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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Table of Contents

Lay version of the report

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. Efforts to encourage EU Member States prioritise and implement prevention and mental health promotion programmes have been in place for some time, particularly since 2005, with the introduction of some landmark EU policy initiatives.

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 mental illness prevention and mental health promotion activities. This was to assist the European Union's work within and between Member States and other countries and provide a further platform for future EU work in the field. 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.

It therefore provides a valuable and important contribution to the existing literature and work of the EU, particularly the Joint Action on Mental Health and Well-being, a three year collaboration between Member States under the EU Health Programme 2008-2013, launched in February 2013 (EAHC, 2013).

Introduction and objectives

In any year, 38.2% of the European Union's population experience a mental illness (164.8 million people) with anxiety disorders (14.0%), insomnia (7.0%) and depression (6.9%) being the most common (Wittchen et al., 2011). Across 30 European countries, the cost of brain disorders is estimated at 798 billion Euros for 2010 (Gustavsson 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.

Stigma and discrimination present significant social costs for people with mental illness (Thornicroft et al., 2009).

Access to mental healthcare for those who need it is essential and yet there is a notable gap in accessing these services. Just under half the people with mental health problems (48%) who require mental health services report not accessing them (Alonso et al., 2007). This treatment gap contrasts with the situation with physical illness where over 75% receive treatment (Wahlbeck and Huber, 2009). There are also concerns about the consequences of mental illness, such as the risk of social exclusion and the significant reduction of life expectancy in this group (WHO, 2012; Chang et. al., 2011).

Prevention of mental illness and promotion of mental health and well-being has recently increased in importance for EU policy makers because it offers an important opportunity to reduce the suffering and onset of mental illness, enhance the well-being of a population and in turn promote social and economic growth. As used in this report mental illness prevention 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 (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).

Within this context, our task was to produce up to date information of the 27 EU Member States, 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 of mental illness and promotion of mental health 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.

European mental health policy - an overview

In 2005, the World Health Organization (WHO) European Region, with the support of the European Union (EU) and the Council of Europe, approved a 'Mental Health Declaration and Action Plan for Europe' (WHO, 2005a; 2005b) to address the key challenges in mental health across Europe. This was followed by the European Commission's Green Paper - 'Improving the Mental Health of the Population' (European Commission, 2005) and the launch of the European Pact for Mental Health and Well-being (2008) as a framework for exchange and cooperation on mental health challenges and opportunities. The Pact outlined five priority areas for promoting mental health, preventing of mental disorders and promoting social inclusion, and noted 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
- Promoting Social Inclusion and Combating Stigma

The economic crisis in Europe that commenced in 2008 has prompted further concerns about the potential impact on mental health. In response, the WHO Europe (2011) outlined some of the benefits of implementing various actions to mitigate the effects of this crisis, which itself is closely tied to the mental health of Europe's population.

Further developments include the adoption of a series of Council Conclusions by the Council of the European Union in June 2011 confirming support for the Commission's Green Paper (2005) and the European Pact for Mental Health and Well-being Pact (2008); and the Joint Action on Mental Health and Well-being under the EU Public Health Programme 2008-2013. Additionally, a forthcoming new European Mental Health Strategy by the WHO aims to draw together mental health promotion, and the prevention and treatment of mental illness. This features three cross-cutting objectives:

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

Project objectives

The main objectives of the project were to:

- profile the mental health status of the population with a focus on the prevalence of mental illness, key risks and protective factors;

- describe how mental health systems are organised and how these operate in relation to existing mental health promotion and prevention of mental illness programmes;
- set out expert proposals to strengthen mental health systems in prevention and promotion at EU, country and regional level and by non-statutory agencies;
- estimate the benefits to be derived from action and investments, performance in health, education, social development and economic growth.

The project also summarised the types of mental illness prevention and mental health promotion programmes that are implemented, the relevant legislative and policy changes, future developments in this area and the potential economic and social gains.

Methods

Four main data sources were used:

- a search of the academic and grey literature since 2000, with a focus on reports and papers published after 2005, using bibliographic databases and the internet;
- information gathered using a standardised template from a network of 25 collaborators from Member States and other countries (Croatia and Norway) working in mental health and related areas;
- a survey of prevention of mental illness and mental health promotion experts across the twenty-nine countries; and
- a search of EU and WHO databases and web sources for EU level statistics on mental health services and other relevant information.

