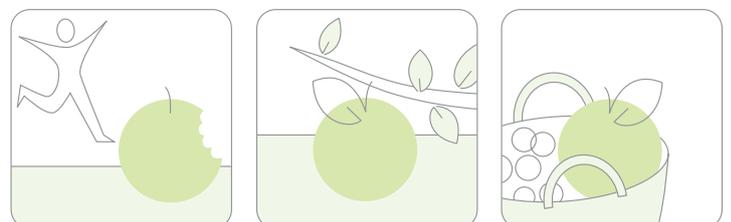


Mental health promotion and mental disorder prevention across European Member States: a collection of country stories

(Second edition)



Mental health promotion and mental disorder prevention across European Member States: a collection of country stories



European Commission



Generalitat de Catalunya
Departament de Salut

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European Network on Mental Health Promotion and Mental Disorder Prevention



Implementing Mental
Health Promotion Action

Partners of countries involved:



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More information on the country stories is available at: <http://www.imhpa.net>

A great deal of additional information on the European Union is available on the Internet. It can be accessed through the Europa server (<http://europa.eu.int>).

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Preface

Positive mental health is an integral part of the health and well-being of the citizens of Europe. In the European Union, mental ill health is one of the leading causes of disease burden. Research suggests that one in four Europeans suffer from a mental health problem at least once during their life, and some 58,000 citizens die from suicide every year, more than the annual deaths from road traffic accidents, homicide, or HIV/AIDS.

The European Commission with its mandate for public health has a long tradition in supporting mental health. It contributed to the WHO European Ministerial Conference on Mental Health, held in Helsinki in January 2005. Through its Declaration and Action Plan¹, this conference created strong political commitment for mental health and established a framework for comprehensive action.

The launch of the European Commission's Green Paper on Mental Health² and the following consultation process (October 2005 – May 2006) support the implementation of this framework. The aim of the Green paper is to stimulate a debate with the European institutions, Governments, health professionals, stakeholders in other sectors, civil society, and the research community about the relevance of mental health for the EU, the need for a strategy at EU level, and its possible priorities.

With the Green paper and activities under the EU Public Health Programme 2003-2008³, the European Commission seeks to give support to EU Member States in developing mental health.

In order to develop infrastructures that will promote mental health and prevent mental ill health, it is important to have a starting point that accounts what is available, and provides information on existing programmes and policies at the country level. The Directorate-General for Health and Consumer Protection of the European Commission therefore encouraged the initiative of the IMHPA Network for Mental Health Promotion and Mental Disorder Prevention to assess the situation and to collect available information on prevention and promotion in mental health.

This report presents a first overview, a snapshot of mental health promotion and mental disorder prevention across Europe describing the available policies and underlying challenges and areas for future development. It constitutes a valuable contribution to building a base line of the situation of mental health promotion and mental disorder prevention across EU Member States, and facilitates the identification of possible areas for future action. As it stands it can already be a first step contributing to the consultation process at the community level and supporting Member States with a first, although not exhaustive, overview of prevention and promotion in mental health across Europe.

I thank all those involved in the preparation of this report for their significant efforts and the leadership of the IMHPA Network in this work.



Robert Madelin

Director General for Health and Consumer Protection



¹ Mental Health Declaration for Europe and a Mental Health Action Plan for Europe, <http://www.euro.who.int/mentalhealth2005>

² European Commission Green Paper. Improving the Mental Health of the population. Towards a strategy on mental health for the European Union. http://europa.eu.int/comm/health/ph_determinants/life_style/mental/green_paper/consultation_en.htm

³ Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008). Official Journal L 271, 09.10.2002



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An introductory word

This report presents a snapshot of the situation of mental health promotion and mental disorder prevention across 30 European countries, Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain (Catalonia), Sweden, the Netherlands, Turkey and the United Kingdom (England and Scotland).

The country stories presented in this report have been prepared by the members of the European IMHPA Network for Mental Health Promotion and Mental Disorder Prevention (see annex I), who are key experts on mental health in their respective countries. For the preparation of this report, the European Network members have involved stakeholders in their countries to collect information about available policies, programmes, workforce and infrastructures for mental health promotion and mental disorder prevention. The European Commission has supported this initiative on the understanding that the country stories are not official and exhaustive reports, but rather a snapshot of current activities.

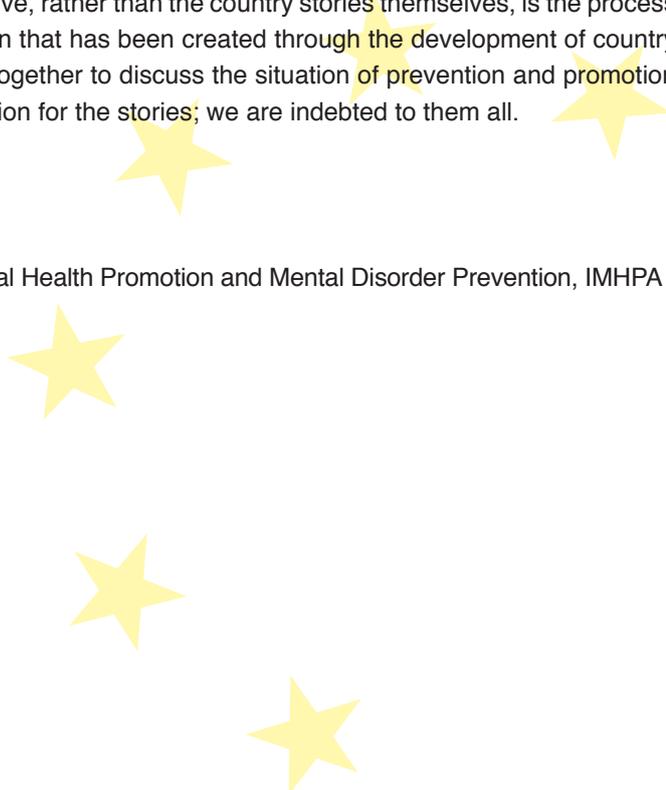
This document is therefore not an official account, but rather a first attempt to collect some baseline information on ongoing initiatives in countries and regions. The selection of information included and the described programmes and policies should not be interpreted as the only available sources of action nor should they be considered evidence based or recommended action, since the report was not intended to be a completely exhaustive or evaluative exercise, but rather the first stage in a process that hopefully will be updated and extended. We welcome any further information that can help in this process.

The country stories presented in this report, by the authors in their own words, highlight the richness of approaches and topics which can be addressed, and that are being implemented as mental health promotion and mental disorder prevention across Europe. These accounts from different cultural, economic and political backgrounds provide a framework for learning from each other and for stimulating cross-fertilization.

Maybe a more remarkable outcome of this initiative, rather than the country stories themselves, is the process of raising awareness, dialogue, and co-operation that has been created through the development of country groups and the 240 or more people that came together to discuss the situation of prevention and promotion in their countries and who provided the information for the stories; we are indebted to them all.

Dr. Eva Jané-Llopis

Project leader of the European Network for Mental Health Promotion and Mental Disorder Prevention, IMHPA
on behalf of IMHPA



Mental Health Promotion and Mental Disorder Prevention: a snapshot across Europe

Prepared by Dr. Eva Jané-Llopis, Sjoerd van Alst and Dr. Peter Anderson

1 Introduction

European mental health

Positive mental health is “a state of well-being in which the individual realizes his or her 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”¹. Positive mental health enhances social cohesion and social capital and improves peace and stability in the living environment, it contributes to economic development in societies, and is a shared principle of European democracies².

Mental and behavioural disorders and poor mental health are present at all ages and across different cultures and population groups. One in four Europeans suffer from a mental health problem at least once during their life. The costs of mental health problems have been estimated at between 3% and 4% of gross national product³.

Mental health promotion and mental disorder prevention can be an effective strategy to reduce the burden of mental disorders, and have shown to bring about health, social and economic development^{4,5}.

Mental Health Promotion and Mental Disorder Prevention^{6,7,8}

Mental health promotion aims to protect, support and sustain emotional and social well-being and create individual, social and environmental conditions that enable optimal psychological and psycho-physiological development, enhance mental health, while showing respect for culture, equity, social justice and personal dignity. Initiatives involve individuals (at risk, suffering, or recovering from mental health problems), in the process of achieving positive mental health, enhancing quality of life and narrowing the gap in health expectancy between countries and groups.

To “prevent” literally means “to intervene or to take steps in advance to stop something from happening”. Mental disorder prevention focuses on reducing risk factors and enhancing protective factors associated with mental ill-health, with the aim of reducing risk, incidence, prevalence and 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 society.

¹ WHO, Strengthening mental health promotion, Geneva 2001 (Fact sheet no. 220)

² Jané-Llopis and Anderson (2005). Mental Health Promotion and Mental Disorder Prevention: A policy for Europe. Nijmegen: Radboud University Nijmegen. <http://www.imhpa.net>

³ Estimation by ILO. http://agency.osha.eu.int/publications/newsletter/8/en/index_23.htm

⁴ Jané-Llopis, Barry, Patel & Hosman, eds (2005). The evidence of mental health promotion: Strategies for Action. Promotion and Education, Supplement 2. <http://www.iuhpe.org>

⁵ WHO. (2004). Prevention of Mental Disorders. Effective interventions and policy options. Geneva: World Health Organization. 6 http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

⁶ WHO. (2004). Promoting Mental Health: concepts, emerging evidence, practice: summary report. Geneva: World Health Organization. http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf

⁷ Detels, R., McEwan, J., Beaglehole, R., & Tanaka, H. (2002). Oxford textbook of public health (Fourth edition ed.) (Vol. 1). Oxford: Oxford University Press

⁸ Mrazek & Haggerty (1994). Reducing the risks for mental disorders: Frontiers for Preventive Intervention Research, National Academy Press, Washington DC

Mental health on the European political agenda

With its Public Health Programmes, the European Commission has long supported the development of mental health at the Community and Member State level. The Commission was a collaborative partner in the January 2005 World Health Organization (WHO) Ministerial Conference on Mental Health, “Facing Challenges Building Solutions”. At the conference, Ministers of Health and high level political representatives of 51 of the 52 Member States of the European Region of the WHO signed the Mental Health Declaration for Europe⁹ and endorsed the European Action Plan for Mental Health¹⁰, which proposes options for action. With the Declaration, mental health and mental well-being have been acknowledged as fundamental to the quality of life and productivity of individuals, families, communities and nations.

The Commission, which is currently active in supporting the implementation of the WHO European Action Plan for Mental Health, states that, to achieve good health for all, co-operation between the European Union (EU), its Member States and its citizens is required. In this context, the Commission has recently drafted and launched a Green Paper on Mental Health¹¹, outlining a framework for exchange and co-operation between Member States, aiming to help increase the coherence of actions in the health and non-health policy sectors in Member States and at Community level, and stimulating the involvement of a broad range of relevant stakeholders into building solutions.

The Commission has launched a one-year consultation process on the Green Paper, starting in October 2005, with the aim of stimulating a debate with the European institutions, governments, health professionals, stakeholders in other sectors, civil society, and the research community about the relevance of mental health for the EU, the need for a strategy at EU-level, and its possible priorities. During late 2006, the Commission intends to present its analysis of the consultation process and a proposal for an EU strategy on mental health.

The European Network for Mental Health Promotion and Mental Disorder Prevention, IMHPA

With the financial support of the European Commission and of the Ministry of Health of Catalonia (Spain) the “European Network for Mental Health Promotion and Mental Disorder Prevention” (IMHPA) has partners across 29 European countries and the participation of different European networks and non-governmental organizations (NGOs).

The European IMHPA Network (www.imhpa.net) aims to develop a comprehensive strategy to tackle prevention and promotion in mental health, developing an integrated approach to information, intervention, training, policy, advocacy and implementation, combining the support for policy priority-setting with the dissemination of tools and evidence-based knowledge.

2 The preparation of this report

The starting point of the country stories and status of this report

During the WHO Ministerial Conference it was recognized that, along with treatment and rehabilitation, promotion of mental health and the prevention of mental disorders are a priority for Europe and its Member States. While information on health care systems has been assessed across European countries, information on available prevention and promotion activities in mental health is mostly lacking at the European level. To develop mental health, and infrastructures that support implementation, it is important to have a starting

⁹ WHO Mental Health Declaration for Europe; <http://www.euro.who.int/mentalhealth2005>

¹⁰ WHO Mental Health Action Plan for Europe; <http://www.euro.who.int/mentalhealth2005>

¹¹ European Commission Green Paper. Improving the Mental Health of the population. Towards a strategy on mental health for the European Union. http://europa.eu.int/comm/health/ph_determinants/life_style/mental/green_paper/consultation_en.htm

point that accounts what is available, and that provides a base line with information on existing initiatives and policies at the country or regional level. Such an overview might facilitate priority identification and agenda setting.

The European IMHPA Network for Mental Health Promotion and Mental Disorder Prevention, with its aim of developing a comprehensive strategy for action, started the process of assessing the situation across the European Union Member States by collecting information on policies, programmes, workforces and infrastructures for prevention and promotion in mental health. The European Commission encouraged this initiative, expressed its wish to publish the compilation of country stories, and indicated that the report could be used during the consultation process of its Green Paper on Mental Health.

This report builds on the previous work of the IMHPA Network, its recent publication “Mental Health Promotion and Mental Disorder Prevention: A policy for Europe²”, the information collected through the IMHPA questionnaire (www.imhpa.net/infrastructures-database) and, in particular, on the work developed by the country partners (annex I) and the country coalitions¹² created across Europe. This report presents a first overview, a snapshot, on the situation of mental health promotion and mental disorder prevention, describing the available policies and identifying areas for future development across countries or regions. The document is a first attempt to identify what is available. It is not an official account but rather a first step towards collecting some baseline information on ongoing initiatives in countries. Nor should the selection of information be interpreted as the only available sources of action, since the stories are not intended to be a completely exhaustive exercise, but rather the start of a process that hopefully will be updated and extended.

The process to prepare the country stories

Partners of the European Platform (annex I) accepted the responsibility to act as focal points for the initiative in each country. It was agreed that information on mental health promotion and mental disorder prevention would be collected through identifying available documents and through consulting, and whenever possible involving, key stakeholders and experts who could provide information.

The starting point was the questionnaire developed by the IMHPA network in collaboration with the EC co-financed project, HP-Source (www.hp-source.net), with the aim to systematically collect information on infrastructures, policies and programmes for mental health promotion and mental disorder prevention at the country or regional level.

The IMHPA questionnaire was used as a tool to collect the information. To complete the questionnaire, it was agreed that, wherever possible, country partners would create an informal expert group or country coalition¹² that could facilitate the reliable collection of information. To ensure heterogeneity and to reach a variety of relevant information, whenever possible, the country coalition or country group involved experts from different backgrounds and positions in the field of public and mental health, including professionals from governmental and non-governmental institutions, universities, health promoting agencies and civil society. A letter of support from the European Commission was provided to all country focal points to facilitate the forming of the coalition and to stimulate the contribution of different stakeholders in collecting information.

The final response to the questionnaire was completed, wherever possible, through discussion and common agreement between country coalition members. Country meetings across 19 countries took place to complete or discuss the questionnaire. All responses to the questionnaires were entered into the IMHPA-infrastructures database (www.imhpa.net/infrastructures-database). The information collected in the questionnaire and the discussions of the members of the country coalitions were translated into a country story, which was

¹² Country coalition refers in this report to an informal expert group created by the country focal points for the purpose of generating these country stories. In some countries, already existing Mental Health Councils or more formal coalitions were invited to join this process; however in general the use of the terms country coalition should be understood as an informal group of stakeholders contacted for the purpose of supporting this initiative.

distributed and discussed further by the different stakeholders. The methodology varied according to what was feasible in each country. Every country story includes a section describing the processes and the stakeholders involved in its preparation.

In this document, the country stories are presented in the authors' own words, with only light editing. Whilst there has been an attempt to present a common structure throughout, individual approaches in each country have not always made this possible, underlying their own idiosyncrasies. The stories are stories; they are not a rigid database, and present in this way a richness of activity. Further, the stories are only a first account of what could be reviewed and described in the time span available; it is expected that extended and updated editions will be prepared in the future.



Figure 1. Colored countries are those involved in the initiative

For Spain and the United Kingdom the country stories have been developed at the regional level, and they include Catalonia for Spain, and England and Scotland for the United Kingdom.

3 Snapshot of the situation at the European level

The chapters in this report provide a first description of the resources, policies, and programmes available for mental health promotion and mental disorder prevention, describe the workforce involved in implementation across countries, provide an account of available monitoring, evaluation and reporting systems for mental health, and outline challenges, opportunities and advances in mental health promotion and mental disorder prevention across European Union Member States¹³. For a few countries, as it is indicated in the stories, only a region or two are described as opposed to the whole country. The following sections present an overview at the European level derived from the country stories, describing some differences and similarities across countries. The examples presented are for illustration purposes only and should not be understood as recommendations or evidence based practice. For more detailed information, the reader is referred to all the country stories in this report and to the infrastructures database (www.imhpa.net/infrastructures-database).

¹³ Figures and information presented in this report when referring to European Union Member States or European Countries, correspond to the information collected from those countries involved in this initiative (figure 1, annex I) with the exception of Spain, which corresponds to the region of Catalonia, and the United Kingdom, which includes England and Scotland.

4 Action for promotion and prevention in mental health

Commitment to prevention and promotion

Mental health has gained political interest across countries during the last few years. Politicians and policy makers refer to mental health promotion and mental disorder in written documents, speeches, talks and press conferences, in a manner that suggests it is a priority topic, in 25 out of the 29 countries that provided information.

However, despite the acknowledgement of prevention and promotion by politicians and policy makers, the priority of mental health promotion and mental disorder prevention seems to be lower when it comes to translation of words into action. Mental health experts across countries rated promotion and prevention as being a low priority and mostly rhetoric.

Reasons for the lack of action are related to inadequate funding and little opportunity for implementation, including, in many countries, insufficient information of what could be implemented, or lack of infrastructures that could develop this task. Provision of tools with effective and simple guidelines to support implementation could stimulate a move from political interest into action.

Availability of funding

Currently, the resources spent in mental health care, (which include prevention and promotion), are far from being proportional to the costs incurred by mental ill health¹⁴. A recent report of the Mental Health Economics European Network (MHEEN) project, co-financed by the European Commission, describes the estimated proportion of expenditure of health care budgets on mental health care (figure 2).

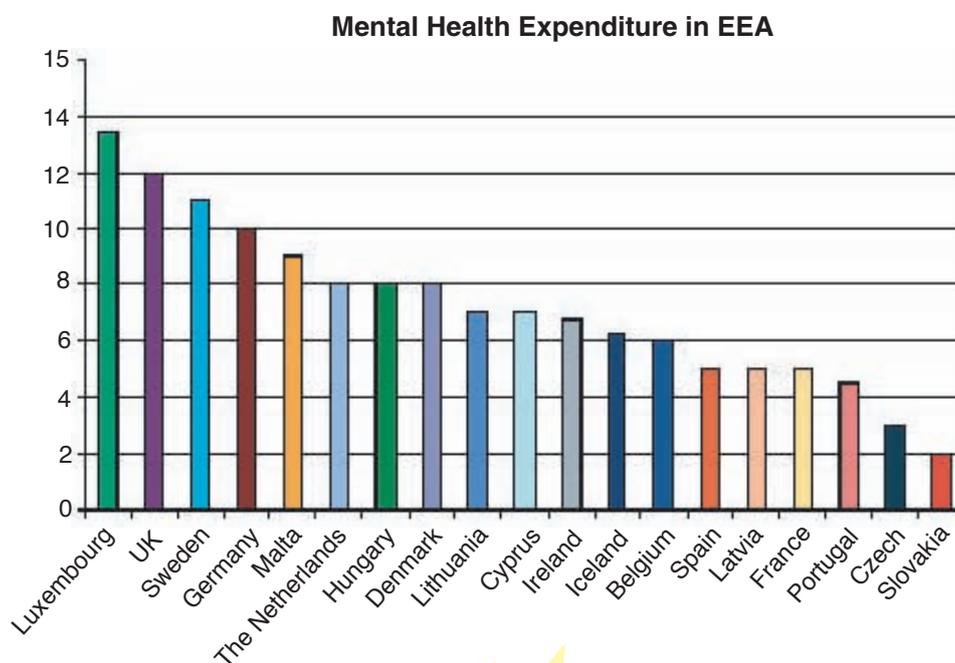


Figure 2. Percent of total health expenditure¹⁵ (MHEEN, 2004)

Figures for Belgium, Spain and the UK are figures for regions rather than for the country as a whole

¹⁴ WHO (2003). Investing in Mental Health. Geneva: World Health Organization

¹⁵ MHEEN (2004). http://europa.eu.int/comm/health/ph_information/implement/wp/mental/docs/ev_20050530_co09_en.pdf

Assessing the available funding for mental health promotion and mental disorder prevention has proven difficult since, in many cases, funding is un-identifiable within the mental health budgets, un-earmarked in overall health budgets, and dispersed across other sectors (e.g., education). Perceptions of recent funding trends across Europe seem to indicate that there have been only small changes in resource allocation to mental health promotion and mental disorder prevention. However, where there have been changes, these have been in the direction of small increases.

In one half of the countries where national funds can be linked to mental health, resources are dedicated to national centres and/or institutes, research, community education programmes, and screening and early detection programmes. There are also important non-governmental funds dedicated to mental health promotion and mental disorder prevention available in one sixth of countries, particularly for research. In addition, non-governmental funds support national institutes and research in four fifths of countries, and support community educational programmes, health professional education and preparation of conferences, workshops, seminars, or symposia in three fifths of countries. As mentioned by many countries, non-governmental organizations (NGOs) play an important role in mental health promotion and mental disorder prevention. For example in Slovakia, whilst NGOs have been in existence for only about 10 to 15 years, they provide many activities which the public sector is not willing to do.

Programmes and policies across settings

1. Policies and programmes for infants and toddlers

Infants and toddlers are not only at risk from social, psychological, biological and environmental factors, but mental health problems or mental disorders in childhood can be important precursors of adult mental disorders. National governmental policies and programmes aimed at providing a healthy start of life, promoting mental health and preventing early mental health problems in infants and toddlers are present in one third of countries.

Pre-natal counselling programmes, as in Romania, and home-based programmes, involving teams of health visitors as described in Cyprus, that aim to identify early signs of mental health problems in infants and toddlers and their families, implementing interventions when needed, are also available in other European countries, in some cases as part of an EC co-financed project¹⁶.

Reducing low-birth weight and cognitive delay through tackling social disadvantage, preventing physical abuse, parenting interventions for divorced parents, and the prevention of violence can be tackled, as for example, by the Sure Start initiative in England. These programmes work with parents, parents-to-be, infants and pre-school age children in disadvantaged communities. Broader effective programmes include relation-based family interventions, attachment based interventions, parent training and emotion education programmes.

Parent training is also available in other countries. For example, training in Austria focuses on issues like “parent literacy”, and includes knowledge on development phases, a partnership approach in parenting, discussion and conflict-solving skills, parenting styles, as well as knowledge about available help if needed.

2. Education policies and school programmes

Children spend much of their time at school, which is thus an efficient setting to reach and influence the behaviour, mental health and development of children and adolescents. National governmental education policies and school programmes are available in over one half of countries, and, in addition, in one fifth of countries, non-governmental organizations have supported the development of such policies and programmes.

¹⁶ Puura, K., Davis, H., Papadopoulou, K., Tsiantis, J., Ispanovic-Radojkovic, V., Rudic, N., Tamminen, T., Turunen, M., Dragonas, T., Paradisiotou, A., Vizakou, S., Roberts, R., Cox, A., Day, C. (2002). The European early promotion project: a new primary health care service to promote children’s mental health. *Infant Mental Health*, 22, 6, 606-624.

Initiatives implementing a holistic school approach, like the one described by Bulgaria in which “teachers are sensitized and supported on the issue of emotional well-being of children; initiatives in and across schools address the school environment from the perspective of eliminating unfriendly and potentially traumatic experiences; and where counselling programmes are available for children with specific phobias and related complaints as well as for their families”, are also available throughout other European countries .

The network of health promoting schools is frequently referred to as being active in promoting mental health in different European countries. For example, the Austrian Network of Health Promoting Schools, “aims at promoting the somato-psycho-social health of students, teachers and parents, consists of 120 schools and is supported by a knowledge centre on school-based health promotion, which provides numerous fact sheets, guidelines and programme descriptions on many topics including mental health issues”. And, in Ireland, the Social Personal and Health Education (SPHE) programme, which includes emotional health, is now a compulsory part of the post-primary school curriculum.

Bullying prevention and specific initiatives to address violence or aggression at the school setting are reported across countries, including for example, Cyprus, Denmark, Ireland, the Netherlands. In France, following US programmes adapted by French Canadians, interventions toward reducing violence at school have been developed and largely implemented. A rigorous evaluation of such an initiative in Norway, the “Olweus bullying prevention programme”, was found to reduce self-reports of bully victimization by 42%, and reporting bullying others by 52%¹⁷.

In other countries, mental health promotion is integrated within the academic curricula, such as in Malta, where “all school children between the ages of 11 to 15 years have a minimum of one hour per week on personal social development whereby they are empowered to build the skills needed to be responsible citizens within society, integrate positively within their social peer groups and cope with every day life situations and stress factors”.

Finally, systems for early detection of mental ill health (e.g., eating disorders, anxiety disorders and depression) and addiction problems are also available across school settings in different countries.

For example, in Luxembourg, efforts to increase awareness of mental problems in schools have been undertaken concerning drug abuse, and educational courses have been implemented, both for teachers and pupils, to prevent suicide and to foster early recognition of mental health problems.

3. Employment and labour policies

Two major sources of stressors that can contribute to poor mental health in adult life are workplace stress (including that created by poor working conditions) and unemployment. Over two fifths of countries have identified some national or regional employment and labour policies and specific mental health promotion programmes at the workplace.

Stress reduction and stress management at work are the most frequently reported workplace interventions among countries. Others frequently reported include the recognition of depression or smoking prevention at the workplace, like, for example, the services for substance disorders and depression reported in Malta.

Other forms of workplace mental health promotion are programmes to improve the health of the workforce, as described in Germany and other countries. Scotland’s “Health at Work” rewards employers who demonstrate commitment to improving the health of their workforce and brings benefits to employers and employees through creating a healthier, more motivated workforce and reducing sickness absence.

¹⁷ Olweus, D. (2004). The Olweus Bullying Prevention Programme: Design and implementation issues and a new national initiative in Norway. In P. K. Smith, D. Pepler, & K. Rigby (Eds.), *Bullying in schools: How successful can interventions be?* (pp. 13-36). Cambridge, UK: Cambridge University Press

In some of the new Member States, as for example in Poland, programmes in the workplace have also addressed the consequences of dramatic socio-economic changes and unemployment.

4. Policies to prevent depression, anxiety and suicide

Depression is the second cause of disability in the European Union and anxiety is highly prevalent in Europe. Depression also increases the risk of suicide, which in the European Union is higher than deaths from traffic accidents, homicide or HIV/AIDS¹⁸.

Policies to prevent depression, anxiety and suicide are widespread in over half the countries. National programmes to prevent suicide address different issues. For instance, in Bulgaria, suicide prevention tackles “the capacity to assess suicidal behaviour by specialist services and by generalists; the sensitization of the public to attempted suicide and its precipitants; and the association of mental illness and suicide”.

Help-lines for people in despair are also reported in seven countries, where, for example in Sweden, a telephone service supports persons in suicidal crises, or in Belgium, an electronic help-line for general practitioners (GPs) aims to promote expertise of GPs on depression and suicide prevention by means of a web-based ‘info cell’ and an interactive curriculum on suicide prevention.

There are also initiatives among European countries, as for example those described by Norway, that aim at restricting access to means of suicide including weapons, medicines and poisons.

A mix of several actions seems to be responsible for reducing suicide, like those described in Norway, Denmark or Finland. For example, during the last 20 years, Denmark has experienced a 60% reduction in suicide rates, probably due to a combination of several policies and programmes, including reduced availability of means to commit suicide; better physical and psychiatric treatment after attempted suicide; increased social and cultural stability in society; a more general focus on prevention; and increased access to telephone counselling and psychiatric emergency services.

5. Policies to fight poverty and social exclusion

Poverty is a main risk factor for mental illness, leading to depression and associated mental health problems. As income differentials widen, the risk of mental ill health widens, with poverty also leading to social exclusion and vice versa.

National governmental policies or programmes to reduce poverty and social exclusion have been identified in nearly two thirds of countries. The reduction of economic hardship by implementing measures such as supporting at risk families, homelessness or developing general action plans against poverty, are available across countries tackling specific issues, for example the measures to reduce economic hardship in the Latvian “Poverty Aversion Strategy”.

Social exclusion also results from disadvantage, racism, discrimination, stigmatization, and from suffering from psychiatric illness. Among the policies for social exclusion there is, for example, the English report: “From here to Equality”, which sets out a framework for a sustained programme to give people back their rights. The long term vision of the programme is to enable people of all ages who have or are affected by mental health problems to live as equal citizens. The scope is to tackle stigma and discrimination associated with a broad range of conditions, including stress and anxiety, phobias, dementia, depression and schizophrenia, working in partnership across sectors such as government, the voluntary sector and private organizations.

Mental health impact assessments that formally identify and measure the impact of broader social policies on mental health outcomes are needed to argue for the development and implementation of such policies. An initiative, co-led by the Ministry of Health in Portugal, will start a pilot project in 2006 to assess the impact of broader social and public policies on mental health.

¹⁸ Green Paper Improving the Mental Health of the population. Towards a strategy on mental health for the European Union. http://europa.eu.int/comm/health/ph_determinants/life_style/mental/green_paper/consultation_en.htm

6. Programmes across settings

It is difficult to make a complete overview of available or implemented programmes for prevention and promotion in mental health across settings in countries, as information is not easily available and programmes are implemented by different organizations and stakeholders, who, very often, are not aware of each other. Information systems such as the IMHPA database of programmes for prevention and promotion in mental health (www.imhpa.net/programmes-database) provide a first attempt to collect and describe available programmes and their outcomes. For purposes of this report, types of programmes identified were divided into 8 categories: 1) home, 2) school, 3) workplace, 4) primary health care, 5) hospital/clinic, 6) facilities for older populations, 7) churches, clubs, recreation centres etc., and, 8) programmes on the internet. Figure 3 is an estimate of the availability of setting based programmes from the 22 countries which provided specific data on this question (www.imhpa.net/infrastructures-database).

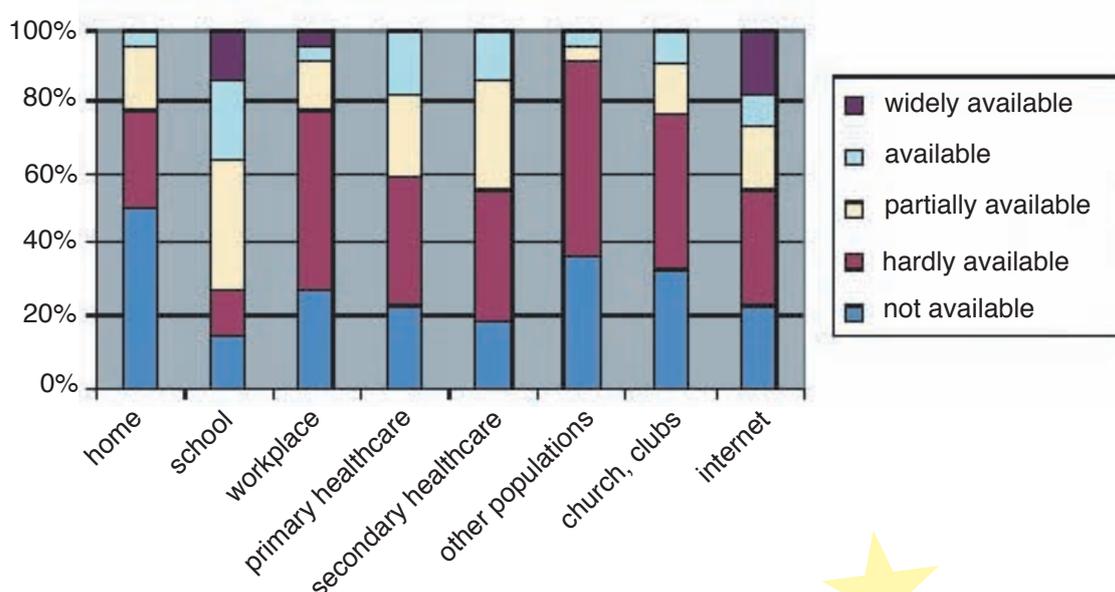


Figure 3. Availability of programmes across European Countries

Data derived from Austria, Belgium, Croatia, Cyprus, the Czech Republic, England, Estonia, France, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Poland, Portugal, Romania, Scotland, Slovakia, Slovenia, Spain and Sweden.

5 Resources to support implementation

Workforce for mental health promotion and mental disorder prevention

The workforce for mental health promotion and mental disorder prevention is very variable across Europe. The most common professional backgrounds include mental health, public health or health promotion specialists, although many other professions, including those in other sectors (e.g., teachers, social workers, police, etc) are involved to a certain extent in the implementation of prevention and promotion activities.

However, the degree to which professionals are trained, supported and have the possibility to dedicate their time to mental health promotion varies greatly. Some countries, such as the Netherlands have specialised “mental health promotion and prevention workers”. Other countries include mental health professionals such as psychologists, psychotherapists, psychiatrists or psychiatric nurses who are charged with prevention and promotion as part of their activities. Other countries, for example as in Turkey, aim to “integrate preventive mental health services into primary health care”. In Italy, a self-administered questionnaire is used to assess the psychological well-being of the health care professionals themselves.

However, because of the relative novelty of this field and a lack of sufficient resources, in most countries, as described in Greece, “professionals throughout most sectors have mental health promotion and primary prevention of mental disorder as only a small part of their brief, while, especially mental health professionals, are heavily involved in secondary and tertiary prevention”.

Education and training

Although not constituted as a separate specialization, in most countries, as for example in Croatia, the Czech Republic, and the Netherlands, under-graduate education in mental health promotion and prevention has been available in different faculties, including medicine, humanities, education, social work and public health.

Higher post-graduate education tends to be unavailable across Europe as a specific specialization, but mental health promotion and prevention, to larger or smaller degrees, are a part of masters of public health, health promotion or post-graduate degrees in nursing or psychology faculties.

Special training for those already working in the field seems to be scarce, and where available, like in England, is reported to be “ad-hoc in nature and although national training has been piloted and delivered through some NIMHE regions there is no commitment to continue to train and support those tasked with delivery”.

Training and support of the workforce for prevention and promotion in mental health is crucial for effective programmes and will determine the quality of the outcomes of implemented action.

In addition to those who would normally be charged with prevention and promotion, many countries noted one of the areas “to further explore and invest is in the training of primary and secondary health care professionals, teaching practical strategies for promotion of mental health and well-being (as distinct from treatment of mental disorders), which are so frequently needed in daily practice”.

Other countries like Finland, Ireland and the Netherlands, have identified the creation of research teams, the appointment of a professor for mental health promotion and prevention, and international collaboration as possible advancements to support training of the workforce at the country level.

Support for programme implementation

Action Plans, programmes and policies on mental health need not only to be prepared, but also to be implemented. In less than one in three countries, have governments developed policies to support implementation. It is essential that more efforts are dedicated to provide the necessary resources that sustain action and improve available interventions.

Despite a paucity of formal sources of support for implementation, action is being carried out to different degrees, and most countries report a multi-disciplinary background of those who are involved in prevention and promotion. For example, as reported in England, the broader networks of implementers in localities include health visitors, primary care professionals, teachers, governors, councillors, housing officers, community development workers, transport co-ordinators, leisure workers, social workers, police, probation officers, prison staff and colleagues in mental health services. In Ireland, partnership and inter-sectoral working are integral to the health promotion function and there is evidence of increased engagement with other statutory, non-statutory agencies and community and social partners in implementing mental health promotion action.

6 Evaluation and monitoring

Research on mental health helps to understand and to improve knowledge on the determinants and risk factors for mental ill health and on the prevalence of mental disorders. Research provides information on the impact and effectiveness of programmes and policies, as well as identifying those interventions that might even have an unwanted and harmful effect. Unfortunately, programme evaluation is part of the public health culture in only a small minority of European countries.

1. Programme evaluation: efficacy, effectiveness and cost-effectiveness

Although only 4 out of 30 countries report official national policies that support research programmes for mental health, more “informal” funding for evaluation might be a reality across more countries.

Evaluations to date have tended to be restricted to research studies assessing the efficacy of a given intervention in an experimental situation. These are mostly undertaken by universities or research institutions, for example those described in Finland, Ireland, the Netherlands, Norway and the United Kingdom. However, programme evaluation remains scarce in Europe and in most instances it continues to be undertaken in experimental situations rather than in the “real world”. There are even less cost-effectiveness evaluations of preventive or promotion interventions, a problem not only for Europe, but also for the rest of the world.

These findings are consistent with the literature searches developed by the IMHPA network in its attempt to collect and describe evaluative initiatives of mental health promotion and mental disorder prevention programmes. For example, taking the proposed gold-standard for evidence-based public health, systematic searches for randomized controlled trials resulted in only a small number of European evaluated and published programmes, compared with a much larger number of US-based studies (www.imhpa.net/programmes-database). The same ratio applied to other well accepted types of evaluation design. The European Commission Working Party for Mental Health has appointed a Taskforce on Evidence that is finalizing a paper outlining the different types of evaluations for mental health promotion and mental disorder prevention, and providing recommendations for future development. This paper will be available on the mental health section of the European Commission website early in 2006.

Some of the country stories describe some of the different reasons for this general lack of evaluation. In Cyprus, where, as for most countries, evaluations of efficacy and cost-effectiveness of interventions are still to be undertaken, reasons include a poor tradition of research initiatives in mental health and in the public services in general, and a lack of university based or research centres adequately resourced for the task.

2. Policy evaluation

Evaluation of the impact of available policies is even less frequent than programme evaluation, and the current available evidence on the health outcomes of government policies is patchy, at best.

Despite the importance of evaluation, only nine of 31 country stories reported that there is some kind of evaluation of the national mental health promotion and/or mental disease prevention policies. For example, in Norway, a comprehensive evaluation of interim progress on the government’s programme for mental health 1999-2008 was published recently, including sector-specific programmes, such as the national programme for mental health in schools.

However, unfortunately, whether it is for policy or programme evaluation, the presence of any kind of evaluation will not necessarily be sufficient or the best use of resources. It is crucial to ensure that evaluation is of high quality, as in some cases, if the appropriate methodology is not used to assess the desired outcomes of policies, results might be unreliable. This is often the case when evaluation is not planned at the same time as the policy but is only considered afterwards, when it might be too late to apply the best possible methodology for its evaluation.

In other countries, for example, England, Estonia, Greece, Poland, and Slovenia, among others, national mental health policies and mental disorder prevention policies are sometimes evaluated, on a regular and structural basis. Methods of evaluation can at times be inappropriate and are still to be improved across Europe.

3. Monitoring

Monitoring systems for the implementation of policies or programmes on prevention and promotion are reported in nearly two fifths of countries. For example, in Ireland a recent review of the National Health Promotion Strategy (2004) provided an overview of current mental health promotion practice at national and

regional level. The current initiative, from which this report arises, was developed as a pilot to explore the possibilities for monitoring prevention and promotion in mental health across Europe.

Monitoring the mental health of the population is more common. Many countries have monitoring systems to assess the mental health of the population, for example the Hungarian National Morbidity and Mortality Registries, which have sometimes been complemented with research studies. In Belgium, several mental health indicators are gathered by means of the four-yearly Health Interview Survey that is conducted on a representative sample of the population of more than 10,000 respondents.

However, as other EC co-financed projects have concluded, there is still a lack of monitoring systems that collect data on mental health that can be comparable at the European level (Mental Health Status report¹⁹; Mindful²⁰). There is also a special lack of indicators that measure positive mental health, with the result that where surveys are available, they provide a picture of psychiatric morbidity, rather than a comprehensive description of the mental health status of the population.

7 Challenges, opportunities and advances in the field

Although there are differences, most of the challenges facing European countries for mental health promotion and mental disorder prevention are similar. One of the biggest challenges seems to be a lack of financial resources and funding. In Latvia, for example, mental health promotion and prevention issues do not seem to be a current priority; limited health care financing goes on other priorities, such as ensuring pharmacological treatments, or the costs of expensive operations. In Turkey in the last few years, resources for public mental health and mental health improvement are still limited in relation to the size of the task. Most countries and regions, including Croatia, the Czech Republic, England, Norway, Poland and Portugal report facing the same challenge.

Since mental health promotion and mental disorder prevention are cross-sectional topics, many different stakeholders are involved from many different sectors. Co-operation between these sectors seems to be difficult in numerous countries and is therefore perceived as a challenge. In Austria, for example, co-operation is difficult because it is a federal country, where many responsibilities rest with the regions. Besides the lack of co-operation caused by political structures, there also seems to be a lack of co-operation between national governmental organizations and other non-governmental organizations as described by Poland, for example, where both types of organizations are developing separate programmes on alcohol and drugs.

Different European countries also underline the importance and paucity of development of evaluation and cost-effectiveness research. In Bulgaria, for example, as is the case in many countries, the lack of cost utility research has probably contributed to underestimating the positive contributions of mental health actions. In other countries, as for example in Finland and the Netherlands, studies on cost-effectiveness are needed just as much as in Estonia where, although a critical mass of health promotion staff at national and local level has been achieved, there is a need for more focus on cost-effectiveness and quality of health promotion activities.

Some European countries would also welcome a shift in understanding. In Belgium, the Czech Republic and Latvia, for example, a treatment related thinking still dominates. Such thinking requires a shift before promotion of mental health and the prevention of mental disorders can be improved.

¹⁹ European Communities (2004). The State of Mental Health in the European Union. European Commission. http://europa.eu.int/comm/health/ph_projects/2001/monitoring/fp_monitoring_2001_frep_06_en.pdf.

²⁰ Mental Health Information and Determinants for the European Level (MINDFUL), Interim technical implementation report 13 May 2005. <http://www.stakes.fi/mentalhealth/mindful.html>

Finally, lack of non-governmental organizations, lack of political will to implement the policies stated in governmental documents, lack of training in the curricula of university studies, and lack of co-operation between state agencies that have funds for mental health promotion, have been identified as key barriers. Strategies need to be developed to overcome these problems and to translate evidence into practice.

Despite the challenges still ahead, major advances have been made in Europe, and mental health promotion and mental disorder prevention has become an issue in countries as diverse as Austria, the Czech Republic, Estonia and Portugal.

One of the major advances perceived by multiple countries and regions, including Catalonia, Italy, Latvia, Lithuania, Poland, Romania, Scotland, Slovenia and Turkey is the implementation or preparation of a National Action Plan for Mental Health or topics related to mental health (e.g. elimination of stigma, suicide and drug demand). The National Action Plans have differing objectives and adopt a range of approaches to involve different sectors. The government in Malta for example, is formulating a national strategy to increase the competitiveness of the local economy to create wealth and employment. The Health Ministry is highlighting the fact that mental illness is a significant cost to the local economy and that additional and adequately funded programmes need to be implemented to improve mental well-being through health promotion, prevention and early intervention.

Another major advance is the diversity of initiatives, including those stimulated through European Commission co-financed projects, or at the national level, those initiated by NGOs, universities or Ministries of Health. These initiatives have increased a broad interest in mental health at the policy, professional and public levels, leading to a positive shift in thinking about mental illness and mental health. This is the case in Lithuania, the first new Member State to have been awarded a major EC grant, under the Public Health Programme, to develop mental health in children and adolescents.

Finally, as the country stories show, there is an enormous wealth of programmes, projects and activities that cover the whole life span from before birth to old age. Not only that, but many different sectors are involved, including education, labour and criminal justice. Perhaps most importantly is the growing realization that policies that tackle poverty and the lack of social inclusion are important to prevent mental disorders and to promote mental health.

8 Summary conclusions

There is an enormous variety of initiatives and action across Member States which reflects the richness of Europe and highlights the added value of monitoring, information sharing, and co-operation.

This report highlights that across all countries, there is some activity being undertaken on prevention and promotion in mental health. Some actions are based on evidence, co-ordinated and sustained, while other actions are more ad hoc and call for support and sustainability. Availability of practice, resources allocated and infrastructures developed vary across countries, reflecting different situations in health care systems, the political history and the traditions and understanding of mental and public health. However this report underlines major advances in the field: there is political and, especially, professional interest, there are existing activities on which to build, and many countries share commonalities in terms of programme availability and implementation. The differences across European countries imply that there are different starting points for action in prevention and promotion in mental health.

There are also common challenges. There remains a lack of understanding of public health and few initiatives engage in inter-sectoral approaches. A dominance of a psychiatric and mental illness oriented approach to understanding and practising mental health creates a focus on narrowing the treatment gap, such that the well-being of the population comes (in some countries more than others) a second or third priority. Although

there is a variety of existing implemented practice, this does not guarantee its positive impact; it is crucial that programmes for implementation are based on evidence, are evaluated and are continuously improved. Uncertainty of concepts, a difficulty in gathering information, a lack of data on mental health and, where available, the difficulties of its comparability across countries, a lack of clear infrastructures for prevention and promotion in mental health, a paucity in training the workforce and scarce support for implementation, all seem to hinder progress and are identified as potential areas for future development.

However the outcomes of this report remain encouraging and identify the potential for development in this field. A remarkable outcome of the process of this initiative is the interest and support of the over 240 professionals who have been involved in providing information and supporting through discussion meetings the issue of mental health. This initiative started as a first pilot that had to be undertaken in a short period of time. However, the professional involvement, in some cases from very different backgrounds, highlights that stakeholders and the workforce are aware, engaged and committed to promotion and prevention in mental health.

Once gaps have been identified, the challenge remains at the Member State level to select priorities and to provide the appropriate tools, infrastructural support and resources to continue improving mental health. This support, in whatever format and to whatever extent it is provided, can be used efficiently by engaging with and improving existing initiatives and by applying the evidence base to policy and practice.

Finally, at the European level, as it has been stressed by countries, “the participation in cross border, European and international policy, practice and research networks and initiatives, has played an important role in ensuring the development of high quality, innovative and sustainable initiatives at the country level”. The European Commission has contributed to this development and the recent enlargement of the European Union has opened this opportunity to new Member States, as well as to Accession and Candidate countries. The continuing and increased support of the Commission and other international organizations, such as the WHO, in cross-country collaborations will contribute to the development of mental disorder prevention and mental health promotion practice at the Community and Member State levels.

General recommendations

1. The gaps that have been identified in countries can be tackled and closed, frequently by strengthening and building on what already exists and by working in partnership across different sectors
2. At the Member State level, it is crucial to develop clear action plans, based on the evidence for prevention and promotion, which can guide the decision making process of implementation
3. There is an urgent need to support implementation in all countries, through, for example, guidelines and tailored tool-kits for implementation
4. Evaluation urgently needs to be strengthened within Member States and Europe as a whole; including evaluating the impact and cost-effectiveness of prevention and promotion interventions across different settings, using appropriate and well-designed methodologies
5. European resources and infrastructures should be identified to provide a European framework and to support co-operative projects, research, monitoring, information collecting, and sharing across countries

Austria

Prepared by Christina Dietscher and Professor Jürgen M. Pelikan

1 Introduction

As in other countries, mental disorders are on the rise in Austria. The prevalence of anxieties and depression is one in six persons over a four week period, and psychiatric disorders are the second most important cause for disability pensions (Austrian Mental Health Report 2003). 6.5 million prescriptions for psychopharmaceutical drugs were issued in 2003 (for a population of 8 million inhabitants), more than 50% of these being anti-depressants [1].

As yet, “mental health promotion” (MHP) and “mental disorder prevention” (MDP) are neither well-established nor well-understood concepts in Austria. There is not one single mental health promotion discourse, but there are several different discourses going on, often without much reference to each other. Different players use numerous divergent terms with slightly different connotations¹, and others use neither of these terms. Therefore, if we speak of MHP and MDP in this report, we refer to the general understanding of health promotion of WHO² and the European Union (interventions oriented at settings, specific target groups, and/or specific lifestyles or issue areas), and to the specific definitions and action areas of the IMHPA project.

For this report we have tried to summarize the different policies and programmes relating to the IMHPA action areas³. Much of these do not have an explicit connection to mental health (promotion), and a lot of assessment would be needed for estimating their actual impact for mental health. Given the state of development of MHP and MDP in Austria, this report can only be understood as a very first attempt in the process of creating a systematic overview.

2 Process to prepare country story

Findings in this report are derived from the following sources:

- Web research of relevant organizations in Austria (i.e. health promotion networks, Austrian ministries, health insurance funds, NGOs, and so on)
- Expert discussion with health promotion scientists, based on the IMHPA questionnaire
- IMHPA questionnaire “European Mental Health Module”. The questionnaire was distributed among 30 experts known because of their involvement in mental health promotion and/or prevention. Feedback to the questionnaire was scarce, only three questionnaires were received, of which two responses stated that they were unable to provide answers to the required information. This can be interpreted as an indicator of the fact that the mental health field in Austria is very diverse, it is difficult to obtain a comprehensive overview, and that the questionnaire requires an in depth assessment which was not possible within the time frame in Austria. To continue with the process of gathering information, in the meantime the Austrian country story has been translated into German and it was circulated during the Austrian EMIP workshop in order to obtain further updates.

Persons involved:

Gerlinde Rohrauer, MA, Austrian Health Promotion Foundation

¹ Amongst others: Mentale Gesundheit (the most literal translation of the English term); Psychosoziale Gesundheit (referring to psychic/emotional and social impacts on mental health); Psychische Gesundheit (referring only to psychic/emotional impacts on mental health); Seelische Gesundheit (literally translated meaning the “health of the soul”); Psychohygiene (an analogue from physical hygiene)

² As formulated in the Ottawa Charter of 1986

³ Jané-Llopis, E. & Anderson, P. (2005). Mental Health Promotion and Mental Disorder Prevention. A policy for Europe. Nijmegen: Radboud University Nijmegen.

Given the diversity of the field, the many involved players, and the fact that MHP is not very well established in Austria, a lot of research remains to be done. Information is especially lacking on the amount of resources invested in MHP and MDP, on cost-effectiveness and long-term effects of interventions, and on mental health effects of policies and programmes across sectors (impact assessment).

3 Organizations and resources for implementation

Given the diversity of the field of MHP and MDP, and given the federal system in Austria where many responsibilities rest with the nine Austrian regions, it is almost impossible to provide a complete list of the relevant involved players.

On the *policy level*, at least four Austrian ministries are of relevance:

- ▶ **Federal Ministry for Health and Women:** responsible for treatment oriented aspects of MHP and MDP, including co-operation between health care sectors, but also for health promotion;
- ▶ **Federal Ministry for Social Affairs and Generations:** responsible for policies and programmes for families, for youth work outside schools, for specific risks groups, and for senior citizens;
- ▶ **Federal Ministry for Education, Sciences and Culture:** responsible for policies and programmes in schools;
- ▶ **Federal Ministry of Justice:** responsible for policies and programmes like “probation support” for delinquents, “therapy instead of penalty” for drug addicts.

At the *level of implementation*, the Austrian Health Promotion Foundation (FGÖ) needs to be mentioned in the first place, since this national body, which is responsible for funding health promotion projects in Austria, has MHP as one priority area in its current 3 year programme. According to the foundation’s 2004 annual report, 18% of all projects supported by the foundation were related to mental health [6].

Furthermore, the Austrian health promotion networks (cities and communities, hospitals, schools, workplaces) have at least some activities in the field of MHP.

Country wide, numerous NGOs (pastoral care, associations, foundations, self help groups, and others) are responsible for implementing specific programmes and activities in most of the IMHPA action areas.

This complex system is partly replicated at the level of the nine Austrian regions, with regional responsibilities for health care, education, and so on, regional health insurance boards, and regional NGOs.

Resources

The diversity of the field and the unclear and fuzzy borders towards other areas did not allow us to further explore the issue of resources allocated to MHP and MDP within the available time frame and with the available financial resources. This is one of the points that remain for further research.

4 Action for promotion and prevention in mental health

Since MHP and MDP are not well-established concepts in Austria, there are no specific policies addressing these issues. But there are a number of policies which apply to many of the action areas of IMHPA (see below). The same holds true for actions and programmes. Whilst mental health or mental disorders are directly addressed only in the health care field (and then mostly treatment oriented), there are a lot of relevant programmes and activities in other areas which do not call themselves “mental health promoting” or “mental disorder preventing”. This shows that it is often very difficult to draw a clear line with other areas of intervention.

For the descriptions given below we follow the IMHPA action areas, which are related to specific settings, target groups, symptoms and issue areas, and try to list relevant policies, programmes and stakeholders both at a national state level and at the level of the Austrian regions. We do not claim that the list of policies and actions is complete with regard to the relevance for MHP and MDP. This is just a first exploration of the field.

Action area 1: Support parenting and the early years of life

Although the support of parents is a priority of the Austrian government (maternity and paternity leave is available for a maximum of three years per child, which can be regarded as an act of MHP for parents and infants in itself), mental health issues do not play an explicit role in the related *policies*. But the Austrian Ministry of Social Affairs advertises trainings for parents, focusing on issues like “parent literacy”, including knowledge on development phases, a partnership approach in parenting, discussion and conflict-solving skills, and parenting styles, as well as knowledge about available help if needed⁴.

Since a change in the penal law in 2001, there is an option for specifically vulnerable expecting mothers to give birth anonymously. This regulation was implemented in order to prevent infant homicide. Mothers who make use of this option can get psychosocial support if needed. For socially disadvantaged families, there is also support and counselling provided by youth welfare institutions⁵. At the regional level, the City of Vienna launched a project on postpartum depression in the framework of its Healthy City’s Project⁶.

Action area 2: Promote mental health in schools/promote mental health for children and adolescents⁷

Mental health (promotion) is not explicitly mentioned in school *policies*, but there are referrals to related topics. National curricula demand that school education shall, amongst other things, support students in the development of so-called “dynamic skills”, i.e. the ability to take over responsibility, to co-operate with others, to develop initiatives, and to participate in social life within and outside school⁸. Thus, the development of mental health skills is one of the explicitly defined tasks of school education.

With regard to *programmes*, school psychology is offered as an integrated part of the Austrian school system for children, teachers, and parents. Services include the prevention, reduction, and solving of problems by psychological and psychotherapeutic information, counselling and treatment concerning individual, social and organizational development in the school setting. Country wide, there are 77 school psychology institutions, employing 140 school psychologists⁹. Thus, one school psychologist is responsible for more than 4,000 students and 600 teachers.

Specific programmes in schools often focus on drug prevention without addressing this subject directly. Rather, programmes focus on developing personal skills and competences (e.g. “Becoming independent”, a programme for primary schools¹⁰). Noteworthy in this field are also activities of the Austrian Network of Health Promoting Schools, which aims at promoting the somato-psycho-social health of students, teachers and parents¹¹. The network (consisting of about 120 schools) is supported by a knowledge centre on school-based health promotion, which provides numerous fact sheets, guidelines and programme descriptions on many topics including mental health issues¹². These activities are co-funded by the Austrian Ministries of Health and of Education. Austria also regularly participates in the Health Promotion in School-Age Children study of

⁴ see web-site of the Austrian Ministry of Social Affairs: <http://www.bmsg.gv.at/cms/site/liste.html?channel=CH0003>

⁵ see web-site of the Austrian Ministry of Social Affairs: <http://www.bmsg.gv.at/cms/site/liste.html?channel=CH0076>

⁶ see project web-site: http://www.diesie.at/uploads/downloads/PPDBroschuere_.pdf

⁷ In addition to school-based initiatives, we added to this action area also youth work outside schools, since this is of high relevance for mental health promotion, especially of adolescents.

⁸ www.bmbwk.gv.at

⁹ further information on the project web-site: http://www.eigenstaendig.net/kms/cms/kms.php?str_id=1

¹⁰ further information: http://www.bmbwk.gv.at/schulen/service/psych/Schulpsychologie_Kennzei4211.xml

¹¹ further information: http://www.gesunde-schule.at/philosophie_1_1.htm

¹² <http://www.give.or.at/>

the WHO. National data analysis resulted in the publication of a fact sheet on the mental health of students in 2004 [7].

The Ministry of Social Affairs, which is responsible for youth work outside schools, has a focus on the prevention of legal drug consumption of minors. Supported projects aim especially at developing social competences and self control¹³. Health promotion for children and adolescents outside schools (although without an explicit reference to mental health) is one of the current priority areas of the Austrian Health Promotion Foundation, which resulted in the implementation of two pilot projects¹⁴.

Action area 3: Promote workplace mental health

MHP plays a rather neglected role in *policies* on safety and health at work. Interestingly, following the Act on Health and Safety at Work, mental health needs to be considered especially for screen workers, and employers have to ensure that psychological consultation is available for staff if needed.

Action on workplace MHP is especially taken by the chamber of employees (has its own section on health at work¹⁵), by health insurance bodies, the association of labour unions ÖGB (has its own section on health promotion with a focus on mental health aspects¹⁶), the Austrian Federal Economic Chamber and the Federation of Austrian Industry who together form the “Austrian Network of Workplace Health Promotion”, which runs many projects addressing MHP/MDP amongst other topics. Action areas range from issue-specific interventions (e.g. stress, mobbing, conflicts, communication skills) to programmes for specific target groups (e.g. women, older employees). Some big employers, like the Vienna Hospital Association, employ psychological consultants for their staff.

The Austrian Network of Workplace Health Promotion is currently running a project on developing small and medium-sized enterprises by health circles¹⁷ and a project on health promotion for staff working in the New Economy sector. Regular upcoming projects in these topics include addictions, stress, communication and leadership styles, which have a known impact on the well-being of staff.

Action area 4: Promote mentally healthy ageing

Although we could not find any specific policies on mentally healthy ageing, the Austrian Ministry of Social Affairs propagates on its web-page Article 13 of the Amsterdam Treaty of the European Union, which contains an anti-discrimination regulation for older people. The web-site also contains a 7 step approach for healthy and consciously ageing which includes one step on mental health (fears, depression, dementia, loneliness). With regard to relevant programmes, the Austrian Health Promotion Foundation has healthy ageing as a priority area in its current work programme. Two pilot projects with relevance to mental health promotion were implemented in this context. The City of Vienna, a member of the WHO Healthy Cities programme, has a focus on healthy ageing¹⁸. Related programmes and initiatives include the support for older people in the development of new perspectives, and the prevention of loneliness and despair in old age.

Action area 5: Address groups at risk for mental disorders

This action area overlaps widely with other areas. We therefore do not list any specific policies and programmes here, with the exception of the Austrian AIDS support centres which provide specific social and mental health support for people living with AIDS¹⁹.

¹³ <http://www.bmsg.gv.at/cms/site/liste.html?channel=CH0233>

¹⁴ <http://www.promente-jugend.at/index.php?region=3&lang=deu>, <http://www.styriavitalis.at/data/WebsiteJGSF/projektbeschreibungjgsf.html>

¹⁵ <http://www.arbeiterkammer.at/www-5335.html?PHPSESSID=91f351861923b07d96c992e7b71630cc&PHPSESSID=0c9176c9611a669517140029ea73a1af>

¹⁶ http://www.oegb.at/servlet/ContentServer?pagename=OEGBZ/Page/OEGBZ_Index&n=OEGBZ_3.9

¹⁷ further information: <http://www.netzwerk-bgf.at/>

¹⁸ <http://www.aktivinsalter.at/>

¹⁹ see e.g. <http://info.aids.at/activityreport2004.pdf>

Action area 6: Prevent depression and suicide

According to Katschnig (2003) [1], the traditionally high Austrian suicide rate, which used to be well over 20 per 100,000, fell below 20 per 100,000 in 1997 and remained low since then. These figures coincide with the expansion of community psychiatric services, with an increase of medication prescription for depression by general practitioners, and with the enactment of the psychotherapy act. Since 1991, psychotherapy is defined as a “compulsory service” for health insurance bodies and is to be provided for the relevant ICD-9 classified mental disorders. Specific regulations for re-funding of services differ between the nine Austrian regions.

In Upper Austria (one of the Austrian regions), the main financiers of the health care sector agreed on ten health targets for the 21st century, one of these targets being the reduction of the suicide rate by one third by 2010. This shall be achieved especially by training GPs in the early recognition of depression.

With regard to *programmes*, Austria has numerous phone help-lines for people in despair, offered by pastoral and non-pastoral providers. There is a nationwide internet platform providing information and consultation on depression²⁰. A specific suicide prevention programme is being run in Vienna. The programme is based on an agreement with the press not to report on suicides in the subway, which led to a reduction of suicides by this method [4].

Action area 7: Prevent violence and harmful substance use

Harmful substances

The development of critical awareness with regard to alcohol is one of the targets listed in the last Austrian health report of 2004 [2]. According to the current programme of the Austrian government [5] there is a specific focus on the reduction of consumption in minors. Each of the Austrian regions has its own youth protection act for the prevention of legal drug consumption (alcohol and tobacco). A national alcohol co-ordination and information centre was implemented already in 2000²¹. In line with the national priorities, the region of Upper Austria listed the reduction of the per-capita-consumption of alcohol by 20% by the year 2010 (and near to zero for those under 15) as one of its ten health targets.

Following WHO’s “Health Behaviour in School aged Children (HBSC)” study, Austrian adolescents have one of the highest smoking rates in Europe. Therefore, there is special emphasis on implementing smoking regulations in the country. Since the last amendment to the tobacco act (January 2005), smoking is forbidden in all public buildings.

With regard to illicit drugs, the Austrian act on addictive substances which regulates penalties of violations against the law, offers an option for delinquents to undergo specific medical/therapeutic treatment instead of a prison sentence, if certain preconditions are fulfilled (this is known as “therapy instead of punishment”; a commitment to prolong this approach was stated in the current programme of the Austrian government in 2003).

With regard to specific *interventions and programmes*, there are many school-based drug prevention interventions, ranking from tobacco (e.g. “Be smart – don’ start”, a joint initiative of the Austrian cancer league, doctors against smoking-induced impairments, the European Union, the Austrian ministries of health and of education) to illicit drugs. For youth work outside schools, there are many drug and addiction prevention centres, including street work in the more urban areas, which provide information and support concerning all types of addictions (substances and behaviours). A rather recent development in the area of drug prevention (started in 2004) is the establishment of protected areas around schools where police are entitled to send away “undesired” people in order to prevent drug-selling to students.

²⁰ www.depression.at

²¹ www.aki.or.at/akis

Violence

With regard to violence prevention, the current programme of the Austrian government (2003) puts emphasis on the prevention of violence against women, and on the protection and support of victims. For many years, there are numerous services for women affected by violence, including information centres, help-desks, help-lines, and women shelters, in all nine Austrian regions (funded by pastoral care, communities, foundations, etc). Since the amendment of the “crime victim act” (1999), free psychotherapeutic treatment is available for persons suffering from the consequences of criminal violence [2].

With regard to criminality as a form of violence, we would also like to mention the so-called “probation support”. This programme of the ministry of justice is an alternative to prison sentence, where delinquents are supported by so-called “probation helpers”. If there is no relapse into criminality within an agreed-upon period of time, the prison sentence is cancelled. This programme aims at preventing a further criminal career and at social re-integration of delinquents.

Action area 8: Involve primary and secondary health care

Austria has a very treatment oriented health care system with one of the highest bed-per-population-ratios in the European Union. In the mental health field, though, there is a general trend towards reducing beds and setting up ambulatory and community based care instead. Most regions have developed their regional policy towards this direction, which is also a national policy priority [1], [2].

Since mental disorders often occur as a comorbidity of other diseases, most Austrian hospitals offer psychological care for patients who are treated for severely chronic or life-threatening diseases. For psychiatric diagnoses, Austria has 40 psychiatric in- and day-patient services with less than 5,000 beds altogether. There are around 1,000 community psychiatric services offered by 250 providers [1]. In addition to specialized primary and secondary care institutions, there is a huge number of self help groups throughout the country, addressing topics like addictions, anxieties, compulsive disorders, crises, depression, loneliness, mobbing, violence, psychological, psychosomatic and psychiatric disorders, suicide, and others²².

The Austrian Network of Health Promoting Hospitals²³ is preparing action in the field of MHP and MDP for hospital patients and staff.

Action area 9: Reduction of disadvantage and prevention of stigma

Action in this field is taken by a number of institutions throughout the country which aim at reducing disadvantages for people with mental health problems e.g. by supporting job finding and housing (one of the most prominent organizations being Pro Mente Austria²⁴. Another important player in the field is the Austrian Association of Solicitors, aiming at supporting persons with cognitive impairments in maintaining their rights and participation in social life²⁵).

Action area 10: Link with other sectors

Since MHP and MDP are not yet established concepts in Austria, there are no specific policies or actions on linking sectors for these purposes. There is no “MHP community” in the country with a common self-understanding as contributors to promotion and prevention as yet.

Commitment to prevention and promotion

From those policy sections where a responsibility for MHP and MDP can be located, the clearest commitment comes from the Austrian Ministry of Health which launched an information brochure²⁶ on mental health issues

²² for further information on self help groups in Austria, see <http://www.fgoe.org/sigisi.htm>

²³ www.oengk.net

²⁴ www.promenteaustria.at

²⁵ <http://www.sachwalterschaft.at/index.php?id=54>

²⁶ The literally translated title of the brochure means “When the soul needs help”

for the first time in 1999. The Minister of Health Maria Rauch-Kallat speaks of “the support and enforcement of health promotion and health prevention” as the major goal of the Austrian health policy also in the mental health area [1]. Furthermore, the minister announced that during the next Austrian EU presidency in 2006 there will be a focus on women health issues, including stress prevention for women. On the ministry’s web-site, one of the topics listed is “mental health/psychology/psychotherapy”²⁷, and there is a web-based initiative called “inner temptation” which addresses person-oriented health promotion issues, including a strand on stress prevention²⁸.

A real sign of commitment at the national level is that MHP is one of the priority areas in the current work programme of the Austrian Health Promotion Foundation (FGÖ). At the level of the Austrian regions, the explicit commitments of Upper Austria (one of the regional health targets being the reduction of suicide, another being the reduction of alcohol consumption per capita) and Lower Austria (one of 10 regional health targets being the promotion of mental health by area-wide therapeutic offers) need to be mentioned.

5 Workforce for mental health

The workforce involved in MHP and MDP is very diverse, which does not mean, though, that there is any common self-understanding of the involved professional groups as a “mental health promotion/prevention workforce”. The most important professions are:

- ▶ Psychologists: Since 1991, there is the state certified profession of “clinical” and “health” psychologists. There were 3,902 clinical and health psychologists registered in Austria in 2002 [1].
- ▶ Psychotherapists: The psychotherapy act (1991) regulates training of psychotherapists and the possibility for reimbursement of psychotherapeutic care by health insurance in some cases. In 2002, there were 5,632 trained psychotherapists (a ratio of 7 per 10,000 population) [1].
- ▶ Psychiatrists: In 2002, Austria had 893 certified psychiatrists (which is one per 9,000 inhabitants) [1].
- ▶ Psychiatric nurses (a specific nursing diploma which is available since 1997).

Further important professions include occupational health experts and centres, occupational psychologists, social workers, teachers, health scientists and public health experts; although it is difficult to estimate the amount to which representatives of these professions are involved in MHP or MDP.

In addition, the Medical University of Graz offers a public health masters training with a focus on health promotion²⁹, although there is no specific focus on mental health.

6 Monitoring and evaluation

Since MHP and MDP are rather new and not well established areas in Austria, and the field is differently organised in the nine regions, there is no overall country-wide monitoring, evaluation or reporting. In the regular health statistics provided by “Statistic Austria”, mental health is included only on the basis of psychiatric diagnoses as reasons for hospital admissions. Further data sources on a national state level are:

- ▶ Austrian Federal Institute for Health Care (ÖBIG): Besides regular related activities like the annual report on the drug situation in Austria, the Institute issues reports on specific health topics on an irregular basis (e.g. report on poverty and health, including mental health relevance of poverty [3]). Another area of work of the centre is psychosocial care and care for the elderly³⁰.

²⁷ <http://www.bmgf.gv.at/cms/site/themen.htm?channel=CH0003>

²⁸ <http://www.isch.at/>

²⁹ <http://public-health.uni-graz.at/>

³⁰ Reports are available via the web-site of the centre. http://www.oebig.at/index.php?set_language=de&ccpage=publikationen_intro&set_z_arbeitsbereiche_kategorien=1

- ▶ Institute of Social Psychiatry of the University Hospital Vienna: Commissioned by the Austrian Ministry of Health, the Institute provides regular reports on psychiatric care in Austria (rather treatment oriented).

At the regional level, mental health issues have a marginal role in most of the regional health reports, with the exception of the City of Vienna where a report on the mental health status of the Viennese population was published in 2004³¹.

For this report we were only able to start looking into monitoring, evaluation and reporting of activities in the health care field, but not in other areas (education, social affairs, justice). Hardly any information seems to be available on evaluations of efficacy and cost-effectiveness of interventions.

7 Challenges, opportunities and advances in the field

With regard to *challenges* for MHP and MDP in Austria, we see at least the following four:

- ▶ Austria has a very treatment-related understanding of health and health care, which makes it more difficult for promotion and prevention to gain momentum.
- ▶ There is a generally low tradition in health promotion and capacity building in the field, which is even lower for MHP.
- ▶ MHP and MDP are cross-sectional topics, involving many different stakeholders from many different sectors. The co-operation between these sectors is difficult in itself, but becomes additionally difficult in a federal country like Austria, where many responsibilities rest with the regions.
- ▶ There is a lack of research, evaluation, training and capacity building on (mental) health promotion issues.

On the side of *opportunities and advances*, we would like to mention the interest of the Austrian Minister of health in MHP issues, which she also publicly expressed at the opening of the first Austrian conference on mental health (December 2004). This might support placing MHP higher on the agenda in the future. Another opportunity is that the Austrian Health Promotion Foundation has included MHP as one priority action area in its current 3 year programme.

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³¹ <https://www.wien.gv.at/who/psych-gesund.htm>

Belgium

Prepared by Dr. Pol Gerits, in collaboration with J. Vandeveldel and M. Absil

1 Introduction

Belgium is a federal state. Besides the federal level, there are three communities (the Dutch speaking community; the French speaking community and the German speaking community) and three regions (the Flemish region; the Walloon region and the region of Brussels Capital). All these different political levels are competent for public health policy. Most of the competences concerning the promotion of mental health and prevention of mental disorders are situated at the levels of the regions and/or communities. Twice a year, an inter-ministerial conference on public health is organized. The objective of this conference is to harmonize the policies of the federal level with those of the communities and regions.

2 Process to prepare country story

The country story for Belgium is the result of the efforts of a group of interested parties involved in mental health. Key people working in the field of mental health promotion and prevention were brought together to complete the European Questionnaire on Mental Health Promotion and Mental Disorder Prevention (<http://www.imhpa.net/infrastructures-database>). We have organized the consultation process in two steps.

Persons involved:

M. Absil, Federal Level

Paul Arteel, Vlaamse Vereniging Geestelijke Gezondheid (VVGG)

J.M. Bienkowski, Psytoyens

Christiane Bontemps, Institut Wallon pour la Santé Mentale (IWSM)

Rafaël Daem, Uilenspiegel

Françoise Delchevalerie, Pasifou

Emmanuelle Demarteau, Walloon Region

D. Demoulin, French Community

V. Fabri, Union Nationale des Mutualités Socialistes

Pol Gerits, Federal Level

Marc Hollevoet, Union Nationale des Mutualités Neutres

J. Holsbeek, Federal Level

Hermann Janssens, Union Nationale des Mutualités Chrétiennes

Geert Messiaen and Sandrine Vandermaesbrugge, Union Nationale des Mutualités Libres

Lucia Scheiders, German Community

Pieter Van Den Bulcke, Flemisch Community

First, because of the rather complex structure of our country, we have asked the participation of the federal level, the communities as well as the regions. The horizontal working group on mental health with representatives of the different ministers of public health was informed about the IMHPA project. It was the first time that Belgium participated in this project. They received the document "Mental health promotion and

mental disorder prevention: a policy for Europe” as well as the questionnaire together with the invitation for the first technical meeting. All agreed to participate in the project. However, most of them did not attend this meeting but sent us information by email and/or by post.

Besides the group of key persons, we also invited the mutual health insurance funds as well as the NGOs specialized in mental health promotion and mental disorder prevention. Representatives of these organizations also received the documents and were asked to participate in a technical meeting. Only one of them participated in the technical meeting. The others have sent us information by email or by post.

Starting from this information we have completed the questionnaire. The answers to the questionnaire form the basis of the country story. The completed questionnaire and the country story were then presented to the horizontal working group on mental health for feedback.

3 Action for promotion and prevention in mental health

Availability of policies

At the national level, there exists a “National action plan social inclusion 2003-2005”. Also, there is the “Law relating to the well-being of the workers at the time of execution of their work” and the “Law relating to protection against violence and moral or sexual harassment at work”. With regard to violence, the Inter-ministerial Conference on Public Health has issued a “Proposal for an action plan against violence towards women 2004-2006”. Finally, with regard to drug problems, the Federal Government has stipulated, in the 2001 “Federal policy note concerning the drugs problem”, the following priority for measures to take: 1) prevention 2) cure 3) repression. Finally, in the fall of 2005, the “Handbook of good practice with regard to benzodiazepine use in stress, anxiety and sleep disorders” will appear.

At the regional level (Flemish Community), there also exists a policy with regard to the fight against poverty and social exclusion. There is a “Flemish action plan for the fight against poverty” and from 2001 onwards there has been a yearly congress on the evolution and the future with regard to the fight against poverty and social exclusion. The Flemish Community also has a policy to prevent depression and suicide. The German Community has set up a prevention project with regard to violence in schools.

Belgium welcomes the WHO declaration and action plan for mental health in Europe. At the federal level we will ask the Belgian WHO Collaborating Centre to evaluate the mental health policy in Belgium on the twelve action points of the action plan for mental health in Europe. This state of the art will be the starting point for the further implementation of this plan in Belgium.

Commitment to prevention and promotion

Since mental health promotion and mental disorder prevention are community matters, there is no real coherent policy at the national level with regard to these issues. The fact that the budget for promotion and prevention is very limited still adds to the fragmentation of the policy. At the national level, most of the promotion and prevention is about drugs, not about mental health (which is not surprising, given the high comorbidity). Generally, more emphasis is given to prevention than to promotion. At the regional level, some regions have a more coherent policy than others. What often hinders concerted action is the fact that the different stakeholders (e.g. the mutual health insurance funds) are not informed about each other’s initiatives and that they use this fact as a marketing approach to attract new members.

Programmes and policies across settings

As regards home-based promotion and prevention, there are first of all brochures for the general public made and distributed by the mutual health insurance funds on selected mental health problems, more specifically

stress and depression, and promotion of a healthy sleep. The VVGG, a Flemish NGO for mental health, has, since 2001, also distributed a series of brochures on mental health themes for the general public. From 2003, these brochures have also been distributed via GPs and pharmacies. The VVGG has also, since 1998, offered “company trainings” for members of the parliament in which they can participate on the work floor in psychiatric institutions for some days.

As regards programmes at schools, there are two programmes bringing together adolescents and people with mental illness: “How different is different?” in the Flemish community and “A la rencontre de l’autre” in the French community. “*How different is different?*” is a programme (in the form of a contest) bringing together adolescents and people with mental illness in the Dutch speaking community. The Flemish Mental Health Association (VVGG) initiated this module of mental health promotion in 1991. When the programme started in 1991, only five schools participated and only 20 pupils were involved. Since 1991, more than 100 schools and 1000 pupils have participated in the project. The Ministry of Public Health of the Flemish Community initiated this project in 1991; subsequently, the programme was taken over by the Ministry of Education of the Flemish Community with co-financing by the bank sector. In addition, there has been a prevention programme against violence at school in the German speaking community.

As regards prevention at work, the Ministry of Employment, Work and Social Dialogue has issued two brochures: “Methods and instruments for an ergonomic and psychosocial analysis” and “Stress at work: risk, evaluation and prevention factors”. Also, within the framework of the “Law relating to protection against violence and moral or sexual harassment at work”, each employer must appoint an internal or external prevention adviser, specialised in the psycho-social aspects of work, which include violence and moral or sexual harassment, who is able to provide appropriate help to the victims.

At the level of the Flemish Community, several projects regarding prevention of depression and suicide have been initiated:

1. The “Werkgroep Verder” (Working Group ‘What Next’) co-ordinates, organizes and supports initiatives for relatives of people who committed suicide in Flanders. Their purpose is to improve the relief for relatives and to make the theme ‘mourning after suicide’ debatable in society. They have made a brochure and co-ordinated the support of self help groups.
2. An electronic help-line for general practitioners with regard to depression and prevention of suicide. The aim is to promote expertise of GPs on the matter by means of a web-based ‘info cell’ and an interactive curriculum on suicide prevention.
3. A pilot project ‘relapse prevention for suicide attempts’ in collaboration with GPs. The aim is to involve GPs in the aftercare of persons who attempted suicide.
4. Recommendations for the media with regard to coverage about suicide. The aim is to inform the media about how to cover suicide without enhancing the chance of imitation and how to stress the preventive possibilities.
5. Pilot project “Children of Parents with Psychiatric Problems”. These children constitute a high-risk group. An intervention study in the province of Flemish Brabant will test the effectiveness of the Beardslee-approach, a strongly cognitive oriented family intervention.
6. Pilot project “Mindfulness-Based Cognitive Therapy (MBCT)”. This is a form of cognitive group therapy in which the patient learns to meditate and to use meditation techniques to distance himself more from negative moods and emotions. The feasibility and effectiveness of this technique will be tested in the Ghent region by means of a randomised clinical study.
7. Psychosocial evaluation and relief in the general hospitals of persons who attempted suicide. In the province of Limburg, the use and usefulness of a specific strategy to improve diagnosis and aftercare of persons who attempted suicide. Means for extra personnel to carry out this psychosocial evaluation and relief will be given to the hospitals, an instrument will be developed for this aim and staff will be trained and coached in the use of this instrument.

As regards the second topic above (electronic help-line for general practitioners with regard to depression and prevention of suicide), a similar initiative has been taken by the French Community Commission for the French speaking community.

With regard to the use of benzodiazepines, since 2001, there have been yearly campaigns at the national level for a wise use of benzodiazepines and their alternatives for stress, anxiety and sleep disorders. As mentioned above, in the fall of 2005, the “Handbook of good practice with regard to benzodiazepine use in stress and sleep disorders” will appear.

Both at the level of the Flemish and French communities, a yearly event on promotion of mental health is held on October 10th, the world mental health day.

Another recent project, “Te Gek”, organized by a psychiatric hospital in Flanders, deserves to be mentioned. As an outgrowth of a tradition of yearly concerts that were given by Flemish musicians in the hospital, at the occasion of which the hospital opened its doors for the general public, Flemish musicians were asked to collaborate to make a CD with songs about mental health, with the aim of promoting de-stigmatization and better knowledge about psychiatric patients and mental health problems. The CD and the campaign were given wide attention by the media.

4 Organizations and resources for implementation

Infrastructure

The main organizations involved in implementation and knowledge dissemination are the three “mental health leagues” (one for each region), the mutual health insurance funds (one from each political area, plus two “independent/neutral” funds) and the three patient organizations (one for each region). For the Flemish Region, the Administration of the Family and Social Welfare of the Ministry of the Flemish Community also contributes to information dissemination for health care professionals (dissemination of the Flemish action plan on the fight against poverty). With regard to knowledge development on prevention and promotion, the Flemish Community established several working groups and a steering committee to develop scientifically underpinned prevention strategies with regard to depression and suicide in preparation of a 2002 conference. The working groups were composed of experts from the different Flemish universities, psychiatric hospitals and ambulatory mental health centres, the “Flemish Institute for Health Promotion”, the “Association for Alcohol and Other Drug Problems”, the “Scientific Organization of Flemish General Practitioners”, the “Centres for Student Guidance” (who work in collaboration with the schools), the organization “Child and Family” (organization for information and services for young families and their children) and the “Centres for General Welfare”. Most probably, similar initiatives exist for the French Community, but due to the fact that we have got only partial information, we do not know them.

With regard to the budget for prevention and promotion, it is difficult to get the overall picture due to the fragmentation of the competences and resources. At the national level, funds are available for mental health, but mixed in with other funding, and hard or impossible to link explicitly with mental health. At the regional level, as regards the Flemish Community, the budget allocation for prevention of mental disorders is about €439.000 yearly.

5 Monitoring and evaluation

In Belgium, several mental health indicators are gathered by means of the four-yearly Health Interview Survey, which is conducted on a representative sample of the population of more than 10,000 respondents. In this survey, the GHQ-12 is used as a screening instrument, as well as 4 subscales of the SCL-90-R, namely Depression, Anxiety, Somatization and Sleep Disorders. Also, 3 questions on suicide (thoughts, attempt) are

included. In addition to this, the Energy and Vitality scale (4 items) of the SF-36 is integrated into the survey, as an indicator of positive mental health. The results of this Health Interview Survey are generally available for the public via website: <http://www.iph.fgov.be/epidemie/epien/index4.htm>.

Evaluation research on efficacy and cost-effectiveness of interventions and on the effect of implemented policies is mostly absent.

6 Challenges, opportunities and advances in the field

Perhaps the most important challenge is to realize a coherent policy on mental health promotion and mental disorder prevention throughout the country. Given the fragmentation of the competences and the limitations of the budget, this is a difficult task. More specifically, the exchange of good practices between the federal level and the communities and regions, and the mutual learning from successes and failures is an important task to prevent overlap and to reduce unnecessary expenses. The second most important challenge is the setting up of a more structured and solid evaluation research. Hopefully, international collaboration will give a stimulus for this. Due to the fact that there exists no structured evaluation research, advances cannot easily be detected. It is advisable that initiatives will be taken in this respect.



Bulgaria

Prepared by Professor Toma Tomov and Dr. Antoaneta Mateeva

1 Introduction

Bulgaria is a country in south-east Europe and aspires for membership in the European Union. Its population is under 8 million, its Turkish and Roma minorities are sizeable, and it is proud of its ethnic model. The public is embarrassed by its malfunctioning judicial system, and blames it for the failure to curb corruption.

Since the political change in the 1990s, the country developed and launched a mental health policy and two prevention programmes - for suicide and for substance use. An Executive Board was established to the Minister of Health to govern the process of change in the mental health field and to co-ordinate the variety of ongoing projects¹.

The driving forces behind change were public bodies and organizations. They lead the way by raising awareness about the degrading nature of mental institutions, the lack of mental health services, and stigmatization; the political, professional and statutory bodies followed suit².

2 Process to prepare country story

For this publication the documents developed by the government were studied. Their authors were interviewed and the responsible officers for their implementation at the Ministry of Health were approached. Special time was devoted to studying the proceedings of the Executive Mental Health Board and to talks with its members.

Views of people from the non-governmental organizations concerned with mental health were collected. Published studies on the mental health system and the country's policy were traced and reviewed³.

At the New Bulgarian University, a group within the Bulgarian Institute for Human Relations processed and facilitated the data collection and story writing⁴. A Bulgarian version of the draft text was sent out among those involved for approval before the final document was put forward.

Professionals who contributed to the development of Bulgaria's country story include:

Christo Chinkov, MD, Chief Expert, Center for the Protection of Public Health

Antoaneta Mateeva, MCSW, Research Scientist, Bulgarian Institute for Human Relations, New Bulgarian University.

Dr Toma Tomov, MD, PhD, Director, Bulgarian Institute for Human Relations, New Bulgarian University.

Dr Liliana Tzoneva-Pentcheva, Co-ordinator, Programme for Suicide Prevention, Center for the Protection of Public Health MD

Anna Varsanova, MD, Chief Expert, Ministry of Health

Galina Veshova, MCSW, Director, Global Initiative on Psychiatry – Sofia

¹ www.mh.government.bg/doc/mental_health_policy_final.doc.

² www.gip-global.org

³ www.mh.government.bg/doc/mental_health_policy_final.doc

⁴ www.nbu.bg, bihr-office@datacom.bg

3 Action for promotion and prevention in mental health

Availability of policies

A point of departure in developing the mental health policy of the country is a distinction made from the perspective of need for care between severe mental disorder and disability on the one hand and common mental illness on the other. In the case of severe psychiatric disorder and mental disability, it was argued, good quality of life could be maintained if accommodation, income and social participation of those affected were made a concern to the local communities, and legal provisions were introduced to enable action on this.

In the policy documents, common mental disorders were deemed a disavowed issue equally by the public, health policy and the health system. A deplorable lack of awareness of the determinants of psychological development has been found among most population groups. Little knowledge of common mental illness presenting as episodes of malfunction in the emotional domain could explain why negligence for the emotional well-being of self and others was so common. Prejudice and stigma were seen as major barriers to reporting for help, even when stress, depression or anxiety became overwhelming. It was recognized, however, that none of these insights could be tested against existing factual data because service statistics and epidemiological research were either unreliable or lacking.

Further, it was admitted that the sheer numbers of people affected and the huge loss incurred by communities in the case of common mental illness demanded a large-scale involvement of general practice in the service provision. This however posed the sensitive and difficult issue of evolving a health care system that lays out carefully thought through pathways of care, with concern for equity, costs and effectiveness.

Bulgaria welcomed the WHO Declaration and Action Plan for Mental Health in Europe and developed a national strategy along those lines. In this endeavour, it was guided by several principles. In the first place it took special interest in introducing reliable, manageable and adequate information systems that would in the near future enable *to base central and local policies on evidence*. As health insurance was brought to the country and managed care followed suit, structured clinical practice in mental health became a reasonable option and rendered evidence-based management possible in the near future.

In the second place the country channelled fresh money made available by international sponsors into demonstration projects attempting to develop and evaluate community based service models. It preserved the state funding of the regional mental health centres functioning on the catchment area principle, reduced their load of curative services, and entrusted them with the development of public mental health. This structural change allowed for the debate on the prevention of mental illness and the promotion of mental health to move beyond the hypothetical realm where it had been stuck for decades.

Commitment to prevention and promotion

The new mental policy states:

"Mental health promotion is most effective when targeted at critical transitions in individuals' lives and when focused on specific communal needs. Mental health promotion attempts to enhance individual mental well-being and consolidate communities in the face of adversity. Health promotion enhances treatment and rehabilitation but it also contributes to every member of the community. At the core of mental illness prevention lies early detection and intervention in the case of both severe and common mental illness. The disabling consequences of mental illness can thus be significantly fewer and the social burden can be reduced."

A telling sign of Bulgaria's commitment to prevention is the fact that its new mental health policy provided salaried personnel at the state financed mental health centres countrywide, with job specifications in the field of promotion and prevention. It also secured these agencies with access to funds on a grant basis thus enabling projects in the field.

In its first five-year implementation strategy and action plan (2001-2005) however, the mental health policy fell short of specifying priority areas in the field of prevention and promotion. Of the several reasons for this, the core one was the desire to strike the right balance between prevention and the beginning of re-provision for severe disorders and disabilities (community based rather than institutional care).

The capacity of the mental health network to absorb change would hopefully be seriously enhanced by 2006, when a new five-year strategy will be adopted, in which the prevention component will be explicitly spelled out. Currently, prevention and promotion in the mental health field are still regarded as a desired but impractical service largely because the supportive organization and requisite competence are not available.

Programmes and policies across settings

Suicide was addressed openly in the early 1990's when the practice of reporting suicide was reviewed, evaluated and shown to yield reliable incidence figures⁵. Once this task had been accomplished by the Centre for Public Health (currently Centre for Protection of Public Health) and following analysis of the trends, a national programme was developed which addressed a host of issues. Among them were: the capacity to assess suicidal behaviour by specialist services and by generalists; the sensitization of the public to attempted suicide and its precipitants; the association of mental illness and suicide. The implementation of the programme in the years that followed relied, on the one hand, on the budgeted funds from the Ministry of Health (which were unduly small) and, on the other, on grants approached through non-governmental organizations. The awareness raising effect, which was central to the idea of the organizers, has been achieved to a considerable degree. What attests to this conclusion is the review of the media involvement over the years, judged by the change in content and language of the publications.

School mental health is subject to a national programme purporting to evolve a network of schools, which cater for the social and emotional development of children by providing a set of services and educational activities⁶. Among them are: sensitization and support to teachers on issue of emotional well-being of children; initiatives in and across schools addressing the school environment from the perspective of eliminating unfriendly and potentially traumatic experiences; counselling programmes for children with specific phobias and related complaints as well as for their families.

The preventive component in the national substance abuse programme amounts to programmes in schools, which introduce the risks of addictive behaviour, to changes in the legislation regarding possession and peddling of illegal drugs, as well as to regulations aiming to constrain availability of addictive substances.

4 Organizations and resources for implementation

Infrastructures

Structures specifically involved in prevention of mental disorders and promotion of mental health operate at the level of the central government and are focused on data collection and processing, programming and planning, monitoring, and dissemination of information. Even at this level, inter-sector collaboration has failed to meet the need of the work tasks. The non-governmental sector is reluctant to contribute on a significant scale to the field of promotion, and when its representatives are invited they are expected to play only a token role.

As the new policy redefined the job specifications of the regional mental health centres (see *Commitment to prevention and promotion* above) a slow but irreversible process of integrating the preventive approaches into the service networks – both health and social – has been set in motion. The position of the agencies

⁵ www.mh.government.bg/doc/mental_health_policy_final.doc

⁶ www.mh.government.bg/doc/mental_health_policy_final.doc

specialized in prevention has traditionally been rather peripheral to the health and social services, the boundary delineating the two fields has only seldom been crossed before, and that has been done almost exclusively under external pressure and not in a genuine and consistent way. To overcome this legacy, clinical governance at local level has been seen as having to play a decisive role. More specifically the introduction of structured clinical practice has been seen as the call of the day.

Structured clinical practice is believed to be the mechanism whereby service provision will be streamlined in terms of programmes of care with specified indications and clinical protocols. The running of programmes of preventive and health promoting nature would then be possible and eventually be shown to be cost-effective and therefore competitive in health market conditions.

A likely first instance of new integrated preventive mental health care will be a programme in clinical depression of minor to moderate clinical severity designed to be operated conjointly by general practitioners, consultant psychiatrists and the health promoting sections of the mental health centres. Each of the partner agencies will contribute specifically to the overall goals: the clinical case management, the consultative back-up, and the awareness raising correspondingly.

Workforce for mental health

Under the new policy the role of specialist community psychiatric nurses in fostering preventive services has been clearly introduced. One year specialization for BA graduates in general nursing has been developed and will be run by the Blagoevgrad Nursing College of the Medical University of Sofia (see Mental Health Project for south east Europe). The curriculum and training methods combine knowledge and skills relevant to the practice of the helping professions in a context of empowering and partnership. An essential component of the training is the development of a common language with specialists with a background in social work and education.

5 Monitoring and evaluation

The new policy clearly states that accountability is the one principle that it seeks to introduce with particular urgency, as it has the potential to drive transformational change in the right direction. The policy admits that:

“The practice of monitoring the implementation and progress of health policy is virtually nonexistent largely because accountability to the public and the consumers has not yet been embraced by either the health administration or the stakeholders. It is only NGOs like Amnesty International which reveal the shortcomings of the system and hold the services accountable. The MHP by adopting planning and budgeting on a project by project basis hopes to build the practice of accounting within the principles of governance in the sector.”
/BCMHP, p.14/

The introduction of standards of care with quantifiable indicators, along with information system allowing for data collection and processing, has been set as a practical task of a collaborative effort of the countries in the Region which co-operate with each other for the WHO governed Mental Health Project for south east Europe.

6 Challenges

A major challenge is the lack of tradition in the area of mental health promotion and mental disorder prevention in Bulgaria. The prevalent belief is still that mental health is a small branch of clinical medicine meant to engage difficult health conditions in which prevention has no place. This and related beliefs have resulted in under-estimating the contributions of the mental health field largely because of lack of cost utility research in the field.

Croatia

Prepared by Professor Josipa Basic, Valentina Kranzelic Tavra and Martina Feric Slehan

1 Introduction

The total population of Croatia is 4.4 million, according to the 2001¹ census. The total land area is 56,542 km². The population density is 78.5 inhabitants per km². The largest city is Zagreb, capital of Croatia, with a population of 779,145 inhabitants. Croatia is divided into 21 counties, which differ considerably in their population density. The population has been decreasing over a long period, and fell by 1.9 per 1,000 inhabitants in 2001. According to the 2001 population census, the share of the population 65 years of age or older rose to 15.7%, indicating a population shift towards the older age groups. 57.7% of the people live in urban areas and 42.3% in rural areas.

In Croatia, national policy for mental health exists as a part of policy within the frame of the Croatian Institute of Public Health. Croatia is missing a formulated and comprehensive mental health policy. General and mental health are surveyed by the Croatian Institute of Public Health. The collected data provides information about mental health, the organization and resources of the health service, as well as health status indicators for the population, and are regularly published (e.g. South-Eastern Europe Mental Health Project, Croatian Institute for Brain Research, project manager: Neven Henigsberg, MD).

2 Process to prepare country story

Key people in the field of mental health in Croatia were involved in creating the country story (advisers). The IMHPA Questionnaire and the Mental Health Assessment – Croatia (document from South-Eastern Europe Mental Health Project) were used. The IMHPA Questionnaire was completed separately and the obtained information was summarized (www.imhpa.net/infrastructures-database). All members of the country coalition agreed with the information presented in the country story for Croatia.

Advisers:

Kramaric Danica, Ministry of Health and Social Welfare

Lazacic Zec Danijela, Institute for Public Health, Region of Istria

Apostolovski Davor, Children's Home, Pula

Kuzman Marina, Croatian National Institute for Public Health

Henigsberg Neven, Institute for Brain Research, School of Medicine, University of Zagreb

Gregurek Rudolf, Clinical Hospital Center Zagreb, Psychiatric Clinic

Grozic Zivolic Sonja, Department for Health, Social Welfare and Labor, Region of Istria

Hrabak Zerjavic Vlasta, Croatian National Institute for Public Health

Rudan Vlasta, Clinical Hospital Center Zagreb, Psychiatric Clinic

¹ www.dzs.hr

3 Action for promotion and prevention in mental health

Availability of policies

Croatia is missing a formulated and comprehensive mental health policy. Consequently, there are no formal strategies and plans. Overall economic difficulties, prolonged humanitarian crises and difficulties in maintaining financial stability of the health care system have impeded more prompt implementation of novel concepts of community-based services, mostly because of the unpredictable flow of funds in the health sector and the lack of resources for initial investments.

Understanding the need for a mental health policy document, several professional associations recently agreed to co-operate in its formulation. Several concerns limit the scope of its development, almost all being related to the economic environment. With this exception, the overall environment, including health authorities, is supportive for restructuring the mental health services, and for the further development of a community oriented system.

The reform of mental health legislation in the Republic of Croatia was influenced by international and regional instruments for the protection and promotion of mental health. Specific individual rights, promotion of mental health and prevention of mental disorders were covered by professional standards and practice. Although there was a growing awareness of the need for the legislative reform following establishment of independence, the biggest impetus came from the country's obligation to adapt its legislation system to European standards as a part of the process of admission to the Council of Europe.

There are some strategic directions for mental health promotion and mental disorder prevention that can be found in some other national policies area: national policy for social inclusion, national policy for human rights, national policies for family and family violence prevention, national programme for children and youth, policy for disabled people, education policies, policy for drug abuse prevention, regional policies for health, and Croatia for 21st century, the strategy for development of health care system.

Mental health reforms were usually considered as one component within overall health reforms. However, the Health Care Act that was passed in July 2003 established the Croatian Mental Health Institute (still in development) and gave this institute the responsibility to formalize mental health policy and plans. The Croatian Mental Health Institute has been established in order to promote and protect mental health; to plan, implement and evaluate preventive measures; to evaluate diagnostic and treatment in the field of mental health; to participate in research and education; and to collect and analyze epidemiological data including the State Register of mental diseases and disorders.

The Health Care Act of 2003 provides an impetus for a significant shift towards community mental health care:

- ▶ Mental health care was for the first time listed as an integral part of primary health care and the Act explicitly defines that activities should be present in each primary health care centre (PHC); and
- ▶ Mental health care in PHCs is provided by psychiatrists in co-operation with other mental health professionals, including psychologists, social pedagogues, social workers and others.

Commitment to prevention and promotion

The Ministry of Health and Social Welfare manages the establishment of the Croatian Mental Health Institute – finding financial support, employment of the head of Institute and administrative staff. At the Ministry level there is an initiative for creating and implementing Mental Health Centres (e.g. there are negotiations for a pilot project of Mental Health Centres in the west part of Zagreb, which could be used as a model for other cities in Croatia).

Key persons involved in the creation of the country story expressed the opinion that there is some level of readiness in government institutions for creating mental health policy. However, it is estimated that mental disorder prevention has higher priority than mental health promotion. There is a small increase in resource allocation to mental health promotion and mental disorder prevention.

Programmes and policies across settings

In Croatia, there are some examples of programmes that deal with mental health promotion and mental disorder prevention, but they are insufficiently developed, poorly evaluated or unavailable for dissemination. It could be concluded that there are some best practice examples, but fields of interventions (family, school, workplace, elder people) are not equally represented. Home-based programmes do almost not exist and elder care facilities are insufficient regarding the needs of population. Most of the programmes are school-based programmes and programmes in the field of primary health care. Examples of best practice are: “Health promotion” programme, then “Say yes to non-smoking” programme, programme for the prevention of AIDS and other sexually transmitted diseases, special programme for psychosocial assistance to war victims having missing persons in their families, prevention programme of alcohol abuse, national prevention programme of drug abuse, community-based behaviour disorders prevention programme, activity of the Centre for crisis intervention, UNICEF bullying prevention programme and others.

The recently established Centre for Prevention Research (by the Faculty of Education and Rehabilitation Sciences, University of Zagreb) has the goal to create the best practice/science-based standards and criteria for evaluation of programmes in the field of mental health promotion and prevention of mental and behaviour disorders. The Centre will contribute to the improvement of programme/service quality in the field, and assist in the modification and harmonization of the system to European standards.

4 Organizations and resources for implementation

Infrastructure

The intention of the health system is to rely on well-developed primary health care (PHC). Despite the prolonged efforts to intensify the PHC service and to prevent over-utilisation of specialists’ services, there are concerns that over-utilisation of in- and out-patient hospital services remains in the mental health area. In the health system, psychiatric services are provided at the primary, secondary and tertiary levels. The primary level encompasses primary health care, which, of interest to mental health, includes general practitioners and school medicine specialists. The secondary level encompasses out-patient psychiatric services in medical institutions and the tertiary level refers to in-patient psychiatric services in medical institutions. The most important institution for policy making and managing the different levels of services is the Croatian Mental Health Institute. Responsible Ministries for creation of policy are the Ministry of Health and Social Welfare, the Ministry of Science, Education and Sport and the Ministry of Family, Veterans’ Affairs and Trans-generational Solidarity.

Croatia is in the process of decentralization of the health care and social welfare systems, which presumes transferring the responsibility and budgeting to the regional and local authorities. In addition to the mentioned structures, at the national, regional and local levels, there are institutions that make efforts on programmes and research in the field of mental health:

- Croatian National Institute of Public Health, Zagreb
- School of Public Health Andrija Stampar, Medical School, University of Zagreb
- Department for Health, Social Welfare and Labor, Region of Istria, Pula
- Croatian Mental Health Institute (in development)
- Croatian Institute for Brain Research, Medical School, University of Zagreb

- ▶ Medical Schools (Zagreb, Rijeka, Osijek, Split)
- ▶ Departments of Psychology (Zagreb, Rijeka, Zadar)
- ▶ Faculty of Education and Rehabilitation Sciences, University of Zagreb
- ▶ Social Work Study Center, Law School, University of Zagreb
- ▶ Polyclinic for Children Protection, Zagreb

Other institutions include preschool institutions, schools, counselling centres, non-governmental centres, recreation centres, elder people facilities, centres for social welfare, and centres for children, youth and families. The National Foundation for Civil Society Development and the Office for Non-governmental organizations are leading institutions for financing the projects and programmes in the mental health field.

Workforce for mental health

Different professionals are working in the field of mental health promotion and mental and behaviour disorders prevention. Interdisciplinary collaboration between general practitioners, medical doctors of school medicine, psychiatrists, psychologists, social pedagogues, and social workers are required for the creation and implementation of policies, action plans and programmes. This is the best way to address all aspects of healthy and positive development of all children, youth and adults, and especially those “at-risk” and in need of different kinds of interventions. Professionals who will be working in the field can gain knowledge and competencies by studying at undergraduate, graduate and doctoral levels of education, or conducting research in the following institutions: Faculty of Education and Rehabilitation Sciences, University of Zagreb, Social work study centre, Law school, University of Zagreb, Psychology department, Faculty of Philosophy, University of Zagreb, Medical school, University of Zagreb (postgraduate training), School of Public Health Andrija Stampar Medical School, University of Zagreb and the Croatian National Institute of Public Health.

The process of creating the country coalition and the experiences of professionals who are working in practice emphasizes the need for improvement in interdisciplinary and inter-sectoral co-operation. This will be an important step in the development of the promotion/prevention field in Croatia.

Two systems have been established that more closely rely on co-operation between different sectors: one is the network of centres for assistance to drug addicts, and the other is the network of centres for psycho-social rehabilitation of war victims. Although formally separated from the health system, both strongly rely on it, and have succeeded in establishing improved co-operation with other mental health professionals, psychologists, social workers, social pedagogues and education and rehabilitation professionals. These systems are county-based and available countrywide without a referral from the health system.

5 Monitoring and evaluation

Monitoring and evaluation do not exist as part of the tradition and experience in the promotion/prevention field in Croatia. There are some efforts made by the Croatian Institute for Brain Research within the South-Eastern Europe Mental Health Project that attempts to monitor mental health, but such efforts are not ongoing and are not incorporated in the wider system. The office for epidemiology (within the National Croatian Institute for Public Health) monitors the mental health of population, but particularly the mental illness in population.

At the regional level, the Network of Healthy counties/regions is the leading structure for creating the Regional plans for health, setting the priorities for each region, and monitoring activities that are derived from Plans for health. As a part of the Plan for Health in the Region of Istria, the scientific project “Prevention of behaviour disorders in the local community” is working with professionals and significant groups to evaluate programmes in the field of prevention of behaviour disorders in children and youth, and the promotion of positive development.

6 Challenges

Mental health activities rely almost solely on the health system, and the national health insurance remains the major source of funding for mental health. Still, some recent activities related to special population groups (like war victims) or to special programmes (like drug abuse prevention) incorporate other sources of funding, are more oriented to community care, and rely on more intensive co-operation between health and other sectors. As present, mental health services are not provided at the primary health care level. However, the new legislation defines the creation of mental health units in primary health care centres, so it is expected that in the future, mental health units will be available as an integral part of primary health care. These intentions are realized through pilot projects at the city level.

Further challenges are knowledge capital and empowerment of human resources as well as interdisciplinary collaboration. There is a need to harmonize the Croatian higher education system to EU standards and the Bologna declaration, of which the main principles are horizontal and vertical circulation, comprising interdisciplinary co-operation, life-long learning and specializations.

A major challenge for Croatia will be to re-direct the law and policy implementation.

7 Opportunities and advances in the field

In last few years there has been a general increase in awareness of the need for a national policy for mental health, as well as making efforts towards implementation of existing laws. Significant improvements have been made in the involvement of various professionals in mental health promotion and mental disorder prevention. An important impact will be the active involvement of the Croatian Association of Psychotherapy Schools (umbrella organization) in the development of the promotion/prevention field, especially by increasing the capacity of human resources.



Cyprus

Prepared by Costas Kyranides

1 Introduction

In Cyprus the mental health system consists of the public Mental Health Services (under the auspices of the Ministry of Health), the private services offered by mental health professionals, and the services, programmes and initiatives that have been developed by local authorities or the voluntary sector. It has to be noted that, due to the division of the island since 1974, the public services are limited to the government-controlled areas that cover about 63% of the Cyprus land (a population of ca. 750,000)¹. The proportion of GDP allocated to health issues is 6.4 % (2003)² of which a proportion of 5.27 % is allocated to mental health (2003). The life expectancy is 77 years for males and 81 years for females; the infant mortality rate is 4.1 per 1000 births (2003)¹.

Since the early 1990s, there has been a growing involvement of the voluntary and community sectors in Mental Health Promotion (MHP) and Psychosocial Rehabilitation programmes, with developing co-operation with the public Mental Health Services: Some examples are the developments of counselling centres, day centres, vocational rehabilitation centres, etc. In the same period, there have been growing trends to decentralize mental health services, to integrate community mental health services into the Primary Health Care (PHC) and to develop home-based treatment and preventive programmes.

In 1995, Mental Health Policy was formulated consisting of five main elements: promotion, prevention, treatment, rehabilitation and advocacy. In the same year a National Mental Health Programme was formulated and presented to the World Health Organization, and in 1997 the new Mental Health Act replaced the 1931 colonial law. Another milestone in 1997 was the establishment of two Community Mental Health Centres in the area of Nicosia which started functioning on the principles of geographical sectorization, integration into PHC and Social and Community Psychiatry.

2 Process to prepare country story

The effort to form a country coalition was not completely fulfilled in time, due to a technical difficulty in receiving the support letters from the European Commission. However, at a first stage the key services/agencies involved in MHP and MDP were selected. Senior officers or persons in charge of five of those were contacted, informed about the IMHPA initiative and requested to provide relevant information, views and suggestions. The main services/agencies selected are the following (the first five were contacted and consulted in person):

- ▶ Mental Health Services (Child and Adolescent Department, Community Mental Health Centres, etc) - Ministry of Health
- ▶ Educational Psychology Services - Ministry of Education
- ▶ Department of Social Welfare Services - Ministry of Labour and Social Securities
- ▶ National Guard Health Service - Ministry of Defence
- ▶ School Health Service - Ministry of Health
- ▶ Counselling and Career Services - Ministry of Education
- ▶ Department of Education - University of Cyprus
- ▶ Department of Psychology - University of Cyprus

¹ www.mof.gov.cy/cystat

² Yearly Report of the Ministry of Health for 2004, ISSN 1450-1899 (Greek language)

Due to the absence of a collective process of evaluation, the views and data presented in the questionnaire (www.imhpa.net/infrastructures-database) reflect the assessment of the national representative in the IMHPA project and the representatives of the aforementioned services/agencies that could be contacted. Thus, the overall picture presented should be viewed tentatively and with caution. This endeavour represents only a first step and a stimulus that will hopefully encourage further exploration, input and comments from other sources and partners. At this point I would like to express my appreciation for the valuable help and support I had from my colleague Korina Ioannou during the drafting of the Country story and the completion of the Questionnaire.

Persons involved:

Evangelos Anastasiou, Senior Specialist Psychiatrist, Mental Health Services (MHS)

Korina Ioannou, Clinical Psychologist, MHS

Michalis Ioannou, Principal Educational Psychologist, Educational Psychology Services (EPS)

Yiannis Kalakoutas, Specialist Psychiatrist, MHS

Christos Kramvis, Specialist Psychiatrist, MHS

Christos Kyprianou, Director of the National Guard Health Service

Rita Pantazi, Senior Welfare Officer

Michalis Papadopoulos, Senior Educational Psychologist, EPS

Anna Paradisioti, Child Psychiatrist, MHS

Mama Paraskevi, Chief Health Visitor, School Health Service

Charalambos Tziogouros, Senior Educational Psychologist, EPS

3 Action for promotion and prevention in mental health

Availability of policies

As mentioned in the introduction there has been an overall policy for mental health since 1995. However, there exists no specific policy addressing promotion and prevention issues, or elaborated in priorities, responsibilities and actions.

In the 2004 Mental Health Services Annual Report there is a general objective targeting public awareness in the areas of Mental Health Promotion (MHP) and Mental Disorder Prevention (MDP). Within this general objective the Community Mental Health Teams in co-operation with voluntary organizations and local authorities organize panel discussions in local communities aiming at informing the public about the roles of the mental health professionals, stressing the importance of mental health and the significant role of the family and the broader community. Moreover, yearly campaigns are organized on the occasion of the World Day for Mental Health; these include public lectures, distribution of information hand-outs, poster presentations, panel discussions and media presentations addressing various topics such as violence, stigma, family relationships, etc.

The most promising step towards upgrading the work on MHP and MDP at the community level is currently considered to be the establishment of the first Community Mental Health Committee (CMHC). This has been developed following initiatives of the Community Mental Health Team of Sector B of Nicosia. Its components are mental health professionals of the public services, professionals from the Social Welfare Department and the local Police Department, representatives of 4 municipalities, representatives of voluntary organizations,

and active members of the clergy. Key objectives of the CMHC are the development of links between various local authorities to discuss, promote, and encourage the implementation of programmes addressing MHP and MDP.

Two programmes are considered as pioneer in the areas of MHP and MDP:

1. Early Promotion Program³ - This is a home-based programme involving the team of health visitors (School Health Service, Ministry of Health) in the areas of Nicosia, Larnaca and Limassol aiming at: a) identifying early signs of mental health problems in infants and toddlers and their families, and b) implementing intervention packages where needed. This programme has been designed and supervised by the Child and Adolescent Mental Health Department of the Mental Health Services and is part of a wider European programme.
2. Needs Assessment and Awareness Raising Program for Bullying in Schools – This is part of the European programme “Dafne” that was launched in September 2005, and involves the Child and Adolescent Mental Health Department and the Educational Psychology Services of the Ministry of Education. The programme is a psycho-educational project aiming at increasing the awareness of educators, parents and students through workshops and lectures.

4 Organizations and resources for implementation

Infrastructures

The Mental Health Services can be considered as the primary national agent for the implementation of existing policies on mental health and the main provider for training mental health professionals and disseminating knowledge among them. Since the 1980's a significant role in the knowledge dissemination on mental health issues have been played by the Cyprus Psychological Association and the Cyprus Psychiatric Association, through conferences, seminars, lectures and workshops.

In the last few years there has been a significant involvement of tertiary education institutions (including the Department of Education and the Department of Psychology of the University of Cyprus) in training mental health professionals, encouraging research initiatives and in facilitating the dissemination of knowledge.

Among the main agencies/services/organizations involved in the implementation of policies/actions for MHP and MDP is the Department of Social Welfare Services of the Ministry of Labour and Social Insurance. Its contribution is multifaceted:

- ▶ through its general policy to support vulnerable groups (low-income persons/families, single-parent families, persons with physical, intellectual or mental disabilities, etc)
- ▶ through various schemes to subsidize the programmes/services of non-governmental organizations which address the needs of vulnerable groups
- ▶ through a supervisory role in key issues, such as family violence, children's welfare, and
- ▶ through various specific services/programmes, such as the Family Guidance Centre, Preventive Service, Child Protection Programme, etc.

All these policies, services and programmes aim at preventing or reducing social exclusion and at promoting the welfare and well-being of vulnerable groups, thus reducing socio-economic stressors and subsequently the risk of mental health problems.

³ The European Early Promotion Project (EPPP). The International Journal of Mental Health Promotion (2005), Vol. 7 (1). Clifford Beers Foundation. ISSN:1462-3730

With regards to specific budgets for MHP and MDP issues, there is an overt provision in the Mental Health Services budget that allocates about 0.06% for mental health education and preventive programmes. These funds cover mostly the activities aiming at raising public awareness during the International Mental Health Day or initiatives undertaken by various departments/services at the community level.

Workforce for mental health

In practical terms, the closer to the community that mental health professionals are working, the greater the extent to which MHP and MDP becomes a real challenge. This is a result of the great importance that community agents/leaders place on mental health issues and their requests, or even demands, for adequate and effective responses and solutions from the public services. The predominant issues of concern cover areas such as healthy psychosocial development of children, family and marital dispute resolution, reducing the risks for drug dependencies and antisocial behaviour of young people, and seeking awareness and guidance to support people with mental disorders. The overall number of mental health professionals who, from time to time, are posed with such issues/challenges and try to develop programmes/actions/activities is about one hundred; these mostly work in the five Community Mental Health Teams and in the two Child and Adolescent Mental Health Departments. In the last few years, two pilot programmes have been developed; these are the Early Promotion Programme and the Community Mental Health Committee (described above). These and similar programmes are a result of a collective and collaborative process of multidisciplinary teams, extended in some cases to other agencies/organizations (municipalities, NGOs, etc).

5 Monitoring and evaluation

Monitoring in the Mental Health Services covers mostly treatment and rehabilitation services and programmes. Epidemiological studies have not yet been carried out and no indicators of mental health have yet been identified, monitored and evaluated. More specifically, a reliable system to collect data on issues such as suicide attempts and suicides, eating disorders or other serious mental health problems is currently lacking. Also, evaluations of efficacy and cost-effectiveness of interventions are still to be undertaken. The primary reason for this paucity of audit/evaluation activity seems to be the poor tradition of research initiatives in mental health and in the public services in general. The delay in the establishment of the first university in Cyprus (beginning of the 1990s) has evidently played a decisive role.

6 Challenges

A major challenge in the field is “how to translate” the very interesting and inspiring strategies, policies, objectives and action plans, elaborated by various bodies and authorities (national councils, ministries, or departments), into specific and measurable actions/initiatives/programmes undertaken at a service/community/district level. This “translation” is closely related to two necessary developments:

- A. Dissemination of information and knowledge existing in various documents, policies programmes, and strategies relating to MHP and MDP, as well as to other relevant areas, such as drug prevention and social inclusion; and
- B. The planning of specific actions/initiatives/programmes undertaken at a service/community/district level should have its foundations on evidence-based information, and be evaluated and assessed in an ongoing fashion. Further, the planning needs to be based on the expertise of the responsible professionals, the assessed needs of the target groups and areas, and the resources and limitations of the specific service/community/NGO.

Another challenge would be to transform the various, more or less isolated, though encouraging, initiatives/actions into a significant trend, or even lobby for an emphasis on MHP and MDP that may persuade the Government to institutionalize a national regulating mechanism. This could monitor, evaluate, support and

guide teams, services, organizations and any other agencies involved or interested in MHP and MDP. Hopefully, this development will be facilitated by the present national and European endeavour, especially to the degree that its conclusions and suggestions will be adopted and supported by the European Commission.

7 Opportunities and advances in the field

A milestone in the mental healthcare system, that created basic infrastructure for developing MHP and MDP, was the establishment of two Community Mental Health Centres in the area of Nicosia in 1997. The centres were staffed by multidisciplinary teams (Community Mental Health Team - CMHT) consisting of psychiatrists, psychologists, community psychiatric nurses and occupational therapists. The scope of the teams' activities included the areas of MHP and MDP, and was developed in close co-operation with various community agents such as representatives of municipalities, voluntary organizations, clergy, local police authorities, local education authorities, etc. The CMHT developed parallel links with PHC professionals by establishing a referral system, offering training to general practitioners and generally empowering PHC staff to provide early screening of mental health problems and implementing interventions, where needed.

Another key development was the establishment of the Departments of Education and Psychology of the University of Cyprus, in the early 1990s and in 2003, respectively. These Departments have triggered the promotion of research and evaluation in the psychosocial sciences, which lacked in the field of mental health thus far. It is hoped that such developments will promote a research and evaluation culture in the mental health care system of Cyprus, through partnerships between academics and professionals of the mental health services.

A third development in the field is considered to be the establishment of the first Community Counselling Centre in 1999 in Strovolos. This was one of the first products of a close co-operation between the CMHT of Sector B of Nicosia and Strovolos municipality. The counselling services cover multiple areas such as dietary habits/issues, family counselling, legal issues, mental health and drug abuse issues, thus minimizing the risk for stigmatization and making mental health counselling more accessible to the citizens. This establishment provided a model for other municipalities and created a tendency for replication and expansion of the services. Apart of the counselling itself, staff of the centre have undertaken initiatives to educate the public on mental health issues through lectures, and carried out research projects to identify major psychosocial problems in the community.

A fourth advance in the context of a wider national social policy is The National Action Plan for Social Inclusion (2004-2006)⁴. This was drafted by the Ministry of Labour and Social Insurance and covers a wide range of issues including social inclusion of vulnerable groups, domestic violence, policies to encourage employment, etc. The National Action Plan for Social Inclusion represents a commitment on the part of the government and the public services to fulfil specific objectives and to proceed to actions in the direction of social inclusion and vocational integration of vulnerable groups (such as the integration into the labour market of a specific percentage of those who receive social welfare benefits). Such policies could reduce the socioeconomic stressors, and subsequently the risk for the emergence (and deterioration) of mental health problems.

Another important development in relation to the school environment and its role in MHP and MDP is the Action Plan on Drug Demand Reduction drafted by the National Anti-Narcotic Council in 2004⁵. The actions proposed in relation to school environment cover a wide range of key issues that are important in terms of students' integration in the school community. The two objectives of the Action Plan are: a) to promote and evaluate a universal strategy for a healthy school environment through the application of evidence-based programmes and with the participation of key actors; and b) to prioritize selective and indicated actions targeted at high risk behaviours, areas or groups.

⁴ www.mlsi.gov.cy/sws

⁵ www.ask.org.cy

Czech Republic

Prepared by Professor Cyril Höschl and Dr. Eva Dragomirecká

1 Introduction

The Czech Republic is a country located in Central Europe with an area of 78,866 km². Its population is 10.22 millions¹. Life expectancy is 72.0 for men and 78.8 for women; the proportion of persons older than 64 years is 14%. Total expenditure on health (in health sector only) represented 7.36% of the GDP in 2003. The predominant part of expenditure on health in 2003 was carried by the public health insurance (79.3%). State and territorial budgets covered 12.1% and private expenditure covered 8.6%². Estimated expenditure from the total health budget on mental health was 3.5%³.

2 Process to prepare country story

Sources of information for the country story and questionnaire:

Dr. Eva Dragomirecká, Laboratory of Social Psychiatry, Prague Psychiatric Centre

Mrs. Barbora Wenigová, Centre for Mental Health Care Development

Dr. Pavel Březovský, Ministry of Health

Institute of Health Information and Statistics - IHIS

The representative of the Czech Psychiatric Society Dr Pavel Baudiš, CSc. was asked to send his comments and additional information which will be used in the next update of the questionnaire. The references both to source of data and to relevant websites are available directly in the country story and the questionnaire (www.imhpa.net/infrastructures-database).

3 Action for promotion and prevention in mental health

Availability of policies

Prevention of disorders and health promotion are included in “Longtime programme of health improvement of Czech population – Health for all in 21st century”. The programme represents a Czech version of the HFA declaration⁴ and was approved by the Czech Government in 2002⁵. Chapter 6 of this document entitled “Improvement of mental health” determined the main tasks for the mental health care and prevention. It stated that the field of prevention of drug consumption has been elaborated sufficiently contrary to mental health promotion, stress prevention and prevention of mental disorders. The document accentuated the prevention of suicidal behaviour.

The policy of mental health care, prevention and promotion is described in “*Conception of psychiatry*” (Czech National Concept of Mental Health Care) elaborated by the Czech Psychiatric Association and the Centre for Mental Health Care Development and accepted by the Ministry of Health in 2000.

¹ Czech Statistical Office, website (www.czso.cz)

² Czech Health Statistics 2003, Institute of Health Information and Statistics of the Czech Republic (www.uzis.cz)

³ Project report 2003, Center for Mental Health Care Development (www.cmhcd.cz)

⁴ “Health For All” declaration was signed by Czech Republic (as well as other Member States of the World Health Organization) in 1998

⁵ Government decree No.1046/2002

The promotion of mental health was also described as an important part of clinical psychology in the document *“Conception of clinical psychology in Czech health sector”*. The document was released in 2000 by the Czech Association of Clinical Psychologists.

Policy of mental health care in Czech Republic is a working document for public discussion prepared by the CMHCD⁶ and funded by the Open Society Fund. The document targeted the care of persons with severe long-term illness including secondary and tertiary prevention, issues of stigma and human rights.

Commitment to prevention and promotion

Mental health development is one of seven priorities in the contract of the Czech Ministry of Health and the WHO Regional Office for Europe for 2004-2005⁷.

Approval of the Mental Health Declaration for Europe in January 2005 led to a revision of the national policy of mental health and preparation of the Conception of Psychiatry. The Department of Psychiatry, Charles University⁸ and the Centre for Mental Health Care Development participated in the project.

Programmes and policies across settings

The National Reference Centre of Programmes for Health Promotion and Disease Prevention⁹ supported programmes focused on stress coping (such as problems in incomplete families, support of children in crises, protecting children against violence, help-lines) and prevention of drug dependence (services for information, counselling and therapy).

The National Health Institute (www.szu.cz) participated in several EU programmes in the field of public health that included issues of mental health such as *EU Project on Healthy Ageing, Alcohol Policy Making in the Context of a Larger Europe, Implementation of Mental Health Promotion and Prevention Policies and Strategies in EU Members States and Applicant Countries, Participation in the European network for health promotion agencies*, and programmes of smoking prevention.

4 Organizations and resources for implementation

Infrastructures

To implement the approved national and international programmes on mental health into practice, the Ministry of Health (www.mzcr.cz) established a special ministerial commission and inter-sector commissions at the regional levels. The National Focal Point, the Czech Monitoring Centre for Drugs and Drug Addiction, evaluated the outcomes of drug preventive programmes in its annual reports¹⁰.

Academic institutions disseminated knowledge and carried out research projects on mental disorder and behavioural problems prevention (Psychiatric Departments of Medical Faculties, Faculties of Education, Prague Psychiatric Centre¹¹), promotion of health and healthy life style (Faculties of Physical Education and Sport, National Health Institute), promotion of mental health (Dept. of Health Psychology in Faculty of Humanities, Depts. of Psychology in Faculties of Arts and Philosophy, Institute of Psychology of Academy of Science in Czech Republic¹²) and prevention of smoking and psychoactive substances abuse (National Health Institute and its regional offices).

⁶ Center for Mental Health Care Development (www.cmhcd.cz)

⁷ Biennial Collaborative Agreement between the Ministry of Health of the Czech Republic and the Regional Office for Europe of the World Health Organization 2004/2005 (www.euro.who.int/document/bca/czh04.pdf)

⁸ <http://psych.lf1.cuni.cz/pk/default.htm>

⁹ The NRC is a part of National Health Institute. The Institute has its Office and respective Center in each Czech region

¹⁰ www.drogy-info.cz

¹¹ www.pcp.lf3.cuni.cz

¹² www.psu.cas.cz

Examples of NGOs involved in primary prevention of alcohol and drug use disorders include Sananim (www.sananim.cz), Podané ruce (www.podaneruce.cz) and Prev-centrum (www.prevcentrum.cz).

An important NGO in the mental health field has been the Centre for Mental Health Care Development (www.cmhcd.cz), founded in 1995 with support of the Dutch Foreign Ministry. The main tasks of the Centre include the transformation of mental health care, de-stigmatization of mental illness and protecting human rights of mentally ill, and secondary and tertiary prevention of mental illness.

The Czech Association for Mental Health (www.capz.cz) was founded in 1996 with the aim of supporting community oriented approaches towards people with mental illness and assistance in creating policies and attitudes protecting mental health. They collaborate with international organizations (such as the World Federation for Mental Health, Mental Health Europe - Santé Mentale Europe and Gamian Europe) and with local centres of providers and users of mental health. The Association has organised campaigns (such as Mental Health Week, Crazy Fest), published a monthly Esprit, and provides legal counselling, a help-line and a community rehabilitation service.

The Association of Community Services¹³, FOKUS Praha¹⁴, the Centre of Gerontology¹⁵ and other NGO's have participated in the improvement of mental health care.

Workforce for mental health

In the past, mental health issues fell within the health sector, and were insufficiently linked with other sectors. Mental disorder prevention was predominantly the interest of psychiatrists and clinical psychologists. At present the inter-sector and inter-disciplinary co-operation has been developed as well as the education of non-medical specialists working in the field.

Under-graduate education in mental health promotion and prevention has been provided in Medical Faculties¹⁶, Faculty of Humanities¹⁷, Faculties of Arts and Philosophy¹⁸ and Faculties of Physical Education and Sport. So far, it has not been constituted as an individual specialization.

In addition to professionals working in the health and social sectors, mental disorder prevention issues have been elaborated and implemented by state officers and authorities at various levels, and by self-help groups.

5 Monitoring and evaluation

In the Czech Republic there are no active monitoring systems for the mental health of the population and/or for the implementation of programmes on prevention and promotion. There are no evidence-based evaluations on cost-effectiveness of interventions. These data are under the control of the General Insurance Company and for the purpose of the questionnaire the information is partly estimated and partly derived from data provided by subjects mentioned in section 3. Also the impact of mental health initiatives of other policies is only weak and indirect. There is no tradition of evaluation research on mental health policy in this country.

Routine health statistics and population health surveys have been carried out by the Institute of Health Information and Statistics (IHIS) (www.uzis.cz). The main task of the IHIS has been to collect and analyse health data, to manage national registers and to provide health information on both national and international level (official source for WHO and EUROSTAT database). The IHIS was found in 1960 and has published mental health data since 1963. Since 1993, the IHIS has carried out the representative survey of population

¹³ http://mujweb.cz/Institute/asociace_komunitnich_sluzeb/

¹⁴ <http://www.fokus-praha.cz/soubory/main.htm>

¹⁵ <http://www.gerontocentrum.cz/denni.html>

¹⁶ Centre of Preventive Medicine <http://sweb.cz/centrumprev/>, Institute of Social Medicine and Public Health <http://dec52.lf1.cuni.cz/fakulta/ustavy/ustavy.php?ustav=socver>

¹⁷ Dept. of Health Psychology <http://www.fhs.cuni.cz/>

¹⁸ Dept. of Psychology, Dept of Social Work, Dept. of Sociology

health entitled Health Interview Surveys HIS, co-ordinated by the WHO. In 2002 the survey modified the name to EUROHIS - Health Interview Surveys in Europe. The survey has been conducted every three years. It includes 31 items that relate to healthy life style (BMI, diet, physical activities), risk behaviour (alcohol and drug consumption, smoking), subjective health status, chronic and acute diseases, care consumption, WHO Well Being Index (5 items), social health (5 items), social support (3 items) and quality of life (8 items).

Yearly evaluation of drug prevention activities is published by the Monitoring Centre for Drugs and Drug Addiction (National Focal Point; NFP) www.drogy-info.cz. The reports include survey data (information about individual aspects of use of licit and illicit drugs) and statistical data (mortality related to drug consumption, treated morbidity).

The Prague Psychiatric Centre, a research and clinical institute affiliated with 3rd Medical Faculty, Charles University and Collaborating Centre of the World Health Organization (<http://www.pcp.lf3.cuni.cz/pcpeng>), participated in several projects monitoring the population mental health¹⁹ and drug consumption²⁰.

The Centre for Mental Health Care Development (CMHCD) conducted census of community services and projects focused on monitoring of quality of care²¹.

6 Challenges

From the past, we inherited a mental health care system based on institutional care and directed by the health sector without sufficient co-operation with other sectors. In the field of mental health promotion it has led to the necessity to redefine needs, responsible subjects and methodology. The crucial issue is to involve other areas than the health sector such as educational bodies, social services, the department of the environment, and local authorities, etc. Corresponding allocation of the budget is the other important condition.

The activities in the field are aimed to motivate government, to formulate conception, to find resources, to educate professionals, politicians and public, and to involve the media.

7 Opportunities and advances in the field

In 2004, a new project "Chance" (2004-2007) aimed at action to eliminate stigma and discrimination from mental disorders is being developed at the Academia Medica Pragensis Foundation²². The project is focusing on achieving positive changes in the perception of mental illness and psychiatry by public and public administration.

The Academia Medica Pragensis Foundation (AMEPRA), the Czech Psychiatric Association and the Centre for Mental Health Care Development held a senate seminar entitled "De-stigmatization and transformation of psychiatry in the Czech Republic" and a press conference.

As mentioned above the Ministry of Health of the Czech Republic signed an agreement with the European Regional Office of the WHO on co-operation in 2004-2005 with mental health listed as one of seven priorities. Also the programme declaration of the new Czech Cabinet²³ in May 2005 included support of preventive programmes in "physical, mental and social health" and "improving mental health in accordance with conclusions of Helsinki Declaration", signed in January 2005.

¹⁹ Project "National Probability Survey of Mental Health and Comorbidity in Population aged 18 and over" (1998-1999) was co-ordinated by International Consortium in Psychiatric Epidemiology (ICPE) using WHO CIDI 2.1 (Composite International Diagnostic Interview), life-time version on a sample of 1534 persons in age from 18 to 79 according to the Czech population structure. The aim of the project was to estimate mental health problems in the general population.

²⁰ GENACIS Project (Gender, Alcohol and Culture: An International Study) and HBSC Study (The Health Behaviour of School-aged Children: A WHO Cross National Study) are examples of long-term monitoring of population health and risk behaviour.

²¹ Project of Internal Grant Agency of Ministry of Health "Model of monitoring, evaluation and improving community care for mentally ill"

²² <http://www.amepra.com/destigma.html>

²³ <http://wtd.vlada.cz/eng/aktuality.htm>

Denmark

Prepared by Dr.Marianne Jespersen, Dr. Barbara Hjalsted and Mrs. Kirsten Nielsen

1 Introduction

The Danish Welfare State guarantees free access to different kinds of support including the prevention and treatment of mental health problems. There is a long tradition of promotional and preventive activities particularly for children since early childhood in the health care, social and educational sectors in order to promote physical as well as mental good health and to diminish the consequences of handicap and disability. Later in life, legislation for workers protection provides basic protection, including mental health problems. The Danish health care system provides free access to diagnoses, treatment and care for minor as well as major psychiatric problems and disorders.

Nevertheless, mental ill health and disorders constitute a heavy burden in Denmark as in many other countries. A wide range of different actions have been established through the years to promote progress and to create change.

2 Process to prepare country story

This report is compiled by Dr. Marianne Jespersen with contributions from Dr. Barbara Hjalsted and Ms. Kirsten Nielsen of the National Board of Health on the basis of existing material and present activities. The National Board of Health is a governmental body responsible for advising and supervising the health care system in Denmark. Many different aspects and activities could be included. Those presented represent only some of the important issues regarding mental health in Denmark.

3 Action for promotion and prevention in mental health

Availability of policies

During the last 15 years, there has been an increasing focus in Denmark on issues concerning mental disorders and its care. A policy to change the system of psychiatric care from the institutional care of earlier times to a community based service was established in the beginning of the 1990s, and is now implemented.

Over the years, there has been a growing political awareness of problems regarding mental disorders and mental health, as well as an increasing political will and commitment in regard to the need for improving mental health services. This has lead to three consecutive 3-year national agreements between the government and the counties (who are responsible for health care services including mental health care). These agreements represent a nationwide strategy for development and improvement of care and treatment offered to patients and persons suffering from mental diseases and disorders. The agreements also contain arrangements for the financing and regular evaluation of progress.

The improvements include education of more specialists - psychiatrists and child and adolescent psychiatrists, psychiatric nurses and other professionals; new and modern hospital facilities (including single rooms for psychiatric patients), further development of community-based psychiatry; improvement in capacity for treatment of children and adolescents with mental disorders and illness; and better intersectoral co-operation. In the beginning, this was particularly focused on community based and social psychiatric services for patients with chronic mental disorders.

Regarding treatment of the individual patient, the major goal has been in securing coherence across sections. The Danish government published a booklet in November 2005 on the central values for intersectoral effort in caring for mentally ill patients¹. The purpose has been to create coherence between treatment and social assistance of the patients. Patients, relatives and professionals from the two sectors have been involved in the establishment of common values.

The focus in the 1990s has been on services for psychotic and severely ill psychiatric patients. In later years activities for non-psychotic patients have been discussed and strengthened, and initiatives have been taken to develop new and better specialized services for specific groups of mentally ill persons, including people with eating disorders and people with dementia.

Non-governmental organizations are actively involved in advocacy, promotion, prevention and rehabilitation activities at national and local levels.

Nevertheless Denmark, as do other European countries, faces a wide range of mental health problems, as outlined in the World Health Organization (WHO) Declaration and Action Plan for Mental Health endorsed at the Ministerial Conference on Mental Health (Helsinki 2005).

In Denmark there are, among other problems, specific problems with suicide, attempted suicide, drug- and alcohol use disorders and growth in psychiatric patients involved in violence and other criminal offences.

Programmes and policies across settings

There are a number of specific policies, programmes and sub-programmes developed in different fields that fit the concept of promotion and prevention. The following represents some detailed examples of activities.

The Danish health policy “Healthy throughout Life”² launched by the Danish Government in 2002, has the overall target of increasing life expectancy, improving the quality of life and reducing social inequality in the health of the Danish population. “Healthy throughout Life” maintains a special focus on collective efforts to reduce the major preventable diseases and disorders through primary prevention as well as support and rehabilitation in relation to patients. Of the eight groups of preventable diseases targeted in the policy, mental disorders constitute a particularly burdensome one. The WHO has estimated that depressive disorders account for the greatest cause of disability adjusted life years (DALYs) in Denmark, amounting to over 8% of all DALYs. The target for the public health policy in relation to mental disorders is that the prevalence of mental disorders should be reduced, and that special initiatives should be taken for children in families with a parent with a substance use or mental disorder.

As part of “Healthy throughout Life”, the National Board of Health initiated the Project on Major Preventable Diseases and Disorders in 2003³. The overall aim of the project is to develop and strengthen the systematic prevention of eight major preventable disease groups and to contribute to systematically integrating disease prevention and health promotion in the treatment efforts of the health care system.

A number of sub-projects have in turn been developed to meet the aim of the Project on Major Preventable Diseases and Disorders, one of them being the subproject focusing on Implementation of physical activity for psychiatric in-patients⁴. The purpose of this subproject is:

- ▶ to strengthen the use of physical activity in efforts to prevent and treat mental disorders among psychiatric patients; and
- ▶ to obtain experience with systematic efforts related to physical activity offered in departments of psychiatry as a model for implementing physical activity in all hospitals.

¹ <http://www.im.dk/>

² <http://www.folkesundhed.dk/media/healthythroughoutlife.pdf>

³ http://www.sst.dk/publ/publ2004/Folkesygdom_Eng.pdf

⁴ <http://www.sst.dk/psykiatriogfysiskaktivitet>

Among people with mental disorders, evidence indicates that physical exercise has a positive effect in supplementing or replacing pharmacological treatment of mild and moderately severe depression. In addition, people with certain mental disorders have an excess prevalence of obesity and type 2 diabetes, and excess mortality from cardiovascular diseases. The reasons include lack of physical activity, inappropriate diet, smoking habits and the side effects of medication. Psychiatric in-patients have longer hospital stays than other in-patients, and this makes it even more important to maintain and expand meaningful and appropriate patterns of activity.

The sub-project is being implemented with a set of specially designed tools as well as staff training in four psychiatric departments across the country. Both process and outcome of the sub-project are evaluated, and a final report is expected by the end of 2006.

Initiatives on suicide prevention⁵

Every day two to three Danes commit suicide – but ten times as many attempt to commit suicide. Denmark has a high rate of suicides and attempted suicides compared to other European countries.

In 1980, the suicide rate in Denmark reached a level that was among the highest in the world, with 35 suicides per 100,000 inhabitants. After 1980 the number of suicides decreased each year, and in 2001 the rate (adjusted for age) was 14 per 100,000 inhabitants, a 60% reduction. The suicide rate among men is about twice as high as among women.

The decreasing number of suicides over time has been explained by the following hypotheses: effects of reduced availability of means to commit suicide; better physical and psychiatric treatment after attempted suicide; increased social and cultural stability in society; more general focus on prevention; and increased access to telephone counselling and psychiatric emergency services.⁶

Measuring the suicide attempt rate poses several methodological problems and results should be interpreted cautiously. Fyn County in Denmark has registered all suicide attempts that have resulted in hospital treatment since 1990. The county registration forms part of the WHO/EURO Multicentre Study of Suicidal Behaviour and Suicide Prevention (MONSUE). The calculated overall suicide attempt rate has remained relatively stable over this period at 180-200 per 100,000 inhabitants. Within the last few years however, there has been a disturbing rise in attempts among young women aged 15-29 years.

In the period 1999 to 2004, the National Committee on Prevention of Suicidal Behaviour under the Ministry of Social Affairs and the Ministry of the Interior and Health, followed up on recommendations for suicide prevention. The recommendations from 1998 were the result of a committee's work under the Danish National Board of Health⁷. The follow-up has consisted of giving advice to and co-ordinating the joint efforts of the government, the counties, the municipalities and the voluntary organizations in suicide prevention work. Major players are centres for the prevention of suicides in Århus county, Fyn county and Copenhagen Hospital Corporation (H:S), "Center for Selvmordsforskning" (the Danish Center of Suicide Research) and the volunteer telephone hot-line "Livslinien" ("the Lifeline").

Some of the most important initiatives were the generation and dissemination of knowledge, capacity building, support of networks and research, and establishing model projects with process evaluation. As a part of the work, the National Board of Health has published guidelines for health professionals for the assessment and management of people at risk of suicide. The Danish Network of Health Promoting Hospitals has launched suicide prevention as a special focus area, and is in the process of securing implementation of the national guidelines for health professionals.

⁵ www.selvmordsforskning.dk

⁶ Nordentoft M, Laursen T.M, Agerbo E, Qin P, Høyer E H, Mortensen P B. Change in suicide rates for patients with schizophrenia in Denmark, 1981-97: nested case-control study. *BMJ* 2004;329:261

⁷ www.selvmordsforebyggelse.dk

The Ministry of Social Affairs has granted financing (DKR40millions) for the next four years, 2005-2008, in order to increase suicide prevention activities, with special focus on young girls, elderly people and the mentally ill.

4 Organizations and resources for implementation

Infrastructures

The counties are responsible for delivering health care services in hospitals and community based psychiatry. The municipalities have certain responsibilities mostly in the field of health promotion and prevention and in the care for infants, schoolchildren and the elderly.

Local initiatives of health promotion are widespread, at schools typically regarding bullying, information about alcohol and drug abuse, physical activities, etc. Non-governmental organizations are often involved in local initiatives regarding mental health issues, by providing information and in supporting activities for people with mental disorders and their relatives.

Workforce for mental health

The primary health care services deal with a large amount of persons with a variety of mental health problems as part of their regular activity. The primary health care system is responsible for caring for the majority of the mental health problems in the population. Only problems needing specialist services are referred to psychiatric specialists and psychiatric departments at hospitals. Social workers, psychologists and others in the social and the educational sector also play an important role in preventive and promotional activities regarding mental health.

The majority of people working in the mental health field are employed by county councils in the psychiatric and child and adolescent psychiatric services at hospitals. Interdisciplinary team work among psychiatrists, psychologists, physiotherapists, occupational therapists, nurses and social workers are regarded as an important part of the psychiatric services delivered at the hospital level. Presently, there is a lack of trained, specialists, particularly psychiatrists, highlighting a special need for action.

5 Monitoring and evaluation

There are a number of governmental organizations that are responsible for monitoring the health services. The major one is the National Board of Health, which has national registers of mortality, patients treated in hospitals and in the primary health care system, and a specific register for monitoring involuntary psychiatric treatment.

Over time, great efforts have been made to develop sufficient and transparent statistics in the National Board of Health and in other settings, regarding health care services in general but also specifically regarding mental ill health. Data are published regularly in the public domain⁸. Statistical reviews and special reports about mental disorders and problems are prepared regularly, dealing with different specific objectives and quality of care.

Psychiatric disorders and treatment are particularly included in quality improvement projects in the health care sector and in health policy programmes, underlining mental health and psychiatry as integrated parts of health and the health care system.

⁸ <http://sundhedsdata.sst.dk>

Estonia

Prepared by Dr. Helja Eomois and Professor Airi Varnik

1 Introduction

Mental health oriented actions in general health promotion and prevention do not form a part of the specific mental health promotion and disorder prevention network. Systematic health promotion activities were launched in 1993, when the Ministry of Social Affairs created a system for financing national and community-based health promotion (establishment of such a system was a condition of the World Bank loan to support health reform). The demand driven system was financed from an earmarked share of the Estonian Health Insurance Fund (EHIF) budget and managed by a committee of experts. The objective was to create demand for health promotion and prevention at a national level and in Estonia's 15 counties, as well as to help to build up capacity and competence in health promotion and prevention. The period 1995-2000 could be described as using the supply of funds by the EHIF to stimulate demand and capacity development in health promotion in general.

According to the Health Care Administration Act (2002), health promotion and prevention activities in Estonia are to be accomplished via intended use projects (health promotion/prevention project applications are submitted once a year on a competitive basis, with all organizations being eligible to apply), financed from the EHIF budget, although there is no specific allocation for mental health in the Health Insurance Fund. All actions that are financed by EHIF have to be in line with the strategies of the Ministry of Social Affairs. There are also promotion activities undertaken by national public health programmes funded from the state budget that belong to the administrative field of the Ministry of Social Affairs.

At present, none of the public health programmes is directly aimed at mental health, neither is any specific disorder prevention programme related to mental health. Today, mental health promotion and prevention have remained a priority mostly in speeches and in documents, rather than in nationwide actions.

2 Process to prepare country story

A general problem of Estonian mental health promotion and prevention is incomplete information. Defining and understanding promotion and prevention is not always clear enough in society and makes information gathering even harder. Promotion projects do not include medical actions like early intervention. When talking about prevention, it is often mixed in with promotion.

3 Action for promotion and prevention in mental health

Mental health became a priority since 2002, because the incidence of mental and behavioural disorders has increased considerably. Priorities set for health promotion and disease prevention for the three year period 2005-2007 are prevention and early detection of cardiovascular diseases, prevention and early detection of cancer, prevention of injuries and poisoning, reducing alcohol related harm, and promoting children's health.

From 2001, the responsibility of setting priorities for EHIF funded health promotion and prevention activities is with the Board of the EHIF following a consultation process with the Ministry of Social Affairs and the main stakeholders to agree the most important topics and to avoid duplication with other programmes. In 2005, the priorities have mainly targeted risk factors of non-communicable diseases like HIV/AIDS.

Although there are no concrete projects referring to mental health promotion and disorder prevention, there are activities that promote health, including mental health, under projects in different settings.

4 Organizations and resources for implementation

The key stakeholders are local governments who, according to the law, must guarantee accessibility of necessary social services for people with mental disorders and must co-ordinate health promotion and disorder prevention activities in their area; for this, EHIF finances the salaries of health promotion officers in county governments. Although the duties of health promotion officers are to co-ordinate and give advice on the implementation and evaluation of local health promotion projects, mental health promotion and prevention are developing slowly.

There is a National Institute for Health Development whose aim is the health promotion of the Estonian population and an increase in the quality of life through knowledge-based development and research activities. The Centre participates in the drawing up of health and social welfare policies and strategies, national health programmes and development plans in its fields. It also co-ordinates the activities of networks of health-promoting kindergartens, schools and hospitals, and the operations of county health councils. The National Institute for Health Development deals primarily with informal training for health care and social welfare professionals.

The Estonian-Swedish Mental Health and Suicidology Institute's (ESSI) main statutory objective is research and development in the field of mental health and suicide. Together with training and research, the ESSI participates in explaining the importance of promotion and prevention activities in the mass media, and disseminates information about promotion and prevention to the leaders of the Republic of Estonia.

The main source of funding of health promotion projects is from the EHIF. Resources dedicated from the general budget to mental health are limited. There are no commitments of the stable funding of mental health promotion/prevention development and not as much support as needed is given at national and community levels. Every three years, the EHIF establishes priorities for health promotion and disease prevention and funding goes mainly to priority areas and to programmes that are not covered by national programmes. About 14 million EEK is allocated for health promotion up to 2007, but it is clear that not all areas are covered. The EHIF invests annually between 0.3% and 1% of its budget for health promotion. In absolute terms, this is between €0.62 and €0.70 per capita. In 2003, the EHIF allocated 13% of the health promotion budget for mental health promotion projects.

5 Evaluation and monitoring

In general, no evaluation studies on the effectiveness of mental health promotion or implementation of mental disorder prevention programmes have been undertaken. There have been evaluation studies on cost-effective interventions for depression and schizophrenia in order to develop mental disorder prevention. Studies on how to increase the involvement of community, primary and secondary health care professionals in the field of mental health promotion and prevention and what might be the benefits for the whole society are missing.

Since 2002, the EHIF has paid more attention to health promotion project evaluation, with the weight of cost-effectiveness accounting for 20% of the overall evaluation score of assessed projects. Evaluation of health promotion/prevention projects is random: only 10% of funded health promotion projects are randomly audited annually.

6 Challenges, opportunities and advances in the field

Estonia has taken steps towards best practices and quality in general health promotion, but not specifically in the area of mental health. There is an urgent need to speed up concrete actions for mental health promotion and prevention, since the proportion of psychiatric disorders in the disease burden is growing. Mental health needs to be incorporated into national health promotion policies and activities. There is a need for strategic

planning and policy development for mental health promotion and disorder prevention, and a need to define roles and responsibilities of multi-year funding of projects and their evaluation.

Promotion and prevention activities have been too much project based and fragmented and have often not been sustainable or reproducible, leading to losses in terms of economies of scale and cost-effectiveness. Activities must meet higher quality criteria and project applications need to include outcome measurement criteria. There is a pressing need to set up a fund for mental health promotion and prevention activities. Per capita allocation of health promotion funds has its strengths and weaknesses. These principles support equity between counties but quality standards can not always be maintained in full, and relatively weaker projects have received funding. A critical mass of health promotion staff at national and local level has perhaps been achieved, but now there is a need for more focus on cost-effectiveness and quality of health promotion activities. Strengthening the evidence base for health promotion and evaluation of cost-effectiveness of actions has been recommended by various sources.

Setting priorities for mental health promotion and prevention in Estonia is expected to happen following the January 2005 WHO European Ministerial Conference on Mental Health, where the Declaration on Mental Health was signed.



Finland

Prepared by Dr. Juha Lavikainen and Dr. Irma Kiikkala

1 Introduction

The roots of the Finnish mental health work reach as far back as the 1800s. Earlier, mentally ill people were isolated, and, later, hospitals were founded for these people. Nowadays, the mental health work is expanded involving various activities and collaboration between citizens, mentally ill patients and their relatives, various experts, and social and health care professionals. The first Finnish Non-Governmental Organization was founded in 1897. Today we have several organizations for mental health promotion and for mentally ill people and their relatives. The legislators have made laws, which have given a good basis for action. Mental health work has become a dimension of the Community policy.

The Finnish society is changing rapidly. The population is becoming older and a smaller group of the people are employees and responsible for the tax revenue; the planned economy system is out of date and we have moved towards a market economy system, in which free competition is strict; information technology is widely in use; commercial and industrial life is changing; new ethnic groups have moved into the country; and values are harder than earlier. The welfare state or affluent society is in transformation and the population has experienced societal stress. So the need for new mental health work, especially for mental health promotion and prevention of disorders is high.

During the last decades the Ministry of Social Affairs and Health has organized several national mental health programmes e.g. Suicide Prevention Programme, Schizophrenia Programme, the National Depression Programme, Meaningful Life, and Mental Health in Primary Services. In this process, there has been a movement:

- ▶ from a sickness approach towards a health approach;
- ▶ from task and worker centred orientation towards client and family centred orientation;
- ▶ from institutional care towards community care; and
- ▶ from special themes (suicide, schizophrenia, depression) towards broad, regional and holistic approaches.

The new regional programmes financed by the Ministry of Social Affairs and Health and by the municipalities themselves are starting all over the country. Collaboration between various ministries for citizens' health and well-being has increased. The Finnish information technology has become a good tool for peer support and other kinds of services.

We can see the "vision" for the community: the community as well as individuals are more tolerant to various people; citizens create supportive activities for themselves and realize their social capital; politicians understand the human consequences of their legislation; and the mental health promotion and the prevention of mental disorders are an integrated dimension of the community at local, regional and national levels.

2 Process to prepare country story

The 'Country Coalition', consisting of governmental officials from different institutes, academics, and representatives of the NGOs, had a meeting in December 2004. Based on the presentations and discussions in this meeting, a memorandum was prepared. Subsequently, the answers to the IMHPA questionnaire and the data on the infrastructures database (www.imhpa.net/infrastructures-database) have been provided for the most part according to the issues outlined in the memorandum. The tasks of filling in the

questionnaire, submitting the data to the infrastructures database and the preparation of this country story were then undertaken by a group of members of the mental health group of STAKES National Research and Development Centre for Welfare and Health.

Persons involved:

Dr. Arja Aro, National Public Health Institute

Dr. Esko Hänninen, STAKES National Research and Development Centre for Welfare and Health

Dr. Eero Lahtinen, Ministry of Social Affairs and Health

Professor Jouko Lönnqvist, National Public Health Institute

Mr. Vesa Nevalainen, The Finnish Psychological Association

Dr. Mika Pyykkö, Finnish Centre for Health Promotion

Professor Katri Räikkönen, University of Helsinki

Mrs. Kristina Salonen, The Finnish Association for Mental Health

Dr. Tytti Solantaus, STAKES National Research and Development Centre for Welfare and Health

Professor Vappu Taipale, STAKES National Research and Development Centre for Welfare and Health

Dr. Timo Tuori, STAKES National Research and Development Centre for Welfare and Health

Professor Kristian Wahlbeck, STAKES National Research and Development Centre for Welfare and Health

3 Action for promotion and prevention in mental health

Availability of policies

An overall policy of mental health promotion is lacking and an outspoken policy of mental health promotion and prevention does not exist at the national level. Mental health is, however, often taken into consideration alongside the general health promotion policies. Due to the division of the responsibilities, the municipalities are in charge of formulating their own policies as well as for the organization of the health services. Some municipalities do have specific mental health promotion policies available, mainly at the local level.

Commitment to prevention and promotion

The mental health group of STAKES has been defining relevant tasks within the context of the WHO Declaration and Action Plan for Mental Health. Subsequently, the recently designated WHO Collaborating Centre of Mental Health Promotion, Prevention and Policy Implementation (MH3P; a joint Centre of STAKES, KTL and the Finnish Institute of Occupational Health) will take on board certain areas of the work plan, in particular those dealing with promotion and occupational health.

The present Minister of Health and Social Services, who co-hosted the WHO Ministerial Conference in 2005, has shown strong commitment in mental health. Nevertheless, prevention and promotion still need to be strengthened so as to become a clear priority at the national level.

Programmes and policies across settings

As mentioned in the introduction, specific national programmes have been carried out on suicide and depression. Both programmes were positively evaluated. A recently completed large-scale programme, "Meaningful Life", brought together stakeholders across sectors and involved activities in many different

areas. There are specific programmes available for children and for the workplaces, but not so much for older people. The national project of well baby clinics in Finland 1997-2002 (European Early Promotion Project) developed methods for promotion of early parent-child relationships and effective prevention in primary health of psychosocial problems among families with infants and young children. The project utilised the existing primary healthcare services, which are well accepted by families with young children. A particular training programme and a manual for identification of risk factors and for carrying out focused interventions were developed to be used with the primary healthcare personnel. In Finland, more than 2,000 primary health care nurses in half of the municipalities were trained in 1997-2002. The working method is also suitable for other primary health care workers and people working in day care and social services.

4 Organizations and resources for implementation

Infrastructures

A wide range of actors are involved in implementation and knowledge dissemination. The Ministry of Social Affairs and Health has power over a specific budget for health promotion in general, from which money can be applied for mental health promotion annually. Furthermore, very recently, several regional programmes have received money for activities that include mental health promotion and prevention of mental disorders. The Ministry has also set up longstanding mechanisms for funding for social care and health care projects. Finland's Slot Machine Association also supports health promotion programmes and non-governmental organizations with considerable amounts. Several NGOs are actively working in the field. There are national, regional and local organizations which belong to this category.

The Mental Health Act (from 1990) maintains that STAKES is the expert agency for mental health work. This means that it also has a role to play in supporting implementation and knowledge dissemination.

Workforce for mental health

The Ministry of Social Affairs and Health and various relevant organizations directly under the Ministry are involved in mental health promotion and prevention. A large number of non-governmental organizations work in the field as well. What is lacking, however, is a clear position (e.g. a professorship) on mental health promotion in the academic institutes and the universities.

5 Monitoring and evaluation

The National Public Health Institute (KTL) has carried out several comprehensive surveys of the health of the population, including mental health. STAKES hosts the national healthcare register, which provides information also on the use of mental health services. Statistics Finland provides information on certain aspects that can be linked to the mental health of the population. This "official" picture is complemented by academic research on various timely and important questions. The information is made available on publications and on websites.

At present, no comprehensive system for monitoring implementation of policies or programmes on promotion and prevention is readily available. Evaluations on efficacy and cost-effectiveness of interventions need to be developed. The need for mental health impact assessment of other policies has been discussed but, so far, no realizable mechanism for this exists.

6 Challenges

Changes in attitudes are needed and tolerance needs to be increased. Decision makers at local and national levels are those that should be influenced. More sustainable funding - away from a strictly project-oriented approach - should be ensured. There is a lack of resources in the municipalities and at present, there is no body or organization that would be clearly responsible for the planning and organization of mental health promotion and mental disorder prevention in the country. More information needs to be provided of the cost-effectiveness of mental health promotion initiatives.

7 Opportunities and advances in the field

The programmes Meaningful Life and Cornerstones of Mental Health have advanced the field considerably by e.g. maintaining promotion of mental health in the media and in public discussion. The WHO Ministerial Conference in January 2005 raised the visibility of mental health remarkably. Another recent advance has been the earmarked money for focusing on the issues of children and adolescents provided in the years 2000, 2001, and 2002. The implementation of eight regional programmes has just started, funded through the earmarked budget of the national healthcare programme of the Ministry for this purpose.

The international projects (IMHPA and EMIP) provide opportunities for raising awareness of mental health promotion and mental disorder prevention. There is already a long tradition in the mental health group of STAKES in both co-ordinating and participating in EC-funded mental health projects.

France

Prepared by Professor Vivian Kovess

1 Introduction

France has a long tradition with the prevention of mental disorders; indeed “prevention” was mentioned in the “secteur” tasks since its foundation in the 1960s. Catchment teams were supposed to be responsible for providing care, rehabilitation as well as prevention to areas of 70,000 people for the adult “secteurs” and 200,000 for the children “secteurs”.

However, prevention has been diversely implemented across the country. Children secteur teams have implemented remarkable work by sending nurses into schools and, more generally, through their active participation in different childhood interventions. In France, prevention in mental health is mainly focused on informing the various actors about the symptoms of severe mental disorders, so that children can be referred to child psychiatry. The exception to this is suicide prevention, which has been largely developed in most regions, involving different actors in various settings.

2 Process to prepare country story

The national institute for prevention: INPES (Institut National de Prévention et d'Éducation pour la Santé) has undertaken a review of the different experiences, in association with the mental health division at the Ministry of Health. This has been supplemented with information from some key people working in the field.

3 Action for promotion and prevention in mental health

Beside the “secteur” policy mentioned above, which refers to prevention as a general goal, different regions have placed prevention on their agendas since health policy has been decentralised. Notably, most regions have addressed suicide prevention with policies oriented to young people, people attempting suicide, and older people. Some local areas have developed training programmes for general practitioners, and some have developed actions toward socially fragile populations.

To support suicide prevention, the health ministry commissioned a task force on managing people who have attempted suicide, with nation wide influence. Training in suicide prevention has been provided to at least one person in each region who has then become a trainer in their own region. Specific programmes have been developed in prisons, where suicide is a major risk, through information and training of prison staff.

The national institute of prevention has been commissioned to publish guidelines for suicide prevention for youth.

More recently, a mental health and psychiatry plan recommended mental health networks to support joint working of general practitioners and psychiatrists; the basis is continuing education, which will hopefully enable the general practitioner to be more effective in managing most mental disorders, particularly depressive disorders which increase the risk of suicide.

A major public campaign is being prepared by INPES to inform people about the most frequent mental disorders. It will begin with depressive disorders in order to facilitate recognition and adequate treatment, which hopefully will reduce suicide rates.

Exchanges have been organised between recognised mental health promotion programmes for under privileged children such as “starting well” in Glasgow or “Triple P” in Australia and one deprived area in the Parisian suburb. Other preventive actions have been developed in obstetric wards through intensive interdisciplinary work in order to prevent mental health problems in the children of underprivileged and at risk women.

For children, some programmes have been implemented to reduce violence at school, based on French Canadian adaptation of programmes developed in the United States. At the national level, a violence plan is being developed proposing interventions for at risk women, children and older people.

Prevention of alcohol related problems is being implemented at local levels and at work places.

The WHO Declaration and Action Plan for Mental Health, endorsed at the WHO Ministerial Conference on Mental Health (Helsinki 2005), are coherent with current actions and have provided important support for officials working in the Ministry of Health.

4 Organizations and resources for implementation

Infrastructures

INPES is the main national level structure that provides documentation and manuals in order to support training and action, including mental health, although it is only a small part of its work.

INPES co-ordinates a nationwide network of health educators who act at the regional level along with regional health education committees.

The social security system and the complementary system (mutuelles) can also provide prevention, although very little is currently implemented in mental health.

Workforce for mental health

In theory the “secteur” workforce is part of the prevention mental health workforce, but its action remains mainly focused on secondary and tertiary prevention. In the health prevention workforce there is no specific workforce for mental health.

5 Monitoring and evaluation

INPES conducts regular mental health surveys in order to monitor if information campaigns have modified attitudes towards mental health problems. Regional programmes on suicide prevention have been evaluated by the Public Health National School (ENSP) with findings of decreased suicide rates in those regions which have implemented plans compared to those regions which have not.

6 Challenges

There is no formal training at universities, there is no research in mental disorder prevention, and there is nearly no evaluation of implemented interventions.

Mental health and psychiatry are not differentiated in the field creating much confusion, which is counterproductive, since a scarce psychiatric workforce may involve itself in prevention, without proper training.

More generally, there is a complete ignorance and eventually a suspicion toward prevention and promotion literature, which are perceived as in contradiction to psychoanalytic theories that are prominent in child

psychiatry. Since psychiatry has involved itself in prevention, this makes promotion/prevention interventions difficult to set up.

Domains and professionals are compartmentalized. Educators, psychologists, health educators, social workers, general practitioners, psychiatrists, and judiciary professionals do not work together and do not share a common vision about mental disorder prevention, although the child “secteur” provides a good example of trying to work together in the field.

7 Opportunities and advances in the field

The creation of a national institute for education and prevention, in which mental health has been identified as part of the mandate, is a big step forward. The involvement of cities and regions in the field is also a major asset, together with the place given to prevention/promotion in the mental health psychiatric plan.



Germany

Prepared by Dr. Karl Kuhn

1 Introduction

There have been several phases in the discussion of the German Health system, about the role of prevention and about health reforms. Input was given by the report of the Advisory Council in Health Care. Output has been reforms in the health system. And now there are concerted actions in health promotion and in prevention, including a proposal for prevention legislation, and a Forum for prevention and promotion, etc.

In May 1999, the Federal Ministry of Health (MoH) ordered the Advisory Council for Concerted Action in Health Care to compile a special report on the improvement in the health care system. The report was to give special consideration to quality assurance and new approaches for the reimbursement of health care services, the role of health objectives, prevention, and the competence of the insured and general medical practice. The report was referred to the legislative bodies immediately upon receipt. For the first time, the Advisory Council attempted to provide a basic definition of the appropriate provision of health care in the sense of Book V of the German Social Code. It surveyed the pertinent organizations in the health care sector, including patient groups, to gather information on overprovision, underprovision and inappropriate provision. The responses of the surveyed organizations were weighed against scientific knowledge and the expertise of the Council members and used in the analysis of the German health care system to identify deficiencies as well as opportunities for improving quality and efficiency. For the first time, the Council had a clear remit to identify the weaknesses of the German health care system. The Council provided a broad range of valuable information that has been used in the course of future health policy decisions and planning.

According to the Advisory Council, the German health care system suffers from structural deficiencies in the provision of health care services for the seven chronic diseases analysed in the report as well as from wrong trends and misallocation. These are due in part to ingrained habits and modes of behaviour that lead to overprovision, underprovision and inappropriate care, with a predominance of acute medical care.

Appropriate and efficient care is defined under the terms of the German Social Code when a health care benefit is medically indicated, when there is scientific evidence that a health care service provides a net benefit, when the care is provided at accepted medical standards, and at an acceptable cost-benefit ratio. These concepts provide the basis for the definitions of overprovision, underprovision and inappropriate care. **Underprovision** is given when health care services are not provided even though there is individual, professional, scientific or social acknowledgement of need, adequate evidence that treatment will provide a net benefit and that the required service can be provided efficiently. **Overprovision** is the provision of health care services that include unnecessary services or services for which there is no solid evidence of their net benefit, services with so few benefits that the costs are not justified or services that are provided inefficiently. **Inappropriate provision** is health care that results in an avoidable damage, including the provision of appropriate services that result in avoidable damages due to the unqualified provision of the service, the provision of inappropriate services that result in avoidable damage, and the failure to provide appropriate care or the failure to provide appropriate care promptly. Inefficiencies may result from any of a number of inappropriate forms of health care provision.

Focus on prevention and goals. With its remarks on the need for and increased focus on prevention and targets in the health care system and the demand for centering care on patients, the Council confirmed the necessity and correctness of the legislative initiatives and supporting measures taken during the legislative period after 1998. Prevention and health promotion have a higher policy status since the Health Care Reform 2000. In particular, prevention has been reinforced by the procedure for the development and agreement on health targets, which the Council also called for. The planned anti-smoking campaign and additional

educational measures on healthy eating habits, physical activity and the avoidance of stress are intended to provide the public with a practical concept for a healthy life-style that is aimed not only at avoiding certain diseases but at the long-term prevention of a range of health impairments.

Depression

Building on the progress attained since the Psychiatry Study of 1975, it has been necessary to follow the Council's call for the continuation of efforts to increase public awareness for the special significance of mental health in the context of a broad concept of health and to continue to reduce existing social prejudices against psychiatric diseases. Depressive disorders, which affect the elderly in particular, are a classic example of the need for intersectoral health policies that are not restricted to health care measures in the strict sense. This is evidenced by the recent position paper of the German federal government on the Report on the Elderly.

The use of guidelines. Early diagnosis is of central importance for the treatment of depression. Therefore, evidence based guidelines for the diagnosis and treatment of depressive disorders in general practice must be developed and implemented in order to promote improvements in the care of patients with depression. The necessary initiatives have already been launched by the scientific medical societies. Self-government can provide effective support for the implementation of guidelines for detecting and treating depressive disorders by combining them with fee regulations. This recommendation of the Council could be taken into consideration in the current round of negotiations for a sweeping reform of the reimbursement system for office based doctors.

The MoH has a positive view of the recommendations for making the remuneration of certain services contingent on continuing education requirements and on the structured co-operation of general practitioners and specialists, e.g. with respect to mutual referral practices and indications for depressive patients. It remains to be seen whether a legal solution will be required. These measures should be supported by an increase in psychiatry courses and content in the training and continuing education curricula for general practice and internal medicine. Initiatives of the self-governance institutions and state authorities are necessary for this purpose.

Research projects and pilot projects. Since the detection and treatment of depression require intersectoral and interdisciplinary measures, a competency network entitled "Depression and Suicide" was created as part of the joint health research programme of the MoH and the Federal Ministry of Education and Research. Total funding for the project is €9 million, which makes it the largest project on depressive disorders in the history of the German health care system. The project is aimed at increasing doctors' competence in the detection and treatment of depressive disorders, in particular by initiating co-operation among research centres, special clinics and office-based doctors, especially those working in family practice. The creation of such networks has a considerable potential for enhancing efficiency and improving health care. As part of its research programme, the MoH is promoting a "Geriatric Psychiatry Leaflet" for family doctors and general practitioners. The leaflet focuses on the early detection of dementia, but this requires a differential diagnosis in which depression plays an important role. The MoH believes that the creation of a geriatric psychiatry network as recommended by the Council as a means for improving co-operation among existing facilities will be an important factor. A number of projects in geriatric psychiatry have been funded as part of the pilot project entitled "Psychiatry" and are still serving as a model at federal and state level.

The Guideline for Outpatient and Semi-Stationary Geriatric Psychiatry Care (Volume 114 of the MoH Publications), which analyses the current state of knowledge in different areas (medicine, nursing, socio-economic issues, etc.), also deserves mention in this context. The publication provides information on diseases, the necessary practical concepts, procedures, co-operative approaches and financial measures. In addition to a wealth of special literature, the book also provides the results of completed pilot projects of the MoH. The guideline contains general recommendations for the organization of health care services from a professional perspective.

In addition to the measures of the MoH are those of the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) that are concerned with “geriatric services of the future” and focus on the situation of the elderly. Together with legal measures, the BMFSFJ has promoted pilot projects that build on the Council’s call for more consideration of the special needs of elderly patients with psychiatric disorders in the design, construction and staffing of homes for the elderly. In the same vein, the MoH commissioned a model expertise on “The Situation of Patients with Psychiatric Disorders in Homes”. The report should provide additional concepts for systematic surveys on this topic.

Since 1999 the Federal Ministry of Education and Research (BMBF) funds the “German Research Network on Depression and Suicidality (Kompetenznetz Depression, Suizidalität)” within a large-scaled national programme addressing various diseases including psychiatric disorders like schizophrenia, dementia and depression. The network links more than 15 university hospitals and other research institutions as well as the most important institutions of the German health care system (e.g. health insurance funds and associations of consultant practitioners), scientists, general practitioners, psychotherapists, self-help groups, patients and many other institutions and individuals involved in the care for depressed or suicidal patients. The project addresses professionals and scientists, affected patients and their relatives and the total population at the same time. Since 1999 more than 20 individual projects have been initiated with the goal of improving awareness of the general population for depression, suicidality and related problems and provide information about diagnosis and treatment options. The instruments used include professional press and media work, preparation and dissemination of information material to training for experts and the development of differentiated train-the-trainer concepts. During the last years the homepage of the network has become a very important tool for this purpose (www.kompetenznetz-depression.de).

The outstanding role of GPs and the primary care level is reflected by the fact that two GPs are members of the steering committee of the network and several projects have established a close cooperation between research institutions and the primary care level. Further education of GPs (e.g. concerning the communication with suicidal patients), evaluation of screening instruments for depressive disorders and their establishment in everyday practice of GPs are important elements of these aspects. Even though effective treatment strategies already exist, their application can not be assured in all cases. Thus a relevant topic of the network is to develop, improve, establish and disseminate easy-to-apply guidelines, ranging from simple screening procedures to strategies for correct diagnosis and detailed treatment guidelines for pharmacological treatment of depression. The identification and definition of the interface between general practice and specialists (psychiatrists, psychiatric services) is closely linked to these tasks.

As a project to prevent depression and suicide, the “German Alliance against Depression” (“Deutsches Bündnis gegen Depression e.V.”) emerged in the framework of the “German Research Network on Depression and Suicidality“, following a so-called multi-level approach. By initiating parallel interventions on different levels the action-oriented “Alliance against Depression” aims at the improvement of adequate supply for depressed patients. The project has been tested in the city of Nuremberg for the first time. First results during the pilot phase have been promising and indicate a decrease in suicidality. In 2003 the “Alliance against Depression” was also launched in several other regions in Germany. By November 2005, 26 regional Alliances have been formed, adapting the multi-level-approach and joining a federal Alliance.

Flanking measures. There is a need for further work on the appropriate expansion of semi-stationary care services and semi-stationary geriatric psychiatry care facilities that are close to home. Initiatives of the states in co-operation with hospitals to shift the focus of excess capacity in the hospital sector are welcomed by the MoH. Furthermore, geriatric psychiatry should be granted a greater role in the curricula of medical specialists and their continuing education as well as in the continuing education of psychiatric nurses. To reduce existing prejudices against patients with depressive disorders, the project “Psychiatric Patients e.V.” conducts public education initiatives on psychiatric diseases with the support of the MoH. The improvement of social acceptance for psychiatric patients is also a topic that will be dealt with and evaluated for any

necessary action in the course of a survey of the care situation by a MoH working group for the development of psychiatric care. Additional action to reduce existing social discrimination and reluctance to speak openly of depression can result from the project health targets (“gesundheitsziele.de”).

Increasing the focus on patients. The MoH assumed that the inclusion of quality considerations in contracts will increase transparency in the provision of health care. Along with improved methods for revealing the strengths and weaknesses of the system, this will serve to increase the focus on patients as well as to improve the protection of patients. The status of patients and of persons in need of care, who are supposed to be the focus of the health care process, has been improved through expanded rights to information and counselling. Furthermore, there are plans for the introduction of a voluntary health identity card. This could contain more information on treatment, would help avoid the duplication of examinations and increase patient safety by reducing the undesired effects of therapies.

Joint action on a social basis. Overall, the MoH viewed the analysis and recommendations of the Advisory Council as a call for all actors in the health care system to focus on patients in the health care system; to analyze their own priorities and positions; to reduce the weaknesses of the system and build on its strengths; to recognize the proven elements of the system and promote necessary reforms.

The report of the Council was the beginning of a phase strengthening health promotion in the health system of Germany.

2 Process to prepare country story

The first report was drafted by Karl Kuhn.

3 Action for promotion and prevention in mental health

Availability of policies

Due to the modification of Article 20, of the law, SGB V (2000), health promotion is now an obligation for the health insurance funds in Germany. The general aim is to improve the health condition of members of the insurance and their families, and to reduce social inequalities in health. Moreover, the implementation of outcome oriented prevention and health promotion should be stressed in order to achieve mid-term positive results on quality of life and productivity. Only qualified providers of health activities are allowed by the insurance funds.

In the year 2000, the Associations of Health Insurance Funds developed guidelines, which were modified and enlarged during the following years. The guidelines assure quality management of health promotion activities, documentation of all activities, and evaluation. There are clear orientations for the qualification of providers of health promotion activities. There is a difference between individual approaches to change behaviour (physical activity, nutrition, stress reduction, drug abuse), and setting oriented approaches by building structures and changing adverse conditions (i.e. for schools, municipalities/local activities, establishments and workplaces). Mental health promotion and prevention of ill health are clearly targeted within this frame.

Because of the legal base there is a clear commitment of all social security carriers to promotion and prevention. In the year 2003, there were 638 different documented programmes in 955 different settings with coverage of 539,000 persons. Nearly 66% of these activities were oriented to mental health promotion. Thirty per cent of interventions in schools were oriented to mental health promotion, and 15% to drugs and addiction. In the year 2003, there were 1,555 workplace health promotion programmes which covered 680,000 persons at work; 24% of all programmes dealt with health oriented leadership, 20% with stress management and 13.4% with addiction.

4 Organizations and resources for implementation

Because the costs of promotion are covered by the health insurance funds there exists a very tight net of institutions, providers and services at the federal, state, and local levels. At the Federal Level there is "The German Forum for Prevention and Health Promotion", a platform established in 2001 by the Federal Ministry for Health and Social Affairs, involving associations, institutions, public authorities and co-operatives. The Forum develops health goals and it co-ordinate the policies in this field with all relevant stakeholders. Linked to this Forum is the German Network for Workplace Health Promotion (WHP). The network aims to strengthen the development and dissemination of good workplace health practices in Germany. It aims to improve the profile of WHP and to make co-operation possible between all relevant stakeholders. The network operates in six forums, each independently covering specific WHP settings: health care and welfare, education and training, (larger) private sector enterprises, small and medium sized enterprises, labour markets and public administrations. The network secretariat is based at the Federal Association of Company Health Insurance Funds (BKK). Its work is overseen by an advisory board which involves all relevant institutional stakeholders such as the social partners, the responsible federal ministries, a representative of the German Laender, the umbrella institutions of social insurance and relevant professional associations. The network is financed by the Federal Association of Company Health Insurance Funds (BKK) and the German Federation of Institutions for Statutory Accident Insurance and Prevention (HVBG). The network is open to all stakeholders in workplace health promotion. This applies to enterprises as well as to networks and individuals. Mental Health Promotion is part of the work of this Forum.

Each forum holds an annual "Forum Conference" and presents its conclusions and working programmes to the "Network Conference". Each forum is led by a team of co-ordinators and develops its own agenda. Based on this agenda, each forum reviews the current state of development, collects successful WHP methods, builds up a pool of arguments which helps justify investments in WHP, and develops recommendations and strategies for future implementation.

5 Monitoring and evaluation

All funded programmes are documented (content, target group, kind of intervention, etc.). A new concept is under discussion for the evaluation of the programmes.

6 Challenges

Prevention is defined in the social system of Germany very differently in the various security funds. There is a discussion of new legislation about prevention and promotion to standardise this field and to develop and strengthen prevention in all different social security systems. This prevention legislation has passed the parliament but not the Federal Council.

Greece

Prepared by Dr. Athanassios Constantopoulos

1 Introduction

In Greece, before 1983-4, mental health care was traditionally based in nine large psychiatric hospitals. The reform of the mental health services began in 1983 through the passing of the National Health System Act, in combination with Regulation 815/84 of the then EEC (now EU), which provided co-funding for the reform of the mental health services in Greece. The components of the policy thus formulated were advocacy, promotion, prevention, treatment and rehabilitation. Since then, there have been a number of 10-year National Plans for Mental Health that were co-funded by the EU, the latest of which (code name "Psychoargos") was drawn up in 2001, and which will be revised every five years. The current plan is anticipating the closure of five out of the nine psychiatric hospitals by the end of 2006, and the remainder by 2015. The first psychiatric hospital that closed through this plan was the Petra-Olympus Hospital, in January 2004. Through the reform process of creating alternative facilities to traditional care, 31 mental health centres, 60 psychiatric units in general hospitals, 12 day centres, 27 child guidance clinics, 302 rehabilitation units (hostels, boarding houses, sheltered flats) and 69 vocational rehabilitation centres were in operation by the end of 2004. Since the reform process began, 65% of the beds in psychiatric hospitals have been closed.

2 Process to prepare country story

The country story for Greece has been drawn up following the efforts of a group of interested parties involved in the field of mental health.

A small expert group was initially convened to discuss the structure of the questionnaire, to clarify certain questions, to discuss globally the available information, the spectrum of organizations active in the field, and the methodological approach for processing the data to be gathered in case consensus could not be reached by the network. Following this, a larger group of people active in the field of mental health were brought together to complete the European Questionnaire on Mental Health Promotion and Mental Disorder Prevention (www.imhpa.net/questionnaire). The aim of the meeting was to share information and knowledge, and to seek agreement on response to the questionnaire. Many documents had already been received from the members of the group, and were available for reference.

It was expected that participants would have different perspectives on and levels of knowledge about mental health promotion and mental disorder prevention. Following a lively process of information exchange, it proved relatively easy to reach consensus. It was therefore not necessary to resort to the statistical processing of individual responses which had originally been envisaged following the initial meeting of the small expert group.

The co-ordinator later completed the questionnaire (www.imhpa.net/infrastructures-database) and drew up the country story, using the results of the group process. Group participants came from the Department of Mental Health of the Ministry of Health and Social Solidarity of Greece, academic institutions, mental health practitioners, public health experts, various NGOs, and included representatives from the field of Primary Health Care (Greek Union of General Practitioners, Greek Association of General Practitioners - "Elegeia").

Persons involved in the group/coalition:

Dr Stella Argyriadou, Health Centre of Chrisoupolis

Mr Haris Asimopoulos, Association for the Psychosocial Health of Children and Adolescents, (A.P.H.C.A.) – NGO

Dr Anastasia Christofelis, Greek Union of General Practitioners

Dr Athanassios Constantopoulos, Mental Health Centre of Xalandri – Ag.Paraskevi

Dr Susan Gregory, Department of Health Economics

Mr Dimitris Hondros/ Mr Nikos Gionakis, Monitoring & Support Unit for the implementation of the “Psychoargos – B Phase” Programme

Dr Kyriakos Katsadoros/ Mr Constantinos Prouskas, KLIMAKA – NGO for the Development of Human and Social Capital

Professor Christos Lionis, University of Crete, Faculty of Medicine, Department of Social Medicine, Division of Social and Family Medicine

Professor Michael Madianos, Athens University Nursing School, Mental Health Centre of Zografos

Mrs Kalliopi Mavratzotou, Department of Mental Health, Ministry of Health and Social Solidarity

Professor Eleni Petridou/ Mr Sakis Dinapoyas/ Ms Stellina Kiosse, Centre for Research and Prevention of Injuries, CEREPRI

Professor Dimitris Ploumpidis, Athens University Medical School, Mental Health Centre of Vironas – Kessariani

Dr Athanassios Simeonidis, Greek Association of General Practitioners (ELEGEIA)

Ms Ekaterini Sokou, Sector of Health Promotion in Schools, Institute of Child Health

Dr Stelios Stylianidis/ Mr Panayotis Chondros/ Ms Stella Padelidou, Scientific Association for Regional Development and Mental Health - NGO

Mr Costas Yannopoulos, The Smile of the Child - NGO

Mr Petros Yannulatos, National School of Public Health

3 Action for promotion and prevention in mental health

Availability of policies

The mental health policy was initially formulated in 1983-84^{1,2} and has been continuously updated^{3,4,5} a fact which is reflected in the successive ten year National Plans for Mental Health. The latest ten year National Plan for Mental Health (“Psychoargos”⁶) was revised in 2001 and will be revised every five years. The main points of this plan are: the continuation of de-institutionalization and de-stigmatisation; sectorisation of the mental health services throughout the country; continuation of the development of primary mental health care

¹ Act 1397/83 National Health System. Article 21 “Psychiatric Care”. Government Gazette 143/A/7.10.1983.

² Commission of the European Communities. Council regulation (EEC) No 815/84 of 26.03.1984. Official Journal L088, p 0001-0003, 31.03.1984.

³ Commission of the European Communities. Council Regulation (EEC) No 4130/88 of 16.12.1988. Official Journal L362, p.0001-0002, 30.12.1988.

⁴ Act 2071/92 Modernisation and Organisation of the NHS. Chapter 6 “Mental Health”. Government Gazette 123/A/15.07.1992.

⁵ Act 2716/99 Development and Modernisation of Mental Health Services. Government Gazette 96/A/17.05.1999.

⁶ Psychoargos 2001-2010. Programme for the Development of Infrastructures in the Mental Health Sector. Ministry of Health and Welfare of Greece, Athens 2001.

units (mental health centres) and psychiatric units in general hospitals; continuation and intensification of the development of rehabilitation facilities; establishment and development of patient co-operatives in order to promote the social, economic, and occupational reintegration into society of patients with severe psychiatric problems; and, establishment of detailed guarantees and procedures for the protection of patients' rights. In addition, for the period 2000-2006, there is special emphasis on the areas of child psychiatry, psycho-geriatrics, and the development of specialist services (e.g. Autism, Alzheimer's).

Promotion of mental health and prevention of mental disorders are included in the current health policy and legislation on mental health as well as in the areas of employment policies, social justice, education and social inclusion.

Commitment to prevention and promotion

Mental health promotion and mental disorder prevention feature in all key legislation and policy documents, though in practice the priority remains the development of community mental health services which primarily focus on secondary and tertiary prevention.

There has been a continuous increase in resources for mental health since the beginning of the reform; this increase has been accelerated in recent years. Under current legislation there is no provision for a separate budget for mental health within the overall health budget. It follows, therefore, that there is no possibility for a defined budget for mental health promotion and mental disorder prevention.

Greece welcomed and is a co-signatory of the *WHO Declaration and Action Plan for Mental Health in Europe*, which establishes a solid framework for mental health policy, and which hopefully will encourage and facilitate more emphasis on mental health promotion and mental disorder prevention, through raising awareness of policy makers, mental health practitioners, service users, and the general public.

Programmes and policies across settings

There is no nationally co-ordinated programme for mental health promotion and mental disorder prevention across settings. However, there are programmes operated by various agencies, such as those run by mental health units (mental health centres) of the Ministry of Health and Social Solidarity, the Ministry of Education, academic institutions, local authorities, and NGOs. These programmes often run in isolation, illustrating the need for more exchange of information, dissemination, and co-operation and co-ordination between the agencies involved in them.

4 Organizations and resources for implementation

Infrastructures

There are a number of government departments and units, academic bodies, professional bodies, and NGOs involved in developing the knowledge base for mental health promotion and mental disorder prevention, implementation, and information dissemination for health care professionals. These bodies act more or less in isolation, aiming at specific target groups, and therefore potentially valuable information and experience is not disseminated for wider use to the multiplicity of agents in the field, again demonstrating the need for more co-operation and co-ordination.

There is no specific budget for mental health promotion and mental disorder prevention, as there is no separate mental health budget within the overall health budget, as explained in the section on commitment to promotion and prevention above.

Workforce for mental health

The workforce involved in mental health promotion and mental disorder prevention in Greece comes from a diversity of settings and sectors. These include the National Health System (primarily the mental health centres), NGOs involved in mental health and public health, professional bodies, the Ministry of Education, and local authorities. The professions involved in this field include psychiatrists, child psychiatrists, psychologists, social workers, psychiatric nurses, psychiatric health visitors, speech therapists, occupational therapists, general practitioners, health visitors, teachers, school psychologists, etc. It must be noted that the vast majority of the above professionals throughout most sectors have mental health promotion and primary prevention of mental disorders as only a small part of their brief. However, mental health professionals are heavily involved in secondary and tertiary prevention.

Although training programmes specifically targeted towards mental health promotion and primary prevention of mental disorders are scarce, there are initiatives that emanate from in-service training, especially of health professionals, working in different settings and sectors, which are slowly helping to build capacity. Specific higher education on mental health promotion and mental disorder prevention is offered by the Faculty of Nursing of the University of Athens, and the Department of Psychology of the Panteion University of Athens.

Collaboration across disciplines for training and action on mental health promotion and mental disorder prevention is taking place in settings and sectors where multi-disciplinary teams operate, for example mental health centres and most NGOs.

5 Monitoring and evaluation

For historical reasons, a culture of monitoring and evaluation is not yet developed in the wider public sector in Greece, in contrast to the private sector. Information systems are being gradually introduced in health services, but their application is still far from comprehensive. There is no tradition of evaluation research, and there are limited examples of evaluation of efficacy and cost-effectiveness of interventions.

A step in the right direction as far as the strengthening of promotion and prevention, and the encouragement of a culture of monitoring and evaluation are concerned is the recent Act on *Organisation and Operation of the Services for Public Health*⁷, which establishes a National Strategy for public health and a four yearly National Action Plan for public health which is binding for the health services and for regional administration and local authorities. In addition, it is hoped that the White paper on *the Quality and Safety of Health Services and the National Health Information System*, due to become legislation in the near future, will firmly establish evaluation, monitoring and quality control procedures for the health services.

6 Challenges

In Greece there is a need for the development of a culture vis-à-vis mental health promotion, as there is generally (as identified by the country group outlined in section 2) a problem of a clear distinction between promotion and prevention. These two concepts are always referred to together in official policy documents, usually without clear differentiation of which actions belong to each concept, the result being that the emphasis is subsequently put on prevention, and particularly on secondary and tertiary prevention, with which most of the health professionals are familiar through their training curricula and experience.

Despite the positive developments related to the reform of mental health services over the last 20 years, there are many difficulties to overcome in moving towards establishing a national action plan for mental health promotion and mental disorder prevention. Until now, the emphasis of the reform has been on improving

⁷ Act 3370/05 Organisation and Operation of the Services for Public Health. Government Gazette 176/A/11.07.2005

access to appropriate community care, as opposed to the previously available hospital care. The number of new community care units, especially mental health centres and psychiatric units in general hospitals, is still lower than that required to meet the needs of the population, the result being that even those mental health units with an explicit brief for promotion and prevention, such as the mental health centres, due to the pressure of responding to the demand for treatment and care, have not been in a position to develop the appropriate services for promotion and primary prevention that are foreseen by their constitutional mandate. This also reflects what is happening within the wider context of the National Health System, where public concern is focused on access to, and reduction of waiting times for assessment and treatment, and therefore promotion and prevention must compete for limited resources, with treatment issues dominating the agenda. To shift the attention of the general public, policy makers, professionals and service users will require a significant cultural change in Greece. Crucial to such a change is the alliance and co-operation with the media in highlighting and giving prominence to issues of promotion and prevention in the field of mental health, and the factors which influence mental well-being.

7 Opportunities and advances in the field

The main opportunity for the development of mental health promotion and mental disorder prevention arises through the reform of mental health services which now is firmly established and which in recent years has been accelerated. The further development of facilities, which will result in the provision of comprehensive mental health services, will allow for the necessary shift in attention to mental health promotion and mental disorder prevention. The existing legal and policy framework supports such a shift, as Act 2716/1999 *Development and Modernization of the Mental Health Services* states explicitly that the State has the responsibility for the promotion of mental health and the prevention of mental disorders, and the latest National Plan for Mental Health puts an emphasis on providing services for people with a mental illness that are designed to promote their well-being and social development.

It is expected that another major opportunity will arise through the recent Act on *Organisation and Operation of the Services for Public Health*, which establishes a National Strategy for Public Health and a four yearly National Action Plan for Public Health, the application of which is obligatory for central and regional administration and local authorities. An innovative aspect of the Act is the placement of emphasis on an intersectorial and multidisciplinary approach with specific references to the health impact of policies emanating from non-health sectors.

Finally, the White paper on *the Quality and Safety of Health Services and the National Health Information System*, due to become legislation in the near future, constitutes a major innovation, and is expected to promote the development of a culture of evidence-based practice. It provides for the firm establishment of evaluation, monitoring, health indicators, effectiveness, efficiency, economic evaluation, and quality control procedures for the health services. In addition, and very importantly, it provides for the health information system necessary to back up these developments.

Hungary

Prepared by Dr. Csilla T. Csoboth and Professor Maria S. Kopp

1 Introduction

The prevalence of mental disorders, especially of major depressive disorders and substance use disorders are on the rise in Hungary. The prevalence of depression was 19.9% in one population study¹. 7.6% were found to suffer from severe depressive symptomatology, and almost every third person has depressive symptoms which affect their quality of life². At a given moment 300-400 thousand people are suffering from depression, but only 40 thousand have a medical diagnosis³. Mental disorders are also an important issue among the elderly; according to the data of the Hungarian Central Statistical Agency, the incidence of psychogeriatric disorders among Hungarian men and women over the age of 60 years is 131.6/1000 and 144.3/1000 respectively⁴. In Hungary there is an important relationship between excessive alcohol consumption and depression. The estimated number of people with alcohol dependence is 600-800 thousand, but only about 10% of them seek medical treatment.

Hungary has a high suicide rate, which, fortunately has decreased by 35% from 4,500 in 1980 to 3,000 in 2000⁵. The cause of the high rates and the reason for the decrease is currently under study, but the political and economic changes from 1990 most probably had an important effect. The numbers of psychiatric outpatient clinics, psychiatrists, and crises hot-lines have increased, with an associated reduction in suicide rates. Nevertheless suicide rates per 100,000 inhabitants are still one and a half times more than in neighbouring Austria.

6.5 million prescriptions for psychopharmaceutical drugs were issued in 2003 (for a population of 8 million inhabitants), more than 50% of these being antidepressants¹.

Despite these statistics, mental health promotion and mental disorder prevention are not a priority at the state level in Hungary. There have been several attempts to improve policies regarding mental health promotion, but financial and human resources are scarce, thus impeding the true implementation and effect of state devised policies. The total health expenditure on health is 7.8% of the GDP⁶. Mental health promotion programmes in Hungary have been mainly implemented by non-governmental organizations, due to the lack of financial support from government agencies. To make matters worse, the number of psychiatrists working in Hungary has been decreasing over the last few years, with less than 800 undertaking clinical work. According to the College of Psychiatrists there is a need of about 1,200 specialists.

2 Process to prepare country story

Findings in this report are derived from a web-based research of relevant organizations in Hungary (i.e. Hungarian Ministry of Health, Research Institutes, Mental Health promotion networks, social security, health insurance funds, NGOs, etc.) and Hungarian Scientific publications.

The assessment of information is currently a first step in data collection, which should be expanded in the future. Hungarian data should be pooled into one centre and made available to the public as a mental health resource centre.

¹ Szádóczy, E. (2000). Kedélybetegségek és szorongásos zavarok prevalenciája Magyarországon. Budapest: Print-Tech Kiadó.

² Hungarostudy, 2002

³ http://www.radio.hu/index.php?cikk_id=39672

⁴ http://www.informed.hu/index.nfo?tPath=/betegsegek/betegsegek_reszletesen/geriatrics/&article_id=42310

⁵ Central Statistical Agency, 2001

⁶ <http://www3.who.int/whosis/country/indicators.cfm?country=hun&language=en#economic>

3 Action for promotion and prevention in mental health

After extensive research, we were unable to find publicly available policies for mental health. Since the ruling political party changes every four years, the mental health policy that was devised in 2001⁷ for a ten year period is currently disqualified and an effective substitute policy has not been formed. The goals of the former policy were to decrease suicide among youth and adults, to support the primary prevention of mental health disorders, to support international projects, to develop the existing mental health promotion institute, to improve the treatment of depressed patients, and to improve the psychiatric outpatient clinic network. Actions planned included research, prevention projects, long-term care, rehabilitation, and public relations activities. The current Johann Béla National Public Health Program includes a subprogram for mental health, with specific actions in the areas of epidemiologic surveys, reduction of stigmatization, strengthening of primary prevention, decreases in suicide rates, and improvements in treatment facilities, early detection and interventions, and rehabilitation⁸. There are specific policies and actions concerning alcohol and drug abuse prevention, through strengthening the National Drug Policy, improvement or treatment facilities, and informing civil society.

The commitment to prevention and promotion of mental health on the agendas of governmental organizations is lacking. The National Health Promotion Institute has initialized some programmes concerning mental health promotion. The Semmelweis University Institute of Behavioural Sciences, The Hungarian Psychiatric Association, the Red Cross, the Végeken Foundation, and the Protective Net for Mental Health Foundation are the few governmental and business organizations who are committed to improve the mental health of the Hungarian population.

The Better Health for Women health promotion programme was initiated in 1998 by the Vegeken Foundation and the Semmelweis University Institute of Behavioural Sciences. The programme was made possible by funding from the Bristol-Myers Squibb Foundation. The aim of the programme was to increase awareness regarding the importance of women's physical and mental health, focusing particularly on the health of young women between the ages of 15-24 years. The programme included a nationally representative health survey among young women and the planning, organization, and implementation of health promotion programmes. The results of the study showed that depressive symptomatology was highly prevalent among young Hungarian women, which led to the conclusion that health promotion programmes should focus on mental health promotion, with an emphasis on screening and primary and secondary prevention of depression in schools, families, and communities.

Model programmes for mental health promotion were planned by local organizational teams supported by training programmes conducted by the Vegeken Foundation. The local teams, depending on the type of programme, included teachers, school nurses, persons volunteering for the Association of Large Families, and health district nurses. The overall goal was to initiate programme development and initiation, give basic funding to the local programmes, and to teach the local organizers skills to maintain the programmes. The main concept of the mental health promotion programmes was to enable local teams to design and implement programmes according to the needs of the schools, families, or communities with the assistance of the Vegeken Foundation. Local needs were assessed and the designs of the programmes were constructed according to these results. The programmes were planned to be long-term and ongoing in order to continuously increase awareness regarding mental health. Skills needed for programme maintenance were also emphasized.

Even after initial funding for the programmes ceased, the local teams were able to find other financial sources for their activities. The programmes were designed to be able to operate and continue on a low budget, since

⁷ Egészséges nemzetért, népegészségügyi programme, 2001- 2010, Hungarian Health Ministry, 2001

⁸ http://efrirk.antsz.hu/down/kulso/egeszssegfejlesztes/nepeuprg/johan_%20bela_program_v6.0-2002-11-04.rtf

programme leaders work on a voluntary basis and the basic infrastructures are already present in schools, family organizations, and medical facilities. Due to lack of central funding, the dissemination of programmes is impeded and the effectiveness of programmes has not been measured.

4 Organizations and resources for implementation

The following organizations support implementation of mental health promotion initiatives:

- ▶ National Health Promotion Institute
- ▶ National Public Health Agency
- ▶ Semmelweis University Institute of Behavioural Sciences
- ▶ Végeken Foundation
- ▶ Protective Net for Mental Health Foundation

Post-graduate training for mental health promotion specialists is available at the Semmelweis University Mental hygiene Institute and in several other institutions.

5 Monitoring and evaluation

There is a monitoring system for the mental health of the population through the National Morbidity and Mortality Registries. Some research studies have also been conducted measuring the mental health state of the population. Some examples are the HUNGAROSTUDY 1988, 1995, and 2002, the Better Health for Women survey of young women between the ages of 15-24 years, and the OLEF survey conducted in 2000.

6 Challenges

The biggest challenge is to prioritize mental health as an important issue at the national level. Until mental health gains priority, it will remain under-funded and the effectiveness of initiatives and programmes will be in-substantial. There are many well organized and effective programmes, such as the Hungarian Alliance Against Depression, whose effectiveness would increase were they to be supported with government funding. Although there are many committed organizations and individuals who put a lot of effort into mental health promotion, the key to enhanced success would be to join resources and to implement actions at a national level.

Ireland

Prepared by Professor Margaret Barry

1 Introduction

Within the Republic of Ireland, there has been increasing recognition in recent years, at both policy and practice level, of the importance of mental health promotion and prevention of mental disorders for overall population health and well-being. The National Health Strategy 'Quality and Fairness: A Health System for You' (2001) calls for the development of a new action programme for mental health including mental health promotion and stigma reduction. An Expert Group on Mental Health Policy was established in 2004 to devise a new national mental health policy. A sub-group on Mental Health Promotion and the Prevention of Mental Ill-health was set up in April 2004 in order to inform the Expert Group's recommendations in relation to the inclusion of mental health promotion and prevention as an integral part of the new Mental Health Policy. The National Health Promotion Strategy (2000-2005) includes, as one of its strategic aims, the promotion of positive mental health through identifying models of best practice, and initiating research into the development of a national positive mental health strategy. The Report of the National Task Force on Suicide (1998) makes several recommendations concerning the use of mental health promotion and primary prevention strategies in preventing suicide, now the leading cause of death among young men in Ireland. A National Strategy for Action on Suicide Prevention "Reach Out" was published in 2005 and a National Office for Suicide Prevention was established within the Health Services Executive. A number of strategies and initiatives have also been developed by national voluntary organizations (e.g. Mental Health Association of Ireland Strategic Plan 2000-2005) and the Health Promotion departments in the regional health service areas e.g. a specific regional Mental Health Promotion Strategy and Action Plan (2005-2010) is being implemented in the North West region.

2 Process to prepare country story

The country story for Ireland is based on the responses of the Irish country coalition members to the European Questionnaire on Mental Health Promotion and Mental Disorder Prevention (www.imhpa.net/infrastructures-database). The country coalition is made up of the members of the Sub-group on Mental Health Promotion and the Prevention of Mental Ill-Health established as part of a National Expert Group on Mental Health convened in 2004. This group includes policymakers, practitioners and academics with representation from; the Department of Health and Children, the regional Health Services Executive, the Mental Health Commission, the academic and voluntary sectors. Following discussion of the purpose and structure of the questionnaire, the members of the coalition completed the questionnaire independently. The responses were then collated and a consensus approach was adopted in completing the final version, in order to represent the views of the different members. Additional information was sourced through the work of the Sub-Group on Mental Health Promotion and the Prevention of Mental Ill-Health in preparing its submission papers, together with information derived from a recent report on a Review of the National Health Promotion Strategy, 2004, (www.doh.ie). Data were collated and entered by Professor Margaret Barry, National University of Ireland, Galway, who takes responsibility for the writing of the country profile included in this report. This country story is not intended as an official or comprehensive account of mental health promotion and prevention in Ireland, but rather as a general overview.

Persons involved:

Margaret Barry, Professor of Health Promotion and Public Health, Department of Health Promotion, National University of Ireland, Galway.

Joe Casey, Mental Health Commission.

Brian Gaffney, CEO Health Promotion Agency, Northern Ireland.

Brian Howard, CEO, Mental Health Ireland.

Fiona Keogh, Department of Health and Children, Dublin.

Dee Mahony, Administrative Officer, Health Promotion Unit, Department of Health & Children, Dublin (Secretary to the Group).

Shay McGovern, Assistant Principal, Health Promotion Unit, Department of Health & Children, Dublin.

Biddy O'Neill, National Health Promotion Advisor, Health Promotion Unit, Department of Health & Children, Dublin.

John Saunders, CEO, Schizophrenia Ireland (Chair).

Anne Sheridan, Senior Mental Health Promotion Officer, Health Promotion Department, Health Services Executive, North Western area.



3 Action for promotion and prevention in mental health

Availability of policies

At present, mental health promotion and prevention of mental ill-health are included within the following national government policy documents: the National Health Strategy (2001), the National Health Promotion Strategy (2000-2005), the Report of the National Task Force on Suicide (1998) and the forthcoming Strategic Action Plan for Suicide Reduction (2005). Unlike in Northern Ireland, where a specific mental health promotion strategy has been developed (Promoting Mental Health: Strategy and Action Plan, 2003-2008), there is no discrete national strategic policy or action plan on mental health promotion in the Republic of Ireland. There is however, co-operation in the border regions between Northern Ireland and the Republic, in developing mental health promotion initiatives through the work of CAWT (Co-operation and Working Together). A new mental health policy is currently being developed in the Republic of Ireland by a National Expert Group on Mental Health and it is envisaged that mental health promotion and prevention will be included as an integral part of this new mental health policy.

Mental health promotion and prevention initiatives are also supported through a number of related government policy documents such as; the National Children's Strategy, Best Health for Children, Get Connected: Developing an Adolescent Friendly Service, the National Anti-Poverty Strategy and a number of school (e.g. SPHE), workplace and related health promotion policies and initiatives (see further details below). Mental health NGOs have also produced policies and actions on promotion and prevention e.g. Mental Health Ireland, AWARE, GROW, Schizophrenia Ireland and the Samaritans, among others.

Programmes and policies across settings

There are a number of mental health promotion programmes available across the home, schools, communities, workplaces and health services settings. These include:

- ▶ Family support and parenting programmes, including home visiting programmes such as the Community Mothers and Life Start programmes and peer-led parent training initiatives such as Fás le Chéile programme.
- ▶ In the school setting, the Health Promoting Schools initiative and the full implementation of the Social Personal and Health Education (SPHE) curriculum on a nationwide basis, provide a useful conduit for the implementation of mental health promotion initiatives. The SPHE programme is now compulsory in post-primary school in Ireland. Specific initiatives include anti-bullying programmes together with the Mental Health Matters programme (Hastings et al., 2004)¹ and the Mind Out positive mental health programme (Byrne et al., 2004) which have also been implemented and evaluated in post-primary schools.
- ▶ Community health development initiatives and the Healthy Community programmes for disadvantaged groups, hold potential for integrating mental health promotion initiatives. Specific initiatives such as the community-based Rural Mental Health Project have been developed and evaluated for promoting positive mental health in rural communities (Barry, 2004; Reynolds et al., 2004).
- ▶ In relation to older people, there are a number of active retirement initiatives and the nationally available programme 'Go for Life' encourages participation of older people in physical activity.
- ▶ Health promotion workplace initiatives include the implementation of workplace stress reduction programmes and work life balance initiatives.
- ▶ In relation to health services, postnatal depression pathways to care have been developed, and brief intervention and exercise referral programmes have been initiated and evaluated at the regional level.
- ▶ A wide range of suicide prevention programmes such as ASSIST, Mental Health First Aid, service related initiatives and help-lines have been established.
- ▶ A number of stigma reduction campaigns have been conducted by NGOs, including depression awareness raising.
- ▶ In relation to mental health service users, initiatives include supported employment schemes such as Work Link, outreach support for families and carers and befriending projects. There are plans to extend the Irish Health Promoting Hospital Network to the mental health services.

4 Organizations and resources for implementation

Responsibility for the development and implementation of mental health policy and practice rests with the Department of Health & Children and the Health Service Executive at national and regional levels. Other statutory bodies, non-governmental mental health organizations, professional bodies and the university sector also play an active role in knowledge and research development, policy and programme implementation, evaluation and dissemination.

Workforce for mental health

In relation to the mental health promotion workforce, there has been considerable progress and investment in the health promotion infrastructure in Ireland over the last 15 years. This includes the establishment of national strategies and policies concerned with promoting positive health together with the appointment of teams of dedicated Health Promotion specialists and senior managers at the regional level. In recent years, Mental Health Promotion Officers, with a specific brief in relation to promoting positive mental health, have been appointed in the regional health promotion departments. Partnership and inter-sectoral working are

¹ Complete references are available at: www.imhpa.net/references

integral to the health promotion function and there is evidence of increased engagement with other statutory, non-statutory agencies and community and social partners in implementing mental health promotion action.

In terms of training, research and knowledge development, the academic Department of Health Promotion at the National University of Ireland, Galway (www.nuigalway.ie/hpr) provides postgraduate level training in Health Promotion to Masters and PhD level, which includes specific input on mental health promotion. Through its research centre, the Department of Health Promotion also conducts a programme of research and evaluation in mental health promotion.

In relation to prevention activities, funding has been provided through the report of the National Task on Suicide (1998) for the appointment of Suicide Resource Officers in each of the regional health service areas. Increased funding has been made available for suicide prevention activities and research through the National Suicide Review Group and the work of the National Suicide Research Foundation. In many of the regional health service areas, staff have a dual remit for both suicide prevention and mental health promotion. The situation regarding specific training on prevention of mental disorders at the national level is less clear. Knowledge development and dissemination is, however, facilitated through the organization of national and regional conferences on both mental health promotion and prevention of mental disorders. These include conferences, such as the annual meeting of the Irish Association of Suicidology which addresses suicide prevention, together with seminars and other training initiatives by the Irish College of Psychiatrists, NGOs and regional health service agencies.

The participation by key players at the national level in cross border, European and international policy, practice and research networks and initiatives has played an important role in ensuring the development of high quality, innovative and sustainable initiatives in Ireland.

5 Monitoring and evaluation

At a national level, there are quite limited data sets concerning the mental health status at a population level, in particular in relation to positive indicators of mental health among Irish adults. From those national surveys that have been carried out e.g. the national health and lifestyles surveys (SLÁN, 1999; 2003) and the Living in Ireland Survey, the most commonly used scales are the GHQ-12 and the SF-36. Surveys such as the WHO Health Behaviour in School-aged Children (HBSC) study, conducted among school children in Ireland (Nic Gabhainn et al., 2003) and the College Lifestyle and Attitudinal National (CLAN) survey (Hope, Dring and Dring, 2005) include some indicators of positive mental health and well-being (reports available through www.doh.ie).

Regarding monitoring the implementation of policies and programmes, a recent review of the National Health Promotion Strategy (2004) provides an overview of current mental health promotion practice at national and regional level. This report evidences a high level of activity in relation to mental health promotion programmes at national and regional level, which was bolstered by recommendations from the report of the National Task Force on Suicide (1998). Funding provided through the report has led to the appointment of Suicide Resource Officers in each of the regional health service areas and increased funding has been made available for suicide prevention activities and research. The National Suicide Review Group also funded a range of specific initiatives and research projects and produces an annual report on progress. An evidence briefing on youth suicide prevention was prepared in 2004 by the Institute of Public Health in Ireland (www.publichealth.ie).

The Health Promotion Unit at the Department of Health & Children has provided funding for specific research initiatives, led by the Centre for Health Promotion Studies at NUI, Galway (www.nuigalway.ie/hpr) in collaboration with regional health service agencies, in adapting models of best practice for implementation and evaluation in Ireland. Key developments include:

1. The – piloting and evaluation of the international JOBS depression prevention programme (Caplan, Vinokur and Price, 1997), which was implemented on a cross border basis by health and training and employment agencies in the Republic and Northern Ireland (Barry et al., 2005).
2. The development and implementation of the Mind Out positive mental health promotion programme, which is concerned with adapting curriculum materials from the Australian Mind Matters programme for use in Irish post-primary schools. A randomised controlled study was conducted to evaluate the implementation and impact of this programme (Byrne et al., 2004, 2005).
3. Funding of research to inform the development of a regional evidence-based mental health strategy and action plan for the North West region (2005-2010).
4. Grant aid for a global review of the effectiveness of mental promotion being undertaken by the International Union for Health Promotion and Education (Jané-Llopis, Barry, Hosman and Patel, 2005).

The evaluation of specific programmes across the schools, work and community settings is also supported by statutory and voluntary agencies at the national and regional levels.

6 Challenges and opportunities

A number of important advances have taken place in recent years in relation to mental health promotion and prevention in Ireland. These include:

1. Through the Report of the National Task Force on Suicide (1998) funding has been provided for the appointment of regional Suicide Resource and Mental Health Promotion Officers and for suicide prevention research.
2. The establishment in 2004 of a National Expert Group on Mental Health Policy to develop a new mental health policy in Ireland for the next ten years. A sub-group on Mental Health Promotion and the Prevention of Mental Ill-Health was convened and has made specific recommendations regarding the inclusion of positive mental health as an integral part of this overall mental health policy.
3. A National Strategy for Action on Suicide Prevention “Reach Out” was published in 2005 and a National Office for Suicide Prevention was established within the Health Services Executive. The Strategy sets out priorities for action in the area of suicide prevention.
4. There has been substantial development of the infrastructure and workforce in health promotion, at national and regional levels.
5. At a regional level, The North Western area has developed a Mental Health Promotion Strategy and Action Plan (2005-2010) for the region.
6. The implementation of the Social Personal and Health Education programme in schools as a compulsory component of the post-primary school curriculum provides a firm basis for mental health promotion.
7. The undertaking of training and research on mental health promotion programme development and evaluation through the academic Department of Health Promotion at NUI, Galway.

A number of key challenges and opportunities have also been identified:

1. There is a need for a National Policy and Action Plan in order to co-ordinate inter-sectoral approaches and to support the full implementation of national priorities and objectives in the area.
2. Dedicated ring-fenced resources are required to fund the development and implementation of national initiatives.
3. There is a need to promote greater awareness and understanding of the integral role of mental health promotion in overall functioning and its effectiveness in promoting health and social well-being and reducing risks of mental health problems.
4. Greater attention to, and specific training in, the implementation of evidence-based policy and practice at national and regional levels is required.

5. Need for the re-orientation of mental health services to include prevention and promotion activities.
6. Greater investment in mental health promotion research.
7. A training and development strategy for capacity building of the mental health promotion workforce and professionals in the relevant non-health sectors e.g. teachers, community workers, prison officers, etc.
8. Identifying and supporting the implementation of models of best practice.
9. The development of a national database of mental health promotion projects and practice.
10. Consolidation of the integral role of mental health promotion and prevention within the current reform of the Irish Health Services.
11. There is a need for national data collection on population mental health status, in particular positive indicators of mental health, at community, regional and national levels.

In building on the positive achievements to date, a comprehensive strategy and action plan for the promotion of positive mental health and the prevention of mental ill-health is required in order to advance work in the area. The action plan needs to be time framed and clearly identify those responsible for each action. The action plan also needs to be comprehensively resourced and monitored for effective implementation. Given the current Health Service Reform Programme, a prerequisite for effective implementation will be to ensure that the required structural arrangements are in place to meet national and regional needs and ensure effective delivery. These include the development of a national policy framework, planning and facilitation of partnerships across all relevant sectors, commitment to capacity building and training, and the development and dissemination of evidence based mental health promotion and prevention programmes including needs assessment. This must be accompanied by a national research plan including the establishment of an evaluation and monitoring process.

In summary, there is a need for an explicit and co-ordinated national policy framework, an appropriate organization structure to support effective implementation, the provision of dedicated resources and a sound knowledge and research base. The integral role of mental health promotion and prevention within the Irish health service needs to be consolidated.

Acknowledgements

I wish to acknowledge the assistance of Kathryn Meade, mental health promotion researcher at the Centre for Health Promotion Studies, NUI, Galway, in inputting the Irish data from the European Questionnaire on Mental Health Promotion and Mental Disorder Prevention on to the imhpa.net database (www.imhpa.net/infrastructures-database). Thanks are also due to the members of the National Expert Sub-group on Mental Health Promotion and Prevention of Mental Ill-Health, who served as the Irish Country Coalition Group for this exercise.

Italy

Prepared by Dr. Angelo Barbato, Dr. Barbara D'Avanzo, Dr. Alberto Parabiaghi, Dr. Mirella Ruggeri and Dr. Marco Stegagno

1 Introduction

The first national survey of mental disorders in a probability sample of the general population was carried out in Italy in the years 2001-2002, in the framework of the European Study of the Epidemiology of Mental Disorders (ESEMeD) Project¹. This study provided the first assessment of the prevalence of mental health problems in Italy. The sample (4,712 subjects) has been selected in order to represent a population of about 47 millions inhabitants aged 18 years or over. The findings showed that the 12-month prevalence of any mental disorder was 7.3% of the whole population aged 18 years or over (3.9% in men and 10.4% in women) and the lifetime prevalence was 18.3% (11.6% in men and 24.4% in women). 12-month prevalence of major depression was 3.0% (1.7% in men and 4.2% in women) and lifetime prevalence 10.1% (6.5% in men and 13.4% in women); 12-month prevalence of specific phobias was 2.7% (0.5% in men and 4.6% in women) and lifetime prevalence 5.7% (2.5% in men and 8.6% in women). About 8.5 million Italian citizens had suffered mental distress at least once in their lifetime, women are at major risk of developing any mental disorder (except alcohol use disorders) and being unemployed, housewife or disabled increases the risk of mental disorders. The survey highlighted that the rate of mental disorders in Italy are among the lowest in the surveyed European countries.

2 Process to prepare country story

This country story was written by the Unit of Epidemiology and Social Psychiatry of the 'Mario Negri' Institute for Pharmacological Research in collaboration with the Department of Medicine and Public Health, section of Psychiatry, University of Verona. The documents on which the report is based are quoted in the text, and available at: www.imhpa.net/infrastructures-database. The main difficulty in collecting information for the country story consisted in dealing with local initiatives rarely evaluated, published or disseminated and scarcely co-ordinated at national or regional level.

Persons who provided information for the country story:

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¹ Alonso J, Angermeyer MC, Bernert S et al, Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project, Acta Psychiatrica Scandinavica, 2004, 109 (suppl 420): 21-27.

3 Action for promotion and prevention in mental health

Policies

Central mental health policy in Italy provides a framework for comprehensive local mental health services, highlights priority targets and interventions, recommends outcome assessments, but relies on local authorities to plan and provide mental health services and interventions. The Italian National Government indicated through the Piano Sanitario Nazionale (National Health Plan) the health policy guidelines. Health policies are developed by the Regional Councils and implemented by the Regional Governments. This was established in 1978 by law 833². Also for mental health, the level of implementation and interpretation of the central law are heterogeneous across regions, as well as quality and coverage of mental health services.

The current Piano Sanitario Nazionale (National Health Plan) was approved in 2003³. However, special provisions on mental health were previously included in the Progetto-Obiettivo Tutela Salute Mentale (Target Project on Mental Health Protection), approved in 1999⁴.

The Target Project on Mental Health Protection included among its goals the following:

- ▶ Health promotion in the entire life cycle, also within the framework of preventive medicine and health education;
- ▶ Primary and secondary prevention of mental disorders, with special reference to risk-taking behaviours through early identification of psychosocial distress, especially in young people, and to the realization of proper therapeutic and preventive interventions.

Poor attention to primary and secondary prevention has been pointed out by the current Piano Sanitario Nazionale as a critical issue for mental health planning and provision. Commitment to prevention and early diagnosis is stated for mental disorders in childhood and adolescence and for mental distress among prisoners (Decreto Legislativo 22 giugno 1999, n. 230)⁵. Mental health promotion among prisoners has been included among the goals of the Progetto-Obiettivo Tutela Salute in Ambito Penitenziario (Target Project on Health Protection in Jails). Priority has been given to interventions to prevent violent and self-injuring behaviours (Decreto Ministeriale 21 Aprile 2000, n. 120)⁶.

The National Law 138, 2004 ("Urgent interventions for confronting public-health hazards"), established the Centro Nazionale per la Prevenzione e il Controllo delle Malattie (CCM - Italian National Centre for Disease Prevention and Control) which was founded by the Ministry of Health through Decreto Ministeriale 1 luglio 2004⁷. As specified by Law 138, 2004, the CCM was founded as a network of existing institutions and experts. In fact, the activities of the CCM are to be co-ordinated with those of the Regional Health Authorities and the following institutions and organizations: Istituto Superiore di Sanità (ISS - Italy's National Health Institute); Istituto Superiore per la Prevenzione e la Sicurezza del Lavoro (ISPESL - the National Institute for Prevention and Safety in the Workplace); Istituti Zooprofilattici Sperimentali (IZS - the Institute of Zooprophyllactic Research); various University research centres; various Medical and Research Institutes, the Istituti di Ricovero e Cura a Carattere Scientifico (IRCCS); other public and private institutions involved in healthcare and in research; military health organizations.

The Ministry of Health defined the following objectives for the CCM: analysis of health risks; co-ordination, in collaboration with the Regional Health Authorities, of the programmes for surveillance and prevention

² Legge 23 dicembre 1978, n. 833

³ Piano Sanitario Nazionale 2003-2005

⁴ progetto-obiettivo tutela salute mentale

⁵ Decreto legislativo 22 giugno 1999, n. 230

⁶ Decreto ministeriale 21 aprile 2000, n. 120

⁷ Legge 26 maggio 2004, n. 138

⁸ Decreto ministeriale 1 luglio 2004,

developed by Italy's national alert systems and of the rapid response to public-health situations, including bioterrorism; promotion, updating, and training for the realisation of annual programmes at the national and regional level; realisation and evaluation of the annual programmes; co-operation with other institutions and analogous organizations in Europe and worldwide; dissemination of information.

The CCM also actively participates in a number of international networks developed by institutions such as the European Centre for Disease Control and Prevention (ECDC), the World Health Organization (WHO), and the U.S. Centres for Disease Control and Prevention (CDC). The whole budget for the CCM is €32.65million in 2004, €25.45 million in 2005 and €31.9million in from 2006 onwards. However, the CCM did not include mental health issues in its agenda.

According to the Direttiva Ministeriale 26 novembre 1998, n. 463, mental health promotion should be actively pursued in schools⁹. The “Fondazione Angelo Celli”, which is supporting a post-graduate school and publishing a journal, can be considered a centre of excellence in this area¹⁰. Although this plays a significant role in training for mental health promotion in schools, and despite many programmes implemented in the schools, unfortunately, no documentation is available to appreciate the real extent, quality and effectiveness of mental health promotion in schools. “Educazione Sanitaria e Promozione alla Salute” is the journal published by the “Fondazione Angelo Celli”, which addresses and disseminates Italian and European experiences on health education aiming at the health objectives indicated by the WHO¹¹.

The Conferenza Permanente Stato-Regioni (Permanent Nation-Regions Conference) approved the Piano Nazionale per la Prevenzione 2005-2007 (National Prevention Plan) in March 2005. Commitment to prevention is declared in the fields of cardiovascular diseases, cancer, accidents, and infectious diseases (vaccination plan)¹².

The Agenzia per i Servizi Sanitari Regionali (Agency for the Regional Health Services) represents a public resource for evidence-based clinical practice guidelines, and is in charge for drafting, updating and disseminating clinical guidelines^{13,14}. No guideline targeting mental health issues has so far been published or planned.

The Regional Governments issue regional Health Plans, Prevention Plans, and Mental Health Plans. We examined those of three large regions, namely Lombardy, Veneto and Lazio. The Head Office of Public Health of the Regional Government of Lombardy published the Piano Regionale Salute Mentale (Regional Mental Health Plan) in September 2003. This document contains a few statements on the prevention of mental disorders. The issue of prevention is discussed in the chapter dealing with the proposal of models of intervention on needs of social relevance. Early intervention on psychosis, employment opportunities for people with mental illness, treatment for double diagnosis patients, and prevention of disturbing behaviours are highlighted as the key objectives of mental health services planning and provision. A single and general commitment to mental health promotion appears in the text. Two or three year projects targeting the priorities identified in the text have been financed. None addresses primary prevention or promotion of mental health¹⁵.

The Regional Government of Lazio approved and published the Piano Sanitario Regionale (Regional Health Programme) 2000/2004¹⁶. Current mental health policy in Lazio reflects the objectives and priorities established in the Progetto Obiettivo Tutela Salute Mentale¹⁷. The following areas of interest have been

⁹ Direttiva ministeriale 26 novembre 1998, n. 463

¹⁰ Fondazione angelo celli

¹¹ Educazione Sanitaria e Promozione alla Salute

¹² Atto 23 marzo 2005, n.2271

¹³ Agenzia per i Servizi Sanitari Regionali

¹⁴ Decreto ministeriale 30 giugno 2004

¹⁵ Piano Regionale Salute Mentale 2003-2005

¹⁶ Piano Sanitario Regionale 2000-2004

¹⁷ Progetto Obiettivo Tutela Salute Mentale

highlighted: to prevent the disabling course of mental disorders by early detection of distressing situations, especially in the youth, and mental health promotion across the entire life cycle. Suicide prevention has been considered as one of the seven most important areas of intervention.

In Veneto, the Progetto Obiettivo per la Tutela della Salute Mentale (4080, 22 december 2000) was issued in 2000. Commitment to primary, secondary and tertiary prevention is stated in the document by involving the Dipartimenti di Salute Mentale (Department of Mental Health) in programming specific interventions and allocating a significant funding to their implementation. Although prevention was stated as characterising the general approach of the text, it has yet to be implemented.

Programmes

The Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute (The National Centre of Epidemiology, Surveillance and Health Promotion) of the Istituto Superiore di Sanità (National Institute of Health) declared mental health as among its interests. Besides this general commitment to mental health promotion, no programme has been developed for its implementation¹⁸.

In 2001, the National Centre of Epidemiology, Surveillance and Health Promotion published a declaration that outlines opportunities to enhance mental health promotion¹⁹. The main indications were about: promotion of self-help groups; entertainment activities at community level; mental health promotion at the workplace; teaching of communication, coping and problem solving skills in groups at risk, like unemployed people and young people; provision of effective support to single mothers; cognitive-behavioural treatment for children exposed to adverse events in the family (divorce or death of a parent); training parents in children's rearing.

In the framework of promotion and prevention of mental disorders at the workplace, the National Centre of Epidemiology, Surveillance and Health Promotion developed and validated a self-administered 28 item questionnaire to assess psychological well-being in health professionals (2004). A reliability test-retest study was performed on 45 health professionals with different roles. Factorial validity and internal consistency of each derived subscale were evaluated on a wide sample of 514 professionals. In addition, professionals' well-being was evaluated and possible relationships were tested between total score and the following variables: age, sex, professional role and years of job. A fairly good well-being was found among general hospital staff. "Help received for problems" and "help received to cope well with criticism" were generally poor. In general, female professionals showed lower levels of well-being. Besides being useful to assess well-being in health staff, it can be used also with other professional types and in the general population. This study can be assumed as a first step toward prevention of mental distress among health professionals²⁰.

The WHO Mental Health Action Plan for Europe has been translated into Italian and disseminated by the Ministry of Health, thus witnessing the importance attributed to European commitment to promotion of mental health and prevention of mental distress.

Initiatives

In the years 1997-2001, the Istituto Superiore di Sanità (National Institute of Health) promoted and co-ordinated the Progetto Nazionale Salute Mentale (PNSM, National Program on Mental Health) which involved the National Health System, and several universities and research institutions^{21, 22}. A total of twenty seven research projects were selected and funded out of forty two proposals, and twenty five projects were approved for a second year grant after a close evaluation made by the scientific board. Among the twenty two topics indicated as of major interest, two referred to primary prevention: (a) planning and evaluation of interventions on primary

¹⁸ Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute

¹⁹ "Mental health promotion" by Pierluigi Morosini

²⁰ "Psychological well-being in health professional"

²¹ Il Progetto Nazionale Salute Mentale I

²² Il Progetto Nazionale Salute Mentale II

prevention at school; (b) prevention of eating disorders among adolescents. Among all the projects supported by PNSM, one project dealt with primary prevention: "Prevention of eating disorders among adolescents", by S. Sirigatti. Nonetheless, the project did not implement and test the effectiveness of a prevention programme, whereas it identified groups at risk²³.

The Centre for Woman's Mental Health is part of the Italian Public Health Care System, whose local extension, "Azienda Sanitaria Locale Napoli 1" (ASL Na 1), is situated in Naples. The Centre "Woman's Mental Health Prevention" (WMHPC) concerns psychological aid with a clinic for women and adolescents, research and training about prevention and control of illness factors. Every year an average of 250-300 women and 100 adolescents (mainly girls) are served by the Centre for mental, stress and life-conditions problems²⁴.

The Italian Association Progetto Itaca (Itaca Project) was founded in October 1999 by a group of volunteers active in mental health. The mission of this association is to promote programmes for mental disorder prevention, care and rehabilitation²⁵. The PreSaM (Prevenzione in Salute Mentale), is the first association created with the mission of promoting mental disorders prevention²⁶.

Short-term research reported fewer suicides among elderly users of a government sponsored telephone helpline and emergency response service (the TeleHelp-TeleCheck Service) implemented in Padua in the years 1988-1998, described and evaluated in a paper issued in 2002. To examine long-term effects of the service on suicide in an elderly population of northern Italy, De Leo et al. evaluated in a recent study the TeleHelp—TeleCheck Service. It represents a rare example of a long-term longitudinal naturalistic observation of an intervention to prevent suicide in older people. The study corroborates previous findings that interventions fostering connectedness to support services, either formal or spontaneous, are effective. Also in line with previous research, this study showed evidence that present models of intervention can benefit females more than males. Overall, these findings suggest the need for alternative and innovative interventions for preventing suicide in males. Suicide prevention in the older population remains a major problem and the present findings offer hope and indication for future research²⁷. A tele-help approach was used also in Trieste in order to prevent lonely deaths and suicides in older people. This was pursued through promotion of social cohesion, real integration and continuity of social and medical services, recognising and valuing the client as central. The pilot phase took place between 1998 and 2001, and the initiative was then implemented on a regular basis²⁸.

As example of mental health promotion, "La mia città – Vivere tutti meglio a Trento" (My town – Improving quality of life for all in Trento) is a community programme with a broad involvement of many City institutions and services, organizations active in the town and common citizens in dissemination of positive mental health and participation²⁹.

4 Concluding remarks

Some concluding remarks on the Italian situation can be drawn:

1. Preventive programmes in Italy have so far seldom targeted mental illness. Attention is mainly addressed on service organization, implementation of information systems, and dissemination of evidence-based treatments. Mental health promotion and mental disorder prevention need to be implemented;

²³ Sirigatti S & Stefanile C. Stili alimentari in adolescenti: ricerca-intervento di prevenzione primaria. In Progetto Nazionale Salute Mentale. Rapporto conclusivo (P Morosini, G de Girolamo, A Picardi and F Di Fabio eds) 2001, 169-171, Rapporti ISTISAN 01/27.

²⁴ Centro Studi Ricerca e Formazione "Prevenzione salute mentale donna" Azienda sanitaria Locale Napoli 1 Responsabile: d.ssa Elvira Reale via Pia, 25 - 80126 Napoli tel. +39-081-2548410 - Fax +39-081-7283990 sito web: <http://www.salumentaledonna.it> e-mail: info@salumentaledonna.it

²⁵ Progetto Itaca, Via Nirone, 2/A - 20123 Milano, Tel. 02.72.02.11.38 - Fax. 02.86.91.57.93 <http://www.progettoitaca.org/>

²⁶ PreSaM, Borgo Santo Spirito 3, 00193 Roma, Tel 06 68352498 - Fax 06 68352592 Email: prevenzione1@virgilio.it

²⁷ The British Journal of Psychiatry (2002) 181: 226-229 <http://bjp.rcpsych.org/cgi/content/full/181/3/226>

²⁸ Progetto Amalia

²⁹ "La mia città - Vivere tutti meglio a Trento"

2. Mental health services, although strongly community-oriented, have focused their attention on treatment, care and rehabilitation of severe mental disorders in young or adult patients;
3. Programmes on mental health promotion and prevention are the outgrowth of local initiatives, with little co-ordination at national or regional level;
4. Although largely present, local programmes and initiatives are very seldom disseminated and even more rarely evaluated and published in scientific literature;
5. Promotion, prevention and treatment must compete for limited resources;
6. The current orientation of mental health providers is more on treatment or early detection than prevention;
7. Unfortunately, good practice interventions, like that organised in Padua, also with the collaboration of the City of Padua, although showing encouraging results, were not continued, thus confirming the weaknesses of prevention in the mental health and social services in Italy;
8. No specific institutions or workforce specifically devoted to the implementation of mental health promotion and prevention activities is operating at present in Italy;
9. Services committed to prevention and promotion in mental health are quite fragmented and the integration among different services at the local level as well among the Departments of Mental Health has been poor.

Latvia

Prepared by Dr. Maris Taube

1 Introduction

Prevention and promotion of mental health in Latvia, ensuring services and treatments, preparing state policy for treatment and development of the overall area is the responsibility of the Ministry of Health. Implementation of the state policy regarding mental health promotion, prevention, and treatment is the responsibility of the Public Health Department of the Ministry of Health, namely – the health care organization division of this department and the health promotion and environmental health divisions.

The Latvian Ministry of Health does not have a separate group, which would deal solely with mental health issues. On the one hand, such a situation can be evaluated negatively, as there is no special attention paid to mental health issues, but on the other hand, positively, as the mental health issues are addressed in context with other public policy and public health issues ensuring an integrated approach to mental health.

There is a range of policy and action documents existing in Latvia, which directly or indirectly refer to mental health promotion and prevention issues. The most essential policy document is the *Public health strategy*¹. For implementation of this policy document, an *Action programme for implementation of public health strategy for 2004 – 2010*² has been prepared and approved.

2 Process to prepare country story

The Latvian country story has been developed by analyzing the approved and publicly available policy documents and action programmes, as well as the legal enactments being under development stage. Due regard was given to information obtained when working in the mental health policy development work group. Also the real activities of the state and non-governmental organizations in the area of mental health promotion and prevention have been analyzed.

Persons involved (Workshop to develop a national mental health policy and plan for Latvia)

A. Apsite, I. Bluka, A. Bredovska, J. Bugins, U. Cacus, L. Caune, I. Cernika, A. Civcs, D. Darniece, L. Embrekte, I. A. Esite, M. Forstmane, E. Ikauniece, B. Jenickis, J. Jeremejeva, A. Kisoro, R. Klotins, I. Leimene-Veldmijere, I. Leisavnieks, V. Mezule, M. Ozola, S. Pablaka, S. Pudane, A. Rurane, S. Skaida, O. Sokolova, A. Stirna, B. Sveile, I. Treimane, S. Upesleja

3 Action for promotion and prevention in mental health

Availability of policies

The most essential policy document, which refers to the mental health promotion and prevention issues in Latvia, is the *Public health strategy*. This strategy follows the World Health Organization's European regional strategy *Health for All in the 21st century*. The 6th objective of this policy document is improvement in mental health. To realize this objective, it is planned, by the year 2010, to improve the mental health of the Latvian population, as well as to ensure access to quality mental health care services to all inhabitants.

¹ Public Health Strategy, March 9, 2001, www.sva.lv

² Action Program for Implementation of Public Health Strategy for 2004- 2010, March 9, 2004, www.vm.gov.lv

The document aims to:

- ▶ reduce mental health problems;
- ▶ improve ability of the Latvian population to overcome stress situations; and
- ▶ reduce suicide rates by 25%.

To achieve these aims, it is planned to:

- ▶ create a home, social and working environment that promotes improvement of mental health and reduces stress;
- ▶ reduce economic hardship by implementing measures mentioned in the “Poverty Aversion Strategy”, which would favourably impact on mental health;
- ▶ train health care and other professionals (especially teachers) for early detection and management of mental health problems;
- ▶ improve stress prevention and management skills (in schools, at family doctors, in employment places, etc.);
- ▶ finish development of the law and strategy “On Psychiatric Assistance”;
- ▶ improve the information system, to:
 - supplement the basic indicators used for mental health;
 - allow monitoring the achievement of the aims, as well as assessing the results;
 - ensure comprehensive information on the mental health of the population by making research on mental health once in ten years, as well as by collecting, analyzing, interpreting and publishing wider routine statistical data and performing respective research.

Currently there is no approved policy for mental health in Latvia. The previous policy document *Psychiatric assistance strategy* was focused mainly on ensuring psychiatric treatment, and comprised a time period from 2001 to 2003.

At present, and with the support of the World Health Organization, a medium-term policy document, *Improving Mental Health in Population for the Years 2006–2016*³, has been prepared. The document was developed by a work group, which assessed different public mental health issues, and was informed by the World Health Organization’s World Health Report 2001, the World Health Organization’s 2005 Helsinki Declaration and Action Plan for mental health in Europe, and the World Health Organization’s Guidance instrument for developing a mental health policy and plan. The document includes health promotion (schools, employment places, etc.) and prevention issues.

Programmes and policies across settings

The issues of mental health promotion, prevention, and development of services are included in the *Action Programme for Implementation of Public Health Strategy for the Years 2004- 2010*². The Action Programme prescribes certain activities, which also refer to health promotion and prevention.

These activities are:

- ▶ implementation of the project “Work optimization of ambulatory psychiatric assistance service”;
- ▶ ensuring availability of psychologist’s assistance in schools;
- ▶ training for doctors and nurses in early diagnosis of psychiatric disorders;
- ▶ ensuring psychological assistance in the armed forces’ training centres;
- ▶ ensuring psychological assistance in the institutions of the Ministry of Interior;
- ▶ improvements in the Latvian mental health information systems; and
- ▶ implementation of a pilot project of multidisciplinary team work.

³ Improving of Mental Health in Population for the Years 2006-2016, draft, www.vm.gov.lv

To implement the policy document “Improving mental health of population for the years 2006-2016”³, in cooperation with the World Health Organization, work has started on the action programme, which will prescribe certain activities and financing for policy implementation. The first draft version of the action plan is expected by the end of 2005.

In practice, there are currently some individual activities carried out in Latvia in the area of mental health promotion and prevention. They are implemented by state authorities within the limits of available financing. Such activities, for example, are the Health Promotion Agency’s activities for establishment of health friendly schools, and information materials for youth on mental health.

Non-governmental and international organizations are involved in mental health promotion and prevention. Currently Latvia organizes an information campaign against violence, which is supported by the United Nations⁴. Involvement of non-governmental organizations might be more effective in the future when these organizations develop and receive larger support from the state.

Policy and action plans in other public health areas

Mental health promotion and prevention issues are closely related to other public health and social welfare activities. Major policy and action plans are the conception of *Equal Opportunities to All*⁵, which prescribe equal opportunities for members of the population in different areas, the *National Action Plan for Promotion of Employment*⁶, which addresses employment problems as one of the risk factors of mental disorders and suicides.

Activities which are connected with the prevention of early acquired mental disorders are included in the *Mother’s and Child’s Health Strategy in Latvia*⁷, as well as the *Action Plan for Implementation of the Mother’s and Child’s Health Strategy for the Years 2004-2007*⁸.

Significant contributions to the prevention of mental disorders and to the promotion of mental health are those of the *HIV and AIDS Spread Limitation Programme for the Years 2003-2007*⁹, the *Latvian Drug Control and Drug-addiction Prevention Programmes for the Years 2004-2008*¹⁰, the *Alcoholic Drinks Consumption Reduction and Alcohol Limitation Programme for the Years 2004-2008*¹¹, as well as the *Implementation Plan for the Alcohol Alcoholic Drinks Consumption Reduction and Alcohol Limitation Programme for the Years 2004-2008*¹².

4 Organizations and resources for implementation

Infrastructure

The Ministry of Health delegates a part of its functions to state agencies. In the area of mental health, there are three state agencies: the Mental Health State Agency, which is responsible for all mental health policy in the country; the Public Health Agency, which is responsible for the public health strategy and combines different health areas for improvement of public health; and the Health Promotion State Agency, which provides health promotion in all issues, including also the issues of mental health.

⁴ Campaign against Violence, United Nations Organization, www.un.lv

⁵ Conception: Equal rights for all, June 30, 1998, www.lm.gov.lv

⁶ National Action Plan for Promotion of Employment, www.lm.gov.lv

⁷ Mother’s and Child’s Health Strategy in Latvia, February 13, 2001, www.vm.gov.lv

⁸ Action Plan for Implementation of Mother’s and Child’s Health Care Strategy for 2004-2007, January 30, 2004, www.vm.gov.lv

⁹ Human Immuno-Deficiency Virus (HIV) and AIDS Spread Limitation Program for the Years 2003-2007, November 27, 2003, www.vm.gov.lv

¹⁰ Latvian Drug Control and Drug-Addiction Prevention Programmes for the Years 2004-2008, draft, www.narko.lv

¹¹ Alcoholic Drinks Consumption Reduction and Alcohol Limitation Program for 2004-2008, January 19, 2005, www.vm.gov.lv

¹² Implementation plan of Alcoholic Drinks Consumption Reduction and Alcohol Limitation Program for 2004-2008, January 19, 2005, www.vm.gov.lv

Workforce for mental health

The issues of mental health promotion and prevention are mainly the field of psychiatrists, psychiatric nurses, health promotion agency specialists and public health specialists. Currently very few other specialists are involved in ensuring mental health in Latvia – psychologists, social workers; but the principles of future development requires a larger contribution of these specialists in direct health promotion and prevention. In the future, there might be a larger contribution of patients, their related organizations and involvement in health promotion and prevention issues. Education of specialists takes place in Riga's Stradiņš' University and the University of Latvia. The Mental Health State Agency maintains the clinic base for training of specialists.

5 Monitoring

Currently information on mental health care in Latvia is provided by the Mental Health State Agency, which collects information on hospital-treated patients, and the financier, the Health Obligatory Insurance State Agency¹³ (in-patient and out-patient information on state-paid services). The Health Statistical and Medical Technologies Agency¹⁴ collects routine statistical data, as well as performing individual surveys. The Health Promotion State Agency undertakes individual surveys on public health habits. Practically there is no current unified system for monitoring mental health promotion and prevention in Latvia. Latvia will attempt to use the World Health Organization's Assessment Instrument for Mental Health Systems as an assessment tool for the future, which will include indicators about mental health promotion and prevention measures.

6 Challenges

The major problems in Latvia for mental health promotion and prevention are due to insufficient understanding of the public and professionals about their significance and efficiency. So far, mental health activities have been focused on medical treatment and secondary prevention. Overall, the whole service has so far been oriented on psychiatric assistance, treatment and solving social issues, without engaging in health promotion or primary prevention. The mental health service so far has been engaged in severe diseases of people (schizophrenia, organic psychic disturbances, severe depression), where primary prevention and promotion possibilities have been limited.

Mental health promotion and prevention issues are not currently a priority in Latvia. The limited financing for health care goes on other priorities, ensuring of pharmacological treatments, and the costs of expensive operations, etc.

Awareness of health promotion and primary prevention issues is neither sufficiently popular nor clear. The situation is likely to improve with the development of the institution of family doctors, since the family doctor will play a leading role in mental health promotion and prevention issues.

A significant challenge for Latvia will be the involvement of non-governmental organizations in health promotion and prevention issues. The role of these organizations will grow, as currently it is minor, and does not significantly impact on developments in mental health.

Currently, the situation in mental health promotion and prevention cannot be characterized by a common approach. Each institution is engaged in its operations as it deems proper. A critical turn and challenge for Latvia will be the approval of the policy and action plan, *Improving of Mental Health in Population for the Years 2006-2016*, as well as adoption of the Psychiatric Assistance law. Further, in the future, with development of a community based mental health care system, a larger role in mental health promotion and prevention will be played by local municipalities, rather than state institutions, as it is now.

¹³ Health Obligatory Insurance State Agency, www.voava.lv

¹⁴ Health Statistics and Medicine Technologies Agency, www.vsmta.lv

Lithuania

Prepared by Associate Professor Dainius Puras

1 Introduction

Lithuania is a country in transition, with public mental health issues becoming increasingly important during the last decades. Suicide rates in Lithuania are the highest in the world (42.1 cases per 100,000 population in 2003). There are ongoing attempts at different levels to introduce and develop effective measures to manage major mental health problems. However, until recently these attempts have lacked a critical mass of evidence-based policies and practices. Modern approaches in the field of public mental health are often met with resistance by dominant biomedical attitudes and approaches prevalent amongst a large part of the population, as well as major stakeholders and decision makers. Such attitudes are based on an historical tradition which lacked tolerance of vulnerable groups, was associated with stigma and discrimination of people with mental health problems, had a dependence on traditional residential institutions, and was based on a simplified biomedical model for solving public mental health problems.

The 2005 WHO European Ministerial Conference on Mental Health was perceived in Lithuania as an opportunity for demonstrating political will and implementing modern evidence based approaches in the field of public mental health. Following the conference, the Minister of Health, Zilvinas Padaiga, appointed a National Mental Health Committee. In June 2005, the Committee presented a draft of a National mental health policy which reflects the values and principles of the Mental Health Declaration for Europe, with a strong emphasis on the issues of mental health promotion and prevention of mental disorders. This draft has been disseminated to major stakeholders who will present their comments and will be involved in the next stages of development and implementation of the action plan.

2 Process to prepare country story

The country story for Lithuania has been formed as a result of the efforts of a group of partners representing the field of public mental health, with the support of Minister of Health Zilvinas Padaiga.

Persons involved:

Dainius Puras, Adviser to Minister of Health

Vytautas Bakasenas, Director, State Public Health Service

Ona Davidoniene, Director, State Mental Health Center

Aldona Jociute, National Coordinator, Network of Health Promoting Schools

Rita Pazdrazdyte, Chief specialist for Public health, Ministry of Health

Robertas Povilaitis, Head of Childline, Researcher, Vilnius University

Romualdas Sabaliauskas, Secretary of the Ministry of Health

Asta Saladiene, Chief specialist, State Public Health Service

Audrius Sceponavicius, Head of Department of Public Health, Ministry of Health

Ingrida Skridaliene, Head of Unit, State Public Health Service

Gene Surkiene, Associate Professor, Director of Institute of Public Health, Vilnius University

Marija Veniute, Lecturer, Institute of Public Health, Vilnius University

Key people working in the field were brought together to complete the European Questionnaire on Mental Health Promotion and Mental Disorder Prevention. The aim of the meeting was to present the IMHPA project and to share tasks collecting the information needed for the questionnaire. After the meeting, information collection spanned two months, supported by e-mail contacts and telephone conversations. Representatives of national and municipal authorities, NGOs and academic institutions contributed to the input to the questionnaire. The questionnaire responses form the basis of this country story.

3 Action for promotion and prevention in mental health

Availability of policies

There are several important policy documents approved by Parliament or Government during recent years, having direct connection to mental health promotion and the prevention of mental disorders. The Lithuanian Health Programme (1999) and the National Suicide Prevention Programme (2002) include clear goals to improve the mental health of the population, to decrease the prevalence of suicides, to decrease levels of alcohol consumption or the prevalence of psychiatric consequences of alcohol use. Other policy documents, such as the National Plan against Poverty and Social Exclusion, Child Welfare Policy, National Public Health Policy, do not have specific chapters on mental health, but their main goals deal with the same risk and protective factors which are important for mental health promotion and the prevention of mental disorders.

In 1999, a National Programme for the Prevention of Mental Disorders was approved by the Government and launched. Despite attempts to balance mental health promotion, prevention and the development of psychiatric services, there was not enough attention during 2000-2004 to the issues of promotion and prevention, and the main attention of the Programme was to clinical mental health services. This led to the conclusion in 2005 that the National Programme for Prevention of Mental Disorders needed revision to better meet the requirements of effective mental health policies and practices.

Commitment to prevention and promotion

During the 1990s, indicators reflecting the population's poor mental health dominated the evidence of a public health crisis in the country. Gradually, there was increasing attention among politicians and the general public to the field of mental health. During the second half of the 1990s, several important decisions were made. The Mental Health Act was adopted in 1995. The network of municipal mental health centres as outpatient mental health teams started to develop. In 1999, the State Mental Health Centre was established to coordinate the development of mental health services. In 1999, the National Programme for Prevention of Mental Disorders was approved by the Government. In 2000, the State Mental Health commission was founded, and a National Conference on Suicide Prevention took place in Vilnius. The first attempts to make an independent assessment of existing mental health system concluded that modern public health approaches based on the principles of effective mental health promotion/prevention activities, were still very un-developed, and that the mental health system was too much dependent on institutionalized and medicalized psychiatric care.

Programmes and policies across settings

There are increasing attempts to implement mental health promotion and prevention activities outside the health sector. A good example of successful activities is the Lithuanian participation since 1993 in the European Network of Health Promoting Schools (ENHPS). The process of dissemination of the Health Promoting Schools (HPS) concept and the creation of the National Network of HPS started in 1997. As of early 2005, there are 155 certificated schools in the network (8.6% of all schools). Also, 199 preschool educational institutions are members of the National Network of the Health Promoting Schools.

The process of the development of the National Network of HPS involved the main institutions responsible for in-service training. A wide spectrum of programmes was offered for teachers' topics or themes closely related

to mental health, like: “Mental and Emotional health”; “Stress and its prevention”; “Children’s rights: concept and problems”; and “Education of social competencies of the disabled young people”. “Promoting Mental and Emotional Health in the ENHPS”, a training manual for teachers and others working with young people, was successfully accepted by pilot schools and introduced in some in-service training institutions.

As a part of implementing the HPS in a more sustainable way, new material was prepared in 2003, using a Life Skills approach, which develops skills in children to build the needed competencies for human development and to adopt positive behaviours that enable them to deal with the challenges of everyday life. It is planned to distribute the material to all schools during the 2005/2006 school year.

4 Organizations and resources for implementation

Infrastructures

During the 1990s, when it became obvious that mental health problems were becoming a serious threat to population health, new infrastructures were developed to implement public mental health activities. The State Mental Health Centre was established at the Ministry of Health in 1999, with a main task of co-ordinating mental health services and public mental health activities throughout the country. The Centre for Drug Control was established in 2004 in the Lithuanian Government. The State Mental Health Commission was founded in 2000 as an interagency group representing several ministries. A network of municipal mental health centres has been developing since 1997, with a mission not only to provide outpatient mental health services, but also to co-ordinate and implement mental health promotion/prevention activities.

Until now, there has been no clear decision about which structures, public health centres or mental health centres, are basically responsible for the development and implementation of regional (municipal) mental health promotion/prevention activities. There is an increasing amount of projects and programmes which are funded by municipal authorities in the field of mental health promotion and the prevention of the main mental health problems, suicide, different forms of violence, and dependence on alcohol and drugs. For example, in 2005, Vilnius city municipality allocated €173,000 to 17 project proposals in the field of public mental health. The City of Klaipeda, and the municipalities of Telsiai, Jurbarkas, Kasiadorys are among the pioneers in developing and implementing modern public mental health activities and introducing them in public health, health care, and the educational and social services. However, there are still unsolved problems in securing continuity and sustainability of activities. This problem is connected with a lack of tradition and culture of evaluation. In the absence of evidence for effectiveness of mental health promotion/prevention activities, there is a serious threat that politicians will discontinue financial support for these activities. It is also important to keep in mind that numerous community based projects in the field of public mental health have been supported by international foundations (for example, the Open Society Foundation) that have recently closed or are in the process of closing grant giving operations in Lithuania, after it joined the EU. This is why it is of vital importance that the Lithuanian government recognizes public mental health as a priority in the health and social sector, also because it is an condition for support from EU funds.

Child mental health should be regarded as the major priority in the national public health policy. After political changes in Lithuania in 1990, a Child Development Centre was founded by the Ministry of Health, which, in affiliation with the Centre of Child Psychiatry and Social Paediatrics, developed a demonstration model of community based services for children and families at risk, currently known in Lithuania and neighbouring countries as the Vilnius model. The model includes both promotion/prevention activities and modern child mental health care services, crisis intervention services, early intervention services for infants at risk and their families, integrated community based schooling services for moderately and severely mentally disabled children, independent living and vocational services in the community setting for mentally disabled youth, and a flexible chain of child psychiatric services. There are still problems to be solved to secure sustainability for funding of these services and replication of the Vilnius model throughout the country. But already, the model is

servicing for neighbouring countries in eastern Europe as a site for study visits, and could become in the near future a training centre in the field of child mental health and a good example of EU neighbouring policy.

Childline started its operation in 1997 in Vilnius, offering anonymous and confidential counselling and psychological support to children and adolescents through the telephone. The initiative was part of a vision of the “Vilnius model”, the implementation of a flexible spectrum of community based preventive and therapeutic services for children and families at risk, with the strategic aim of developing effective alternatives to traditional models, based on institutional care of children from families at risk. Childline has expanded its service and currently offers three forms of help, support by telephone, by internet and by post, nationally and toll free with three centres in Vilnius, Kaunas and Klaipeda. Wide public campaigning has demonstrated the enormous need for psychological support which, unfortunately, exceeds the current limits of the service. In 2005 there were 1.2 million attempts to reach the service by phone, but only 50,000 calls were answered.

Besides offering direct support to children and adolescents, Childline raises important child mental health issues for public debate. In 2004, Childline initiated a campaign “Stop bullying”, with the aim of raising awareness about bullying in schools, which had reached an epidemic level, according to the HBSC study in 1997/1998 and 2001/2002. Childline initiated about 50 trainings for school personnel, addressed several ministries and other governmental authorities encouraging the transfer of international anti-bullying programmes to Lithuania, and initiated information campaigns in the mass media and through the publication of brochures and placards, with the involvement of celebrities. The activities of Childline have, to a large extent, stimulated the development of the project proposal “Child and adolescent mental health in enlarged European Union: development of effective policies and practices” which was submitted and accepted by the EU Public Health Programme. Also, the activities of Childline contributed to the formulation of the draft of the new Lithuanian mental health policy, which has a strong emphasis on the promotion of children’s mental health.

Workforce for mental health

Traditionally, the public mental health sector has been represented by mental health professional groups (mostly psychiatrists, and to some extent psychologists) and the decisions about the development of mental health policies have been largely influenced by the interests of specialized psychiatric institutions. During recent years, the situation has started to change gradually, with an increasing involvement of the public health infrastructure in the field of public mental health. The psychology and social work specialties are looking for a new role in public mental health. Some universities (Vilnius University and Kaunas Medical University) now include public mental health issues in the curricula of training of public health professionals. In Vilnius University, since 2001, a new course in public mental health was introduced in the Masters programme of Public Health, and in the undergraduate curriculum of training of medical students. Kaunas Medical University, in co-operation with Vilnius University, successfully completed a project “Community empowerment in tackling mental health problems” funded by the Open Society Foundation. This was a first attempt to bring together the academic sector with different municipal sectors in the rural district Kaisiadorys (halfway between Vilnius and Kaunas) as well as the NGO sector, to develop modern public mental health interventions in a rural community.

There is an increasing interest from public health professionals and administrations at all levels (country and municipalities) to move from the traditional Soviet concept of public health (“sanitary hygiene”) to a modern public health approach, and to develop and implement effective projects in the fields of monitoring and population based interventions targeted at public mental health problems. The main obstacle for this shift is a lack of knowledge and skills in the field of monitoring public mental health indicators and effectiveness of public mental health interventions. Support from the EU is of utmost importance in this direction.

5 Monitoring and evaluation

During the last several years, there have been increasing efforts to introduce evidence-based levels of monitoring and evaluation in the field of public mental health and thus to change the former measuring processes (mainly, number of facilities, beds, visits and doctors) to outcomes. Mechanisms of monitoring and evaluation have been introduced in the National Public Health Strategy, the Lithuanian Health Programme, and the National Programme for Drug Control and Drug Abuse Prevention. Recently, several reports (National Health Board Report 2001, National Health Board Report 2004, Report on Lithuania Mental Health Country profile 2004) concluded that, despite achievements and efforts to develop an effective public mental health system, there still remain gaps and obstacles for the system to move to evidence-based policy formulation, development and implementation. In the draft of the new mental health policy, one of the main priorities is the emphasis on the need to invest in the system of evaluation and monitoring of the main indicators of public mental health, as well as indicators of performance of the mental health system.

The National Health Board, which is a body working at the Lithuanian Seimas (Parliament) has contributed in a serious and effective way in formulating and emphasizing the need to move to a modern public health approach in the field of mental health, specially in its annual reports to Parliament of 2001 and 2004.

6 Challenges

The first serious attempts to develop and implement modern public mental health approaches revealed serious obstacles which are deeply entrenched in traditional attitudes based on an institutionalised and medicalized mental health care system, a culture of dependency and stigma, and a lack of evidence-based evaluation of the outcomes of system performance. Strong dependency of the national health system and medical education on specialized medical care and a biomedical model is an obstacle for a better balancing of resources between the currently prevailing specialized medical (including psychiatric care) approach and a fragile public health approach (including mental health promotion/prevention activities, mental health in primary care, and community based mental health services). Similar imbalances still exist in the academic sector. Lithuania is only at the beginning of introducing modern public mental health training courses in the curricula of professionals in public health, medicine and other specialties. A lack of state supported research capacity in the field of mental health promotion/prevention is another serious obstacle. Due to former traditions, all national resources in health research are still concentrated in national institutes specializing in biomedical problems (cardiology, oncology, rheumatology), despite the epidemiological shift in the structure of morbidity and the burden of disease. The mental health information system is one more problem which needs to be solved in a modern way. Traditionally, statistical data have been dominated by numbers of beds, visits, doctors, hospitals, as well as data on morbidity which were not reliable, since only a small proportion of individuals with mental health problems are using services reflected by official statistics. There is an urgent need to move to a modern system of mental health information, so that both the population's mental health and the performance of the mental health systems can be monitored in a modern and comparable way.

One of main indicators of poor mental health is the very high suicide rates (42.1 per 100,000 population in 2003). Despite serious efforts to raise this problem as the main priority in the health sector, attempts to develop and implement an effective national plan of suicide prevention have not been successful. This is partly due to the still prevailing views that it is up to the psychiatric services to solve the problem of suicide as a consequence of an untreated medical condition, depression. A broader approach with strong involvement of the public health infrastructure, general practitioners, schools and communities, as well as a modern analysis of the contextual societal factors is needed. Similar challenges are also needed in the field of prevention of violence and alcohol and drug use disorders.

Intolerance for vulnerable groups among large segments of the population is a major societal obstacle, negatively influencing the decisions of policy makers. For example, in an ongoing public debate about harm reduction policies and practices in the field of prevention of drug abuse and HIV/AIDS, there is a popular approach among different politicians, professionals and NGOs to exclude harm reduction activities, despite the existing evidence of their effectiveness.

Similarly, a lack of tolerance is an obstacle for implementation of effective preventive community based approaches to support young parents who have social or mental health problems and have difficulties in their parental roles. To date, effective supportive home-based interventions are not funded in a sustainable way, and this may be one of the explanations as to why Lithuania has large numbers of children living in state institutions as “social orphans”. Effective programmes for increasing competence of parents at risk are much needed, so that the current societal attitudes to parents as being either “good” or “bad” (and therefore in need of punishment, as it is still popular to think in Lithuania) will change and become more mature.

7 Opportunities and advances in the field

The success of modern approaches in the field of public mental health in Lithuania, as well as in other eastern and central European countries depends to a large extent on the growth of civil society and a critical mass of sense of citizenship in the general public. This is a necessary condition for the successful implementation of modern public health approaches in the field of mental health. Gradually, there is a growing understanding both at the political level and among civil society that mental health problems need to be solved in modern ways, based on social inclusion, integration in the public health infrastructure, community, general health, education and social sectors, liberating mental health from political, professional and geographical isolation.

There is a growing informal coalition of organizations and individuals who are willing to contribute actively to quantitative and qualitative changes in the field of mental health and to support promotion and prevention in an effective, systematic, transparent and evidence-based way. Members of this coalition are politicians in the Parliament, ministries (under leadership of the Ministry of Health), municipalities, professionals, state agencies (National Health Board, State Mental Health Centre, Department for Drug Control, National Public Health Service), and numerous non-governmental organizations. The transformation of the mental health agenda from a closed topic with mental health policy decisions dominated by large psychiatric institutions to an open debate with involvement of all stakeholders (including increased involvement of politicians, civil society and public health professionals) will need international support from the EU, the WHO and other organizations.

The draft of a new national mental health policy, which was initiated by the Minister of Health Zilvinas Padaiga after the 2005 WHO Ministerial Conference, has a clear vision with, as one of the main priorities, the development of an effective and evidence based system of mental health promotion/prevention. Bearing in mind the large burden of mental disorders and a mental health system very dependent on specialized psychiatric institutions, the reforms in the mental health sector will take time. Now, it is very important to take the right direction, to target the main priorities and to capitalize on membership of the European Union.

An example of the new approach is the development of the project proposal “Child and adolescent mental health in an enlarged European Union: development of effective policies and practices”, subsequently co-financed by the 2005 EU Public Health Programme. After the WHO Ministerial Conference, and in the context of new political will announced by the Minister of Health, an informal consortium of twelve Lithuanian based partners (governmental, municipal institutions and NGOs) developed a draft project proposal targeted at children’s mental health in the new and candidate EU countries. In a short time, an additional 34 associated and collaborating partners from other European countries expressed their wish to join the initiative. The Ministry of Health and the Vilnius municipality committed to co-finance the project. Thus, in a way which would have been hardly possible several years earlier, a serious project proposal was submitted and granted in 2005, as a declaration from Lithuania that the country is ready to take public mental health seriously at all levels of governance.

Luxembourg

Prepared by Professor Charles Pull, Dr Jean-Marc Cloos and Dr Yolande Wagener

1 Introduction

The Grand-Duchy of Luxembourg is a founding member of the European Union. The territory spans a mere 2586 km². On January 2005, it had 455,000 inhabitants, with 38.6% of them coming from another country. The highest proportion of immigrants come from Portugal. The country has three official languages: Luxembourgian, German and French. People working in the health sector, in particular those working in the mental health sector, should be fluent in the three languages, have at least a working knowledge of English, and either speak Portuguese or be able to rely on another professional who speaks the language.

Health care, including care for mental health, is covered by a system of compulsory insurance. Health services fall under the responsibility of the Ministry of Health. In 2001, the country listed 52 psychiatrists, 120 psychologists, 149 psychiatric nurses, and 151 social workers. Patients may seek services from professionals in the public or the private sector. Services are almost completely reimbursed by social security in both sectors. Patients may see a specialist directly or ask his or her family doctor for a referral.

Mental health promotion can be also found in every day's life. The following story, which was told by a bus chauffeur to one of the authors of this report, is a good example of what mental health promotion is all about:

"In the morning I'm always greeting every girl and every boy who is coming into the bus. Some didn't have breakfast. Some live difficult family situations, some live in poverty, some have drug problems... In the evening I ask them how it went at school. I encourage them... next time you will do better..." It's important to show them that we respect the adolescents, that we are interested in them, that we love them. And look at my bus, the young people would never harm it; they also respect me and my bus".

2 Process to prepare country story

The information for the country story was taken from the annual reports of the Ministry of Health, the Ministry of Family and Integration, the Centre d'Information et de Prévention, the Centre de Prévention des Toxicomanies and the project "Solidarité Jeunes" of Médecins sans Frontières.

Additional information was provided by the following persons:

Mme Marie-Jeanne Bremer, Centre d'Information et de Prévention

Dr Jean-Marc Cloos, Clinique Ste Thérèse

Mr Alain Massen, Médecins sans Frontières – Solidarité Jeunes

Mme Thérèse Michaelis, Centre de Prévention des Toxicomanies

Pr Charles Pull, Centre Hospitalier de Luxembourg

Dr Yolande Wagener, Ministry of Health

In gathering the information for the country story, it rapidly became obvious that the current endeavour should be considered as a first step and as an exploratory initiative, but that it could be the beginning of a longer enterprise of continuous updating of information.

3 Action for promotion and prevention in mental health

Prevention and promotion have become more and more of a priority. In line with changes in other European countries, commitment to mental health has grown considerably in Luxembourg. In particular, Luxembourg has signed the WHO Declaration and Action Plan for Mental Health that was endorsed at the WHO Ministerial Conference on Mental Health (Helsinki 2005).

The year 2005 has been an important year in the overall “vision” and “perspective” of mental health in the country. The Ministry of Health ordered an in depth evaluation of the mental health system in place and the elaboration of recommendations for future development in accordance with the decentralisation of mental health services, the development of community infrastructures, and the development of mental disorder prevention and mental health promotion initiatives. The audit was prepared under the leadership of Professor Rössler, in close collaboration with national key mental health professionals. The general report has been finalized, and, according to specific areas (for example, children and youth, elderly, re-socialisation, community services) a number of working groups have just started their work, in which concrete measures and action plans will be worked out through an interdisciplinary approach. This initiative is an important milestone in the domain of mental health in Luxembourg against exclusion and stigmatisation of mentally ill persons, for the better understanding of mental health disorders and the complexity of their causes, for the possibilities for prevention, and the multi-factoral opportunities for the promotion of mental health in the different life areas of the population.

The WHO and the EU initiatives in the field of mental health are fundamental incentives and tools to bring forward national projects in the country. The international expert recommendations, evaluations of policies and action plans, examples of good practice are all important contributions for the development of the national strategies in the area of mental health.

Programmes and policies across settings

Mental health has been identified as one of the public health priorities in the country. In the field of prevention and promotion many different initiatives have been developed in recent years.

Considerable efforts have been made to increase awareness of mental problems in schools, in particular concerning drug abuse. Different agencies have been involved in this endeavour over the years, including the Police, the Centre de Prévention des Toxicomanies and the Project Solidarité Jeunes of Médecins sans Frontières.

To prevent suicide and to foster early recognition of mental health problems, educational courses (for both teachers and pupils) are regularly organised, for example by the Centre d'Information et de Prévention. In addition, several educational films have been produced (for example, on suicide, on attention-deficit hyperactivity disorder, and on other frequent mental health problems).

In addition, several health promotion programmes have been initiated. In schools, these include projects against violence, initiatives promoting healthy life styles and peer interventions; at the workplace, they include projects to prevent mobbing and to promote well-being; for underprivileged people, they include multidisciplinary support for immigrant or homeless people.

In the years to come, the mental health programme will pursue the following objectives:

- ▶ A process of fundamental change is enhanced, from a rather centralized mental health care system to a decentralized one, and many services will be reorganized. Community services will be developed and interdisciplinary projects will be reinforced and multiplied;
- ▶ The interactions and complementarities of interventions at different levels of mental health will be reinforced and improved, including promotion, prevention, medical therapy and rehabilitative measures;

- ▶ The prevention of mental illness and the promotion of mental health will be, more than in the past, an integral part of the global health promotion and prevention initiatives in different life areas or for specific population groups (for example in schools, at the work place, in favour of underprivileged people); and
- ▶ Particular efforts will be undertaken to improve the information and monitoring of mental health.

4 Organizations and resources for implementation

The Ministries of Health and of Social Security define health policy, provide for its implementation, as well as the application of laws and regulations regarding health, and for the supervision of institutions and services operating in the field of health. The Ministry of Social Security organises the different domains of social security (e.g., health insurance, dependency insurance). The Ministry of Health defines the main lines of public health concerning curative and preventive medicine. Duties are carried out by the government department, the Directorate of Health and the Socio-Therapeutic Services Department. Within the Ministry of Health:

- ▶ *The Preventive and Social Medicine Division* contributes to the elaboration and the organization of programmes of health education and preventive medicine and participates in the application of these programmes. The Division collaborates on a regular basis with schools, health professionals, medical and socio-medical services and private associations and has a targeted contact with the population.
- ▶ *The School Medicine Division* assures that pupils from the pre-school and from every level of school education benefit from a medical surveillance, including a complete check-up, routine screenings, and medical and dental examinations.
- ▶ *The Occupational Health Division* was introduced by a law in 1994, with the aim to protect workers at their workplace by organising medical surveillance and prevention from diseases and workplace accidents. The Occupational Health Division is responsible for the coordination and the control of the different occupational health services.
- ▶ *The Socio-Therapeutic Services Department* is responsible for the promotion, supervision and coordination of public (State, local authorities) and private initiatives in favour of persons suffering from a handicap, mental illness, drug addiction or affected by illnesses associated with old age. It manages contracts between the State and the private associations organising services in these fields.

5 Monitoring and evaluation

Examples of monitoring and evaluation of mental health programmes include the following projects:

- ▶ “Participation project of Youth”, by the Ministry of Family and of Youth, Youth NGOs and municipalities. This project aims to promote the participation of young people in the political, social and cultural life of their communities. The objectives are not only social involvement, but also improvement of self esteem, social cohesion and solidarity, and communication between generations and between cultures.
- ▶ Health Behaviour in School Aged Children Study, Luxembourg. The first HBSC study, according to the WHO protocol, was carried out in 1999/2000, under the responsibility of the Ministry of Health and the Ministry of Education. The completion of the national report, the discussion and the diffusion of the results were carried out in collaboration with a great number of concerned ministries, institutes, youth organizations and other NGOs, such as Family Planning, Drug Prevention Centre, Aids committee, schools, immigration associations, medico- and psycho scholar services, municipalities, and media. This approach promoted a better understanding for young people, for their complaints, problems and needs and, thus, indirectly, was a contribution to the promotion of the mental health and the well-being of young people in Luxembourg.
- ▶ Even if a majority of adolescents have the impression that their health is good, when asked more specifically, the situation appears to be more complex. Twenty per cent of adolescents suffer regularly from different physical complaints, some of which may have an important psychological aspect (headache,

stomach ache, difficulty to sleep), 30% of the young people say that they are often sad, 14% complain about isolation, and 10% suffer from stress.

6 Challenges

Promotion of mental health should be among the priorities of all organizations that are involved with the prevention and treatment of mental disorders. This is a major challenge, because it involves the collaboration of many different institutions and actors that need to work together in a coherent and efficient way.

For the time-being, only a few self-help groups exist for specific mental disorders. The creation and development of similar groups for other disorders should be fostered.

Within secondary prevention, promotion of healthy lifestyles (e.g. abstention from smoking, dietary measures, sports, etc.) should become an integral part of health care delivery in general hospitals. Mental health promotion will play a major role in these initiatives, since there is no health without mental health.

7 Opportunities and advances in the field

Major advances have been achieved in the last few years in many fields related to mental disorders in Luxembourg. Since July 2005, all patients suffering from a mental breakdown or a disorder, including those patients who need compulsory admission, can now receive treatment in a general hospital. Departments have been created for child psychiatry and adolescent psychiatry. Four day clinics have been created for patients who do not or who do no longer need full-time treatment in a psychiatry department. All of these advances have significantly improved the general image in the eyes of the general public, and reduced the stigma associated with mental disorders and their treatment.

Malta

Prepared by Dr. Raymond Xerri

1 Introduction

The Maltese archipelago is located in the Mediterranean Sea, just south of Sicily. It consists of three small islands namely Malta, Gozo and Comino with a surface area of 316 km². The total population in 2003 was 399,867.

Since 1995, mental health has gained importance on the local political agenda and all successive governments have given a priority to reform this sector through an incremental approach given the local culture and resource constraints. The reform of this sector is being implemented within the overall reform strategy of the health sector whose main objective is to provide a comprehensive and seamless service to our clients whilst fostering efficiency and value for money.

2 Process to prepare country story

Given the geographical size of the country and the close inter-ministerial collaboration, the Department of Health Policy and Programme Implementation within the Health Ministry was responsible for the draft of this country story.

Policy Directors within the various ministries meet on a regular basis to co-ordinate national policies and strategies within the overall Government's agenda. During such meetings mental health issues were discussed with key ministries to elucidate current and future action programmes aimed at bettering the mental health status of the country. Various issues were also discussed with the management responsible for the provision of the national mental health services and key health professionals employed within the mental health sector. Public agencies working indirectly in the mental health sector, the University of Malta and the few non-governmental organizations operating in this sector were also heard.

3 Action for promotion and prevention in mental health

Availability of policies

There is no specific policy on mental health promotion and prevention. However, such modalities of service provision are part of the comprehensive mental health policy document, *National Policy on Mental Health Service*, published in 1995 by the then Department of Health Policy and Planning within the Ministry of Social Policy.

The national health policy, *Health Vision 2000*, published in 1996, also identified mental health as one of the priority areas for resource allocation. This document lays various targets to be attained in a specific timeframe in key priority areas pertaining to the local disease burden, health risk factors and health management issues.

Both documents were formulated after extensive discussions using structured questionnaires with all key stakeholders including political parties, health professionals, senior managers in all ministries, the University of Malta, local church institutions, key public non-government organizations and the general public. Extensive epidemiological and operational research was also carried out to give a scientific basis to these policy documents.

The main focus of the national mental health strategy is to empower citizens to improve their mental well-being through integrated and comprehensive services ranging from health promotion to treatment that address the needs of society in general and patients and their social network.

SEDQA, the government agency responsible for providing comprehensive services against substance abuse has formulated a number of national strategic documents (unpublished) to address the ever increasing prevalence of substance abuse.

Commitment to prevention and promotion

The policy document *The Vision behind the Health Sector Reform* espouses the philosophy that all reforms should be client centred, enhance value for money and shift resources from a 'health repairer' to a 'health maintenance' modality of service provision. In this light, the government is committing more resources to health promotion and prevention over the past years. Whilst the Health Ministry takes the lead in most of these initiatives, our approach is not to build structures and organizations to carry out such programmes but to utilise, where possible, resources available in other ministries to attain our objectives. This methodology is possible within the local scenario given the geographical size of the country, the effective inter-ministerial collaboration and the fact that all national policies and strategic implementation in the health and social sector are centrally co-ordinated by the Cabinet Sub-Committee on Social Policy composed of the Ministers responsible for Education, Health, Social Policy and Finance together with key civil servants responsible for these ministries.

Following the Helsinki Declaration and Action Plan for Mental Health in Europe, Malta is committed to attain most of the objectives laid down in these documents especially with regards to mental health promotion and prevention. A multidisciplinary Working Group has been set-up to determine the various community action programmes needed to convert words and vision into action. The initial main target audience of the Working Group are school children between the ages of 11 to 15 years.

The Government has approved the policy paper espousing the reform in the public primary health care sector. The main focus of this reform is to utilise current resources allocated to this sector to provide a spectrum of services ranging from health promotion to care for local health priority areas, including mental health. A pilot multidisciplinary team was set up to provide such services in the mental health sector.

Programmes and policies across settings

Various programmes on mental health promotion and prevention are currently provided by the public sector and non-governmental organizations.

Within the school environment a programme against substance abuse is provided by the national agency responsible for the provision of services in this field. Mental health promotion is also catered for in the national educational curriculum and delivered by teachers trained in Personal Social Development. All school children between the ages of 11 to 15 years have a minimum of one hour per week on personal social development whereby they are empowered to build the skills needed to be responsible citizens within society, integrate positively within their social peer groups, and cope with every day life situations and stress factors. Psychological services are also provided by the Ministry of Education for children needing such care. The Health Ministry is planning to provide secondary prevention services in the mental sector for children at risk of mental or psycho-social problems. A non-governmental organization, Mental Health Association, provides mental health promotion in schools through lectures and educational material.

Mental health awareness campaigns are regularly conducted by the Health Ministry with the active support of the media, especially television stations. An anti-stigma campaign aimed at demystifying mental disorders and to encourage people to seek early intervention is an ongoing initiative. School children are regularly invited to our psychiatric hospital as part of the Personal Social Development programme. The aim of such

visits is not only to de-stigmatise mental health but also to give knowledge on common psychiatric problems like depression, and the importance of early treatment.

Workplace mental health is currently not provided by state agencies although non-government organizations like Caritas provide a service for substance abuse, while the Richmond Foundation provide some services for the detection and treatment of depression.

Given that the immediate family of clients suffering from mental disorders are more at risk to develop mental health or psycho-social problems, support programmes are provided to this client group by the public health sector in collaboration with the Mental Health Association.

Cognisant that depression is a major disease burden within our community and has significant socio-economic consequences, a comprehensive action programme for the early diagnosis and treatment of depression is planned to be implemented in the near future with the assistance of the UK Department of Health and the University of Malta.

4 Organizations and resources for implementation

Infrastructure

The Health Ministry does not support the view that all services have to be delivered by organizations set up within the public health sector. On the contrary, given our quest for cost-efficiency and maximisation of available national resources, the Health Ministry strives to attain its health agenda through collaboration with other Ministries, non-governmental organizations, the private sector and church institutions.

Given the inefficiencies in the health sector and the various cost drivers exerting constant upward pressure on central funds, it was quintessential in our health reform programme to ensure the sustainability of all service provision by curtailing areas of resource wastage and re-directing such resources to better use. This strategy was coupled with the implementation of appropriate management systems and processes that foster accountability and responsibility amongst all health care professionals for resource utilisation, performance and outcomes. Our experience in applying such reforms in the mental health sector were very positive with substantial cost curtailment enabling the Ministry to provide new services at no additional cost to the taxpayer, whilst substantially improving the quality of the services provided.

The public mental health sector is managed by a single agency which is responsible for the provision of all community and institutional services. This facilitates the provision of comprehensive, integrated and seamless services, and the shifting of resources from the hospital to the community sector. The new *Health Services Act* (unpublished), to be enacted during 2006, will ensure that all public health care agencies provide health services through service level agreements between the Ministry and the respective agency. Such service agreements will inter-alia delineate amongst other deliverables and contract provisions, the service required, the expected quality to be delivered, performance targets, method of financing the agreement, and monitoring mechanisms.

As already highlighted, other key Ministries, notably the Ministry of Education and the Ministry of the Family and Social Solidarity are well placed to implement various programmes of the national mental health policy. Similarly, other non-health government agencies responsible for social work services (Appogg), substance abuse services (Sedqa) and mental disability services (Support) actively collaborate with the mental health agency to provide services to this client group through agreed protocols. There is close liaison with the Ministry of Home Affairs to provide mental health services for prisoners and illegal immigrants.

An employment support scheme is run by the government agency for employment and a non-governmental organization, the Richmond Foundation, for clients suffering from long term mental disorders. Another

such scheme is also provided within the mental hospital whereby clients with long term mental disorders are employed within the hospital as part of their rehabilitation programme. The main objectives of such programmes are to empower clients to integrate and live independently within their own community.

Religious and non-governmental organizations work in tandem with the mental health agency for the provision of certain community services like support groups, hostels, mental health promotion and rehabilitation.

Workforce for mental health

The health sector is labour intensive. Conscious that the quality of the services provided mainly depends on the technical acumen of the health professionals and appropriate caseload, various initiatives were implemented to address these parameters.

Since 1999, the Institute of Health Care within the University of Malta initiated training programmes leading to a diploma in psychiatric nursing. Continuous Professional Educational programmes are regularly organised by the mental health care agency in collaboration with the University of Malta, other governmental agencies notably the Social Work Services Agency and foreign institutions. Discussions have been initiated with the UK Department of Health for the provision of ad hoc training courses and short term exchange programmes for health care employees within the mental health sector. Funds provided by the European Commission under the Leonardo Programme have been availed of to train staff in the UK in evidence based community services.

A training programme for family doctors in the diagnosis and treatment of common psychiatric morbidity was implemented on a pilot project. It is envisaged that this programme will be formalised and extended with the assistance of the University of Malta and the UK Department of Health.

The University of Malta also organises credits in mental health as part of a degree programme for students reading social work or psychology and for those studying for the priesthood.

Given that teachers are an important resource for mental health promotion and prevention, plans are being drawn up to implement training programmes for such a professional group.

As the demand for services always exceeds the supply, management systems have been piloted in the psychiatric social work sector to prioritise requests for services. This ensures that those in most need are given priority; social workers have a manageable workload, decreasing the risk of burnout amongst these health care workers.

Due to local constraints, research in evidence based practice is not cost-effective. In this light the mental health care agency is seeking to enter into twinning arrangements with overseas organizations working in such research to implement evidence based practice across all modalities of service provision.

5 Monitoring and evaluation

There are no formalised monitoring systems to evaluate the effectiveness of national programmes implemented in the mental health care sector. In 2002, the WHO Task Force on Mental Health Assessments was invited to Malta in order to conduct an assessment of services provided.

6 Challenges

There are various internal and external challenges for the improvement of the mental health well-being of our country.

Amongst the internal challenges are the reluctance to change amongst certain professional groups in particular to systems that monitor their performance and outcomes. These are perceived by some as an

infringement of their clinical governance. Other challenges include the further integration of mental health services within the mainstream health sector, the availability of adequately trained professionals and the implementation of evidence based practice.

The four main external challenges are stigma, the financing of the mental health sector, the changing social norms and values, and demographic change. Despite ongoing educational campaigns, stigma against mental disorders is still widespread which still prevents people from seeking early treatment. The constraints on central funding is jeopardising the sustainability of current services and limits the implementation of new services. Proposals for a new financing strategy for the health sector that ensures the provision of adequate funds for current and future health needs have been presented to the Government for its consideration. Changing social norms like family separations, the breakdown of the extended family network, and the increasing older population are increasing psychiatric morbidity. Our challenge is to provide effective services that promote mental well-being for such client groups.

7 Opportunities and advances in the field

The close inter-ministerial collaboration should be harnessed to provide evidenced based services and implement new services through available resources across ministries. Similarly, the furtherance of synergistic action with non-governmental organizations needs to gain more momentum to avoid duplication of resources.

In line with the Lisbon Agenda, the government is formulating a national strategy to increase the competitiveness of the local economy to create wealth and employment. The Health Ministry is highlighting the fact that mental disorders are a significant cost to the local economy and further adequately funded programmes need to be implemented to improve mental well-being through health promotion, prevention and early intervention.

A new mental health law needs to be drafted to promote the quality of care and human rights. The abolition of certain consequential repercussions that befall patients that are sectioned under the current legislation may support early recourse to treatment and lessen stigma. In our strategy to combat stigma more effort is needed to harness the media to project positive messages on mental health.

Documents referred to:

1. Department of Health Policy & Planning, 1995, *National Policy on Mental Health Service*, Malta.
2. Department of Health Policy & Planning, 1996, *Health Vision 2000*, Malta.
3. Department of Health Policy & Planning, 1998, *The Vision Behind the Health Sector Reform*, Malta.
4. Ministry of Health, 2005, *Health Services Act*, Malta [unpublished].
5. WHO Task Force on Mental Health Assessments, 2002, *Mental Health in Malta – Report of Assessment Mission*, WHO Europe.

Norway

Prepared by Professor Maurice B. Mittelmark

1 Introduction

The term for mental health in Norwegian, *psykisk helse*, translates directly as mental health, but is used most frequently to refer to mental health problems, as in most countries. In Norway as in the rest of Scandinavia and Europe, mental health problems account for a significant proportion of disability and morbidity. During the past decade there has been increased attention by the government to the need for increased financing of mental health services and improvements in the infrastructure to provide the right services at the right time and place. While serving as Prime Minister, Kjell Magne Bondevik attracted international attention in August 1998 when he reported publicly that he was suffering from depression, becoming the highest ranking world leader to admit to suffering from a mental problem while in office. He took a three week leave, during which time the subject of mental health was very highly on the media's agenda and a topic of conversation everywhere. Bondevik's openness was very much admired, and provided an opening for public discussion and debate about mental health that would hardly have been possible without his revelation. Since that time, there has been a clear increase in government emphasis on addressing mental health challenges in Norway, although of course no one is satisfied that enough resources have yet been committed to improving the country's mental health.

2 Process to prepare country story

This report was compiled by Professor Maurice B. Mittelmark, University of Bergen, from published information from four primary sources:

1. Ministry of Health and Care Services (MHCS), which administers a national mental health plan for the period 1999-2008, approved by the Parliament in 1998. See <http://odin.dep.no/filarkiv/233840/MentalHealthWeb.pdf> for more detailed information on the Norwegian government's mental health services programmes.
2. Mental Health (MH), which is Norway's largest NGO for mental health service users and families and others interested in mental health. See <http://www.mentalhelse.no/> for more information.
3. Council for Mental Health (CMH) is an umbrella organization with members including universities, patients' associations, health professionals' societies and organizations, and NGOs such as the Red Cross. See <http://www.psykiskhelse.no/> for more information.
4. The Norwegian Research Council's Programme for Mental Health, which is a government research programme providing the largest source of public funding for the conduct of research and the training of researchers in mental health subjects. See <http://www.forskningsradet.no/servlet/ContentServer?pagina me=mental/Page/HovedSide&c=Page&cid=1088006004168> for more information.

The author takes full responsibility for the selection of material included in this report, which is prepared for the purposes of IMHPA only. This summary is not intended to be an official or comprehensive representation of mental health services and programmes in Norway. To the contrary, the report is a highly select compilation aiming to sketch the broad outlines of the mental health promotion and mental disorder prevention landscape in Norway, for persons outside the country wishing an overview. The Internet resources given above should be consulted for more detailed information.

3 Action for promotion and prevention in mental health

Availability of policies

A government report submitted to the Parliament in 1997¹ revealed shortfalls in mental health services – primary, secondary and tertiary – and in response the Parliament in 1998 approved a mental health programme (1999-2006)^{2,3} that calls for major investments in, and expansion and re-organization, of mental health services. The Bill mentions mental health promotion in several instances, but the content of the bill focuses on mental disorder treatment and prevention. The programme has seven main aims: (1) empower clients; (2) increase public awareness of mental health issues through education programmes; (3) strengthen community-based prevention and early intervention services; (4) expand specialised mental health services for adults, adolescents and children; (5) improve the mental health workforce; (6) improve accessibility of accommodation and housing for clients of mental health services; (7) stimulate education and research.

The national policy of 1999-2008 contains a well-articulated strategy aimed at the prevention of mental disorders, but does not include a mental health improvement strategy (improved functioning for the entire population). As to prevention, monitoring and early intervention are the main means proposed, and the social, economic and cultural determinants of mental health are not addressed in any significant way. However, national public health policy includes strong elements of mental health promotion without claiming explicitly to do so. As a prime example, a key government report ‘There is Use for Everyone’⁴ emphasises that municipalities’ public health efforts should be conducted in ways that promote better quality of life and participation in society. The concept of empowerment is central to the government’s strategy to act on the conviction that everyone in society – including the disabled, those with functional limitations, retirees, immigrants and youth – can fill their valued place in society, assuming supportive conditions are in place in community, workplace, school and neighbourhood.

Also, policies in other public sectors show recognition that improvements in social and economic conditions have a positive effect on health and functioning, including better mental health. As a prime example, the Social Security Administration administers a programme called ‘Inclusion in Work Life’⁵, that aims not just at full employment, but also worthy and fulfilling employment and working conditions. The programme has elements dealing with control and management of work-related stress, the prevention of bullying in the workplace and the stimulation of flexible working conditions for persons who cannot work normal routines.

Commitment to prevention and promotion

The WHO Declaration and Action Plan for Mental Health endorsed at the WHO Ministerial Conference on Mental Health (Helsinki 2005) is a recent event that has not yet had demonstrable effects in Norway. However, as the above paragraphs describe, the prevention and early management of mental health problems is a top priority of the government and is high in the public discussion and debate agenda. When the subject turns to mental health promotion, complications arise, not because mental health promotion is lacking, but because it is rarely labelled as such. As but one example, there exists a national programme to prevent bullying in schools, part of the government’s national action plan to prevent child and youth criminality⁶. Although the programme ostensibly is aimed at the prevention of problem behaviour, it has obvious mental health promotion significance. This example of ‘hidden’ mental health promotion policy is not an isolated one, quite the contrary.

¹ <http://odin.dep.no/hod/norsk/dok/regpubl/stmeld/030005-040008/dok-bn.html>

² <http://odin.dep.no/hod/norsk/dok/regpubl/stprp/030005-030014/dok-bn.html>

³ The period was later expanded to 2008.

⁴ http://odin.dep.no/hod/norsk/dok/andre_dok/nou/030005-020018/dok-bn.html

⁵ <http://www.trygdeetaten.no/default.asp?strTema=arbeidsliv&path=inkluderende>

⁶ <http://www.uib.no/psyfa/hemil/BFDKOMPRESREDI01B2.html>

Programmes and policies across settings

Settings-based mental health programmes abound, but not identified as such. The examples given regarding the inclusive workplace and anti-bullying programmes in schools illustrate the point. Norway also has a large, well functioning health promoting schools programme (Norwegian Network of Health Promoting Schools)⁷, and national programme for health promoting workplaces⁸, both of which have significant mental health promotion impact, even if mental health promotion is not named as the primary aim of the programmes.

There exist a number of programmes aimed at preventing and/or providing early treatment of depression. The Council for Mental Health, described earlier, has this arena as a priority, having recently devoted an entire issue of its journal, *Mental Health*, to the topic (Vol 3, 2005).

The prevention of suicide is recognised by the government as a shared responsibility⁹. The government's strategy has these elements: (1) engage in prevention in many arenas outside the health care sector, including education, employment, law enforcement, social services, elder care, housing, etc.; (2) engage in measures to curb alcohol and drug abuse, depression, child abuse, social isolation and mental health problems generally; (3) restrict access to means of suicide including weapons, medicines and poisons. An example of local action is the establishment in 1996 of the centre for the Prevention of Suicide in North Norway¹⁰.

4 Organizations and resources for implementation

Infrastructures

The number of organizations and entities that implement mental disorder prevention are several hundred, as virtually every community has activity in this arena. The major national-level organizations are these:

1. Ministry of Health and Care Services (MHCS), which administers a national mental health plan for the period 1999-2008, approved by the Parliament in 1998. See <http://odin.dep.no/filarkiv/233840/MentalHealthWeb.pdf> for more detailed information on the Norwegian government's mental health services programmes.
2. Mental Health (MH), which is Norway's largest NGO for mental health service users and families and others interested in mental health. MH, with local affiliations in all corners of Norway, has since its establishment in 1978 championed openness regarding mental health and sought to rectify myths and eliminate taboos concerning mental health. It plays a key role in public education in the mental health arena with a web site, journal and newsletters and public conferences and meetings. It serves as a lobbying force for mental health. See <http://www.mentalhelse.no/> for more information.
3. Council for Mental Health (CMH) is an umbrella organization with members including universities, patients' associations, health professionals' societies and organizations, and NGOs such as the Red Cross. CMH works to better the foundations for good mental health through professional development, public education and political activity. A key aim of CMH is to improve the daily lives of people with mental health problems and their families. Along with the Norwegian Research Council, CMH is an important source of funding for the training of mental health researchers, and funds also a wide range of education and outreach projects. It publishes the journal *Mental Health*. See <http://www.psykiskhelse.no/> for more information.
4. The Norwegian Research Council's Programme for Mental Health, which is a government research programme providing the largest source of public funding for the conduct of research and the training of researchers in mental health subjects. See <http://www.forskningsradet.no/servlet/ContentServer?pagina me=mental/Page/HovedSide&c=Page&cid=1088006004168> for more information.

⁷ <http://www.uib.no/psyfa/hemil/hefres/>

⁸ <http://www.stami.no/fagsek/whp/>

⁹ http://www.fhi.no/eway/default0.asp?pid=223&oid=0&e=0&trg=Area_4504&MainArea_4320=4498:0:15,2336:1:0:0:4320;4349;;;0:0:0&ContentArea_4498=4504:0:15,2345:1:0:0:4320;4498;;;0:0:0&Area_4504=4336:49751::1:4751:1:4320;4498;4504;;;10:0:0

¹⁰ <http://www.unn.no/avdelinger/spesialpsykiatrisk/selvmord/>

For a partial list of other organizations involved in mental disorder prevention, see <http://www.psykiskhelse.no/artikkel.asp?id=172>.

Workforce for mental health

The professional mental health workforce is highly diversified and not necessarily identified with mental health, for reasons given earlier. Mental health promotion is woven into the fabric of the welfare state, and virtually all health care workers would agree that mental health promotion is part of their work. However, the Norwegian Psychological Association¹¹ deserves special mention. That is because in Norway, clinical psychology enjoys a central place in the health care delivery system, with status, professional privileges and responsibilities on a par with psychiatry. Psychiatry is a well developed specialty in Norway¹², as is psychiatric nursing¹³. Training in these disciplines happens in specialised environments but even in training, cross-discipline interaction takes place. In continuing education and in clinical settings, interactions amongst these and other disciplines (e.g. physical therapy, pharmacy) are common.

5 Monitoring and evaluation

The National Public Health Institute¹⁴ conducts population based research that includes mental health indicators. From various national registries, data on suicide rates and trends are reported regularly, as are data on use of specialised mental health services, and the rate of disability pensions given for mental and behavioural disorders. The information from these data sources is published in government reports and in the academic literature. Publicly accessible data bases are also offered online. Programme evaluation is part of the public health culture in Norway. All major programmes undergo evaluation. For example, a comprehensive evaluation of interim progress on the government's programme for mental health 1999-2008 was published recently¹⁵. Sector-specific programmes are also evaluated, as for example the national programme for mental health in schools¹⁶.

6 Challenges

Far too little is spent in Norway on research in general and on mental health research in particular. This includes basic research and especially applied research to develop and test effective primary and secondary prevention programmes. When effective programmes are developed, there are always too few resources to disseminate them everywhere they are needed. The proportion of resources devoted to community-based mental health promotion is too small, and needs increasing, but not at the expense of the resources now available for mental disorder prevention and treatment.

7 Opportunities and advances in the field

Although no one could ever be satisfied that enough is done to address major social issues, in Norway the years since 1997 have witnessed a truly remarkable response to growing recognition that the prevention, early detection and treatment of mental disorders is vital to the health and functioning of society. Real investments have been made to increase treatment capacity, conduct community-based prevention programmes and expand the workforce. Encouragingly, changes in governments since the mid-1990s have not shaken the resolve to address these issues with long term solutions and resource prioritisation.

¹¹ <http://www.psykol.no/>

¹² <http://www.legeforeningen.no/index.gan?id=56757&subid=0&PHPSESSID=a2178760bab2dd5f8211b420c0aa228d>

¹³ <http://www.sykepleierforbundet.no/Nettside/faggrupper/psyksyk.nsf/docPrCat?OpenView&RestrictToCategory=Nyheter>

¹⁴ http://www.fhi.no/eway/default0.asp?pid=223&oid=0&e=0&trg=MainArea_4320&MainArea_4320=4498:0:15,1213:1:0:0:4320;4349:::0:0:0

¹⁵ <http://odin.dep.no/filarkiv/187063/S.pdf>

¹⁶ <http://www.psykiskhelseiskolen.no/venn1.asp?id=378>

Poland

Prepared by Professor Czesław Czabala, Dr. Krzysztof Ostaszewski and Katarzyna Okulicz-Kozaryn

1 Introduction

Mental health promotion is not a priority in Poland as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers, or by the amount of resources put into the field. However, the National Mental Health Programme, based on the Mental Health Act, has been developed by the Institute of Psychiatry and Neurology many years ago, but has not been accepted until now. The authors of the Programme assumed that the political and economic transformation in Poland is associated with an intensification of the existing risks to mental health and with the emergence of new ones. At present, interventions in the area of mental health promotion and prevention of mental disorders are insufficient. In the Programme of mental health promotion and primary prevention, 6 goals are listed: (1) monitoring of needs in the field of mental health protection, and evaluation of interventions' efficacy, (2) popularisation of knowledge about mental health problems, (3) development of psychological and social competencies of individual persons, (4) development of mental health promoting behaviours and styles, (5) minimisation of environmental and social risks to mental health, and (6) inclusion of mental health problems in the health policy of the State and health care programmes. The main aim of the secondary and tertiary prevention programmes is to make health care and other forms of assistance necessary to living in the familial and social environment available to persons with mental disorders. An important part of the programme is the model of community-based psychiatric services provision.

2 Process to prepare country story

Completing the country questionnaire and preparing the country story were undertaken by the members of the National Council on Mental Health Promotion. All of them received the questionnaire and the collected data which were put together and discussed and accepted during the plenary meeting.

The Members of the National Council are:

Marta Bogdanowicz, Czesław Czabala, Tadeusz Cysek, Barbara Daniluk-Kula, Stanisław Dąbrowski, Antoni Florkