction in the number of health service staff from a peak of 111,000 in 2007 to less than 102,000 in 2012, with a further 6,500 to depart by 2014. While a special allocation of €35m was provided for mental health in 2012, budget reductions, as a consequence of the impact of efficiency, procurement and staff moratorium savings, apply in mental health just as in other care areas. When the additional investment is factored in, the cost reductions applying in mental health in 2012 will be on average just less than 1%.

Workforce

The number of psychiatrists working in the mental health sector in 2011 was 6.06 per 100 000 inhabitants. In the same year there were 113.0 psychiatric nurses, 3.5 psychologists, 3.16 occupational therapists and 3.84 social workers per 100, 000 population (World Health Organization Atlas 2011, Central Statistics Office for Ireland 2011).

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

The promotion of positive mental health represents a cost effective and evidence based approach to protect the population's mental health. The National Office for Suicide Prevention supports this role along with other Health Promotion staff within the HSE. A number of NGO partners are also funded by HSE, either on a once-off or recurring basis, to deliver specific mental health promotion activities.

Mental health status

Prevalence of mental illness in the population

The prevalence of mental disorder in the general population was not obtainable. However, results from a number of surveys of the adult population capture psychological wellbeing or distress. 'The National Psychological Wellbeing and Distress Study' was published by the Health Research Board in 2007 and involved a telephone survey of a nationally representative random sample of 2,711 adults aged 18 years and over, living in

private households (Health Research Board 2007a). Results showed that 12% of the sample [one in eight] exhibited signs of 'current' distress on the General Health Questionnaire (GHQ-12), while 14% of the sample reported experiencing mental health problems in the previous year.

A similar survey carried out in 2007, provided comparable data for the North and South of Ireland. This survey found a higher prevalence of self-reported mental health problems in Northern Ireland (22%) and a greater proportion perceived their mental health status as less than good (20%) compared with the Republic of Ireland (12% and 15%) even after taking into account demographic characteristics such as marital status, education, employment and income (Health Research Board, 2007b). Statistics on depression show for example that over 450,000 people experience the condition at any one time in Ireland or that 1 in 10 adolescents aged 13 - 19 experience a depressive episode (AWARE).

The prevalence rates of psychiatric disorders from one study in population of Irish adolescents aged 12-15 years in a defined geographical area found that 15.6% of the total population met the criteria for a current psychiatric disorder, including 2.5% with an affective disorder, 3.7% with an anxiety disorder and 3.7% with ADHD. Significant past suicidal ideation was experienced by 1.9%, and 1.5% had a history of parasuicide (Lynch et al., 2006).

The following table from the Activities of Irish Psychiatric Units 2010 (HBR 2010) provides figures for the number of people admitted to psychiatric hospitals and units by diagnosis and gender in 2010:

Diagnosis	**Men**	**Women**	**Admissions per 100,000 pop**
Organic Disorders F09	273	267	12.7
Alcoholic Disorders F10	1,115	683	42.4
Other Drug Disorders F10-19	705	261	22.8
Schizophrenia, schizotypal & Delusional Disorders F20	2,291	1,531	90.1
Depressive Disorders F32.9	2,373	3,256	132.8
Mania F30	895	1,199	49.4
Neuroses F48	735	856	37.5
Eating Disorders F50	7	210	5.1
Personality and Behavioural Disorders F60	326	704	24.3
Intellectual Disability F79	72	41	2.7
Development Disorders F80	21	4	0.6
Behavioural and Emotional	24	5	0.7

Diagnosis	Men	Women	Admissions per 100,000 pop
Disorders (youth) F90			
Other and Unspecified F99	1.018	747	41.6
Total	**9,855**	**9,764**	**462.7**

Incidence

Not available.

Protective factors

A Vision for Change identifies the following protective factors for mental health

- secure attachment
- positive early childhood experiences
- good physical health
- positive sense of self
- effective life/coping skills
- basic needs being met
- opportunities to learn

In addition, the Slan 2007 survey (Barry et al., 2009) concluded that having access to a job, income and good education are all critical to positive mental health as is having close supportive relationships.

Risk factors

A Vision for Change identifies the following risk factors for mental health

- physical illness or disability
- family history of psychiatric problems
- low self-esteem
- low social status
- basic needs not being met, e.g. homelessness
- separation and loss
- violence or abuse
- substance misuse
- childhood neglect

The results of the Slan 2007 (Barry et al., 2009) survey confirms that markers of social disadvantage i.e. low education, low income, holding a medical card and being unemployed are all associated with poorer mental health and social well-being.

Prevention and promotion programmes/activities

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Schools			
Beat the blues	Aim: to increase awareness and understanding of depression and mood disorders. Also to assist young people to become more open about their emotional issues and nurture a more positive attitude. The programme targets stigma over mental health issues and examines suicide rates, particularly amongst young men. It seeks to identify sources of support for young people.	AWARE, schools, parents, Transitional Year and Senior students.	On-going
National public speaking project	Aim: to introduce students to public speaking and within that promote awareness and build knowledge in young people about the importance of positive mental health and the causes of mental illness. Mental Health Ireland's promotional programmes for schools feature the National Public Speaking Project. It has a parallel objective to reduce negative attitudes, prejudices and stigma which can be associated with mental illness.	Mental Health Ireland, YMHI, young people in senior classes in Post Primary Schools.	In its 31st year
Zippy's Friends programme	Aim: to increase emotional literacy for young children within schools in the west of Ireland as part of its overall programme for mental health promotion and enhancing coping skills for later life. The programme encourages children to understand and work things out for themselves rather than take a prescribed view in telling the participants what is 'good' or 'bad'.	Health Service Executive, schools, children of 5-7 years and teachers.	from 2008 to 2010
Please Talk.	Aim: to encourage young people experiencing problems to talk to others and identify the supports available to those	Third level students	Since 2007

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	in need. An initiative, running in third level colleges.		
Workplace			
Health and Safety Authority's Workplace Health and Well-being Strategy (2008),	Aim: to (i) develop a service delivery model that will support small and micro enterprises in implementing workplace health prevention, promotion and rehabilitation programmes; (ii) develop support service; (iii) establish a structure that facilitate such support.		
Mental health and wellbeing: A line manager's guide. The Irish Business and Employers' Confederation	Aim: to provide information and direction for line managers in promoting mental wellbeing for all and understanding and supporting employees experiencing mental health problems while in the workplace.	Employees experiencing mental health problems while in the workplace.	
Look after Your Mental Health during tough economic times; National Office for Suicide Prevention	Aim: to inform the general public and organisations on mental health issues related to unemployment and financial difficulties through public leaflets and guidance to organisations. The National Office for Suicide Prevention is also supporting the delivery of mental health promotion programmes targeted at unemployed people.	Programme targeted at workplaces and agencies working with and representing unemployed people	Commenced in 2009
The Veterinary Assistance Programme	Aim: to provide information resources, counselling and health promotion services. This programme consists of a 24 hour Free phone Professional Counselling Helpline; access to Face to Face Professional Counselling; anonymous or "low-stigma" online Professional Counselling accessed through e-mail and real-time "Live Connect"; and a dedicated "Wellnet" internet website, containing over 5,000	The National Office for Suicide Prevention provides this Suicide Prevention Programme targeted at The Veterinary profession;	

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	articles and resources on health, wellbeing, parenting, finances, legal information, consumer rights and workplace issues.		
Older people			
Befriending	Aim: to create supportive and positive relationships. Mental Health Ireland run the befriending project which helps to bring people together for positive, supportive relationships to reduce the isolation often felt by those with mental health difficulties	Mental Health Ireland, the HSE. The scheme is intended for adults over 18 years with mental health difficulties, living in the community	On-going
HSE Senior Help Line	Aim: to provide a listening service for older people. A national peer to peer confidential listening service for older people provided by older volunteers, for the price of a local call.	The service is aimed at isolated and lonely older people.	On-going
Other programs			
OSPI Europe – Optimising prevention programmes and their implementation	Aim: to address the determinants of mental health and risk factors for suicide and depression. A European project in which Ireland is one of four collaborating countries. A community based prevention intervention to train community facilitators such as GPs, teachers, priests, policemen, geriatric caregivers and provide self-help activities.	Members of the community	2009 to present, EU funded
Mental Health Matters project is run by Mental Health Ireland	Aim: to address the mental health in a realistic and relevant manner that is particularly appropriate to young people. And, to challenge young people's attitudes towards mental health and to discuss and correct misconceptions. A further aim is to ensure that young people have an awareness of the mental health services and facilities. A	Young people, 14-18 years.	2011

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
	resource pack and a free structured course with six units, each with its own theme, using a series of exercises.		
Jigsaw	Aim: to address the mental health needs of young people. Jigsaw is a community model of youth mental health. It is an innovative approach which brings together existing community supports to meet the mental health needs of young people. Jigsaw works actively with services and local health managers in an effort to use existing resources in a more efficient way.	Young people aged between 12-25 years and their families. Developed by *Headstrong*, The National Centre for Youth Mental Health.	On-going. Funding sources include the HSE, and philanthropy
Caring for the carer	Aim: to address the mental health needs of carers. Mental Health Ireland designed a scheme to address the mental health needs of carers with an emphasis on mental health promotion.	Mental Health Ireland, Care Alliance Ireland, carers, those using the services of carers.	
See Change -the National Stigma Reduction Campaign	Aim: to reduce stigma. *See Change*, was, and is working to change attitudes about mental health, create a greater understanding and acceptance of people with mental health problems and end stigma.	The reduction of stigma requires a targeted, multifaceted, community-led approach. The campaign's activities and messages are therefore tailored to specific audiences, identified through baseline attitudinal research as being key audiences for stigma reduction. A network of over 50 national and local organisations across the country are working in partnership with *See Change* and are carrying the anti-stigma message through local broadcasts, local print media and a range of other activities.	Launched in 2010 and on-going. The campaign is funded by numerous organisations including the Department of Health through the National Lottery, The Mental Health Commission and The HSE National Office for Suicide Prevention.

Programme name	Aim/approach	Stakeholders/target group	Duration, Cost of programme
Think Big programme designed by O2 and *Headstrong*	Aim: to promote positive mental health and wellbeing for young people in Ireland. Grants of up to €300 are available to enable young people to undertake projects in their community that make a difference to young peoples' mental health.	Adolescents aged between 14 and 25	On-going
Suicide Prevention in the community: A practical guide	Aim: to prevent suicide. Launched by the National Office for Suicide Prevention, HSE West and Console the guide is the first of its kind in Ireland. It contains useful and practical advice on how best to set up a community response group to suicide. It lists the 'do's' and 'don'ts' of how best to support a grieving community and reduce the risk of further suicides in an area.	Good practice guidelines are outlined for schools, third level colleges, youth clubs and centres, workplaces and sports groups.	March 2012
'Your Mental Health' awareness campaign	Aim: to improve awareness and understanding of mental health and well-being in Ireland	The National Office for Suicide Prevention in partnership with many voluntary organisations provide information and support in times of emotional difficulty. See www.yourmentalhealth.ie	On-going
Let Someone Know' campaign	Aim: to promote awareness of mental health issues and to encourage young people to talk about their problems.	The National Office for Suicide Prevention campaign is aimed at youths.	Started in 2007
National Farm TV Mental Health Awareness Campaign,	Aim: to increase mental health awareness. This advertisement campaign commenced in 2009 and is disseminated through Farm TV. Farm TV is a media outlet specifically targeted at the agribusiness sector. The campaign is on-going and is shown in marts throughout the country on a weekly basis. The campaign has been supported with mental health awareness literature distributed at Farming markets.	Members of the farming community.	Funded by the National Office for Suicide Prevention