Data were collected on all 27 EU Member States and Croatia and Norway. The data gathered combined qualitative and quantitative information. These were analysed accordingly using qualitative and quantitative techniques and appropriate software packages to summarise mental health systems in the following formats:

- a set of 29 country profiles, one for each participating country, with a description of their mental health system, status of mental health in the population and information on prevention and promotion activities. Country profiles were validated by Governmental Experts in mental health who also provided additional information, data and guidance where necessary;
- an overall analysis of country profiles at EU level, with supplementary information gathered through EU statistics, websites and databases; and
- an analysis of the responses received from promotion and prevention experts.

Data collected on the types of prevention and promotion activities focused on three settings: schools, the workplace and long-term residential facilities for older people, although this was expanded to include older people in the community given the shortage of initiatives identified for this group.

Review of the literature

Status of mental health in the European Union

Recent estimates of the prevalence of mental illness show that this remains high (Wittchen et al., 2011; Wittchen & Jacobi, 2005). 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 & Jacobi, 2005). Suicide is one of the ten most common causes of premature death and 90% of suicides are linked to mental illness (European Commission, 2010). Reducing the social and economic risk factors for mental illness and suicides and enhancing the protective factors are therefore of considerable importance.

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). Compared with traditional psychiatric hospitals, community mental healthcare leads to better access to services, better protection of human rights of people with mental illness, reduced clinical symptoms, improved quality of life, improved housing stability and vocational rehabilitation; enhanced social life, greater satisfaction, and is potentially a more cost-effective alternative to long-stay hospital care (Caldas de Almeida & Killaspy, 2011). Several recent developments, such as recovery-oriented and patient-centred approaches and better access to psychological therapies, are contributing to improving the lives of people with mental illness, and have implications for prevention of mental illness and promotion of mental health.

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. The evidence from such programmes has expanded a great deal over this time. Several important sources of information list the evidence for effective prevention of mental illness and mental health promotion programmes. DataPrev[2] is a project that supports the implementation of effective programmes in schools, workplaces, home and family, and community settings.

Recent publications demonstrate the cost savings that can be made following investments in prevention and mental health promotion programmes (McDaid & Park, 2011, Matrix Insight, 2012). The literature demonstrates the cost-effectiveness of interventions targeting children (McDaid et al., 2010) and workplace programmes to

[2] http://dataprevproject.net/

reduce high levels of sickness absence and presenteeism[3] (Czabała et al., 2011). There is, however, a gap in the literature on cost-effective interventions for older people in long-term care facilities.

Country profiles

The 29 country profiles, comprising of all 27 EU Member States plus Croatia and Norway, provide a snapshot of each country's current mental health system and an overview of initiatives in mental illness prevention and mental health promotion. Each country profile highlights recent mental health legislation and policy, the inclusion of prevention and promotion priorities; mental health services (numbers and types); financing; access and use of services; variations and gaps; workforce information; the prevalence and incidence of mental illness in the population, where available; and a list of prevention of mental illness and promotion of mental health activities and investments into these; and a summary of strengths and weaknesses.

Analysis of country profiles

The main findings from the descriptive analysis are listed below.

- All participating countries had some legislation guiding procedures on compulsory admissions to hospital. Almost all had mental health policies and included prevention of mental illness and mental health promotion priorities within them, particularly in relation to suicide prevention and health/mental health promotion.
- 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. The number of psychiatric care beds has been steadily declining over the past decade, including those in general hospital units. The lowest psychiatric bed numbers are found in Italy (9.8 per 100 000 inhabitants), Hungary (32.9 per 100 000 inhabitants) and Spain (40.7 per 100 000 inhabitants) in 2010.
- Community mental health services in different forms were present in almost all countries. These mostly comprised primary mental healthcare, outpatient and day care services. 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.

[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.

- All participating countries provided examples of prevention of mental illness and mental health promotion 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.

  The most common type of programme in schools was prevention of bullying/violence (14.3%). In the workplace, health management and counselling were common prevention approaches (15.0%). For older people, although very few in number (4 out of 25 programmes for this group), focused on raising awareness about mental health. Raising awareness about mental health, combating stigma and suicide prevention were also common general programmes targeting wider audiences (e.g. the general population) or groups at high risk.

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, the availability of resources and the delivery of programmes. The data we obtained demonstrated the diverse systems that fund, deliver and campaign to prevent mental illness and promote mental health. Good practice examples show that a focus on prevention and promotion backed by adequate policies, implementation plans and financial resources are critical for success. The main challenge is to generate and direct enough commitment and resources to implement prevention and promotion programmes. Despite many difficulties and challenges described in relation to the implementation of mental health promotion and prevention of mental illness, good progress has been made in many participating countries. Further work, however, is needed to maintain the momentum.

The economic and social gains of investments

Several key publications have outlined economic and social gains from investing in prevention and promotion of mental health. Significant savings can be made when investing, for example, in school bullying prevention programmes; one such programme produced a 21-22% reduction in the number of children victimised, which represented a saving of £1,064 per school pupil in terms of future costs (Knapp et al., 2011). Significant cost savings can also be made from offering enhanced depression care for employees at risk of developing depression and/or anxiety disorders; and from befriending programmes for older people. The social gains to be made from

implementing prevention and mental health promotion are equally important and are often embedded within programmes; although they may be more difficult to fully quantify.

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). This included the number of admissions to hospital, visits to mental health services and/or consultations with professionals. Fourteen countries reported data from epidemiological surveys on the prevalence of mental disorders in the general population. There are emerging attempts to introduce health/mental health and well-being indicators into the repertoire of monitoring systems within a few participating 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. But all have made some attempt to carry out prevention of mental illness and promotion of mental health initiatives. Joining forces with related public health programmes, for example, to reduce tobacco, drugs and alcohol use, and to encourage healthy eating and lifestyles are certainly important for preventing mental illness and promoting mental health. Cross-sector working with other government departments, for example, education and labour ministries represents an important next step for the sustainability of prevention and promotion of mental health programmes.

Conclusions

Our findings show the variety of activity in mental health across Europe over the past decade. The shift from long-stay hospital care to community-based mental health services is evident, but over a third of countries still have this form of care and many countries still lack sufficient community-based mental health services.

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 and central to

economic, personal and social growth. This goes hand in hand with continuing improvements in the access and quality of mental healthcare for the people who need it. Maximising resources in this way is an important investment, and would save costs in the short-, medium- and long-term future.

Key policy recommendations

Recommendations for Member States

Important progress has been made by many Member States to improve mental health services and turn mental health promotion and prevention of mental illness priorities into policy and practice. But some countries still need to prioritise these initiatives. To encourage more implementation and maintain momentum while being mindful of the current economic challenges, we make the following recommendations for Member States:

1. **Ensure commitment and leadership to population mental health and well-being**
   Genuine political will, commitment and leadership are necessary for reform and continuous improvement of mental health systems. Many Member States do show high levels of commitment and determined leadership despite the economic crisis; others need to be encouraged to increase their efforts towards improving mental health and well-being. Member States with dated mental health legislation must be encouraged to revise their legislation to modernise mental health services and practices.

2. **Strengthen mental health promotion and prevention of mental illness**
   Promotion and prevention should be seen as key components of mental health policies and mental health systems. These need to be backed by funding resources which are proportionate to the long-term savings for the healthcare which they can deliver. Guidelines, adequate training for those promoting mental health, use of effective and cost-effective programmes and further research are important for strengthening implementation.

3. **Promote mental health and well-being partnership action**
   Investing in mental health requires partnership action. Cooperation between health policies, systems and practitioners with partners from other sectors such as social affairs, education, workplaces and justice is crucial, both for successful treatment and care services and for prevention and promotion. Partnership is needed between various administrative levels – ranging from national to regional and local levels – and in line with the specific circumstances and definition of roles and responsibilities in Member States. Joining forces with general public health initiatives that overlap with

mental health and prevention, such as drug and alcohol reduction policies and promoting healthy lifestyles for all, will make the most of limited resources.

4. **Promote the transition towards mental health services that are integrated into the community and ensure a better distribution of and access to services**
   The continuing pursuit and development of community-based mental healthcare for people with mental health problems, either common or severe mental illnesses, is critical. Member States with long-stay hospital care should replace these with community-based infrastructures and services as far as is possible. There is also a need to move away from a heavy reliance on inpatient services to ambulatory day care and domiciliary care where users are seen at home.

   Variations and gaps in existing mental health services across Member States, largely in community-based facilities, needs to be addressed to avoid or minimise any unequal access to them.

   More efforts are needed to close the gap in the treatment of common and severe mental disorders and to achieve early interventions in ways adapted to the specific needs of all age groups.

5. **Promote quality of care, data collection and defining indicators**
   Investment into monitoring and assurance of the quality of care and treatment of mental health services and prevention and promotion can support the modernisation of services. This will help improve the quality of services where necessary and prevent services from declining. There are notable gaps in information concerning mental health and well-being levels in the population and the amount of funding allocated to mental health promotion and prevention programmes across Member States. Attempts to gather this information over time represents an important next step.

6. **Empower users, informal carers and civil society**
   Community-based mental health services lead to more responsibilities for users themselves and their informal carers, often family members. Through their critical role, civil society organisations contribute in vital ways to identifying and addressing challenges, and to improving care. Member States should see and involve users, informal carers and civil society as valuable partners in the design and implementation of mental health services.

Recommendations for the European Commission

1. **Continuing a leadership role on mental health and well-being**

Through the launch of the European Pact for Mental Health and Well-being in 2008 and the following implementation process that included a series of thematic

conferences, Council Conclusions of 2011 and the start of a Joint Action on Mental Health and Well-being in early 2013, the Commission has raised awareness about the importance of mental health and well-being, and about challenges and opportunities linked to it, in the context of health policy and other policy fields.

The Commission is encouraged to continue and further develop this leadership role. The importance of giving high priority to protecting and promoting the mental health and well-being of the EU-population, its 'mental capital', has increased even further since the launch of the Pact. Firstly, the mental health and well-being of the population is in many ways a key resource for the implementation of EU's Europe 2020 strategy adopted in 2010. Secondly, the economic and financial challenges which several Member States have entered into, have increased the risks for the mental health and well-being of the population on the one hand, and at the same time led to cuts in public budgets for health including mental health on the other hand.

2. Promoting exchange and cooperation between Member States

The Commission is encouraged to continue its own work with all Member States on issues of common interest in the context of the European Pact for Mental Health and Well-being. There is a need to make this more specific and geared towards clearer commitments and outcomes. One option would be to use, inter alia, this report as a basis for an exchange process with Member States on the progress which they make in working towards the objectives of the Pact, and on the challenges which they may meet in doing this.

3. Integrating mental health into the EU's own policies

This study shows that the population's mental health and well-being is influenced and sometimes addressed by a wide range of policy fields. The study is a resource for these policies. A stronger integration of mental health into EU-policies could contribute to overcoming the fragmentation of health and non-health policies found by the study, and to making good use of limited resources.

Encouraging cooperation and the exchange of good practices between Member States on the integration of mental health into EU-policies and ways to strengthen mental health systems are complimentary. Further EU-research and policy can significantly increase understanding of mental health and mental health problems in terms of its medical, psychological, community and societal dimensions.

EU-financial instruments such as the EU-Structural Funds can provide significant financial support to mental health reforms in Member States. Continuing financial investment in further research to identify the most effective and cost effective mental

health promotion and prevention of mental illness initiatives and transferring these into policy and practice is another important way to strengthen progress in this field.

4. Working with stakeholders

This study shows that the actions of Governments and authorities at various levels have an influence on the mental health of the population, but also those of a great number of non-governmental actors, such as health professionals, social care providers, workplace employers and employees, education professionals, users, informal carers and civil society organisations in a broader sense.

Creating a platform by which Governments can develop recommendations for the protection and promotion of mental health and well-being, make commitments and report on the progress of implementing these, would be a valuable complement to the work with Member States.

Users of mental health services and their family members with their specific expertise should play a prominent role in such a platform.

5. Improving the availability of data on the mental health status in the population and defining, collecting and disseminating good practices

The lack of comparable data on the status of mental health and on mental health resources, infrastructures and programmes in Member States was one of the key challenges encountered in this study.

It is unrealistic to expect these challenges to be overcome in the near future. However, the Commission is encouraged to prioritise mental health and well-being in its health data collection and reporting, which reflects its weight in the burden of diseases and its increasing relevance for health and social systems. The lack of complete data on mental health problems as a reason for work disability and early retirement is, for instance, probably one of the reasons why this issue is not yet as highly prioritised as it should be, given that the available data signal the leading position of mental health problems as cause of health-related cases of work disability and early retirement.

Another challenge encountered was the lack of agreed criteria to define good practices. The Commission is encouraged to invest efforts into this because clarity on what establishes good practice is the very basis for the promotion of exchange and cooperation between Member States, for the success of the Joint Action on Mental Health and Well-being and the functionality of tools such as the inventory and good practice database EU-Compass for Action on Mental health and Well-being.

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Steering group members

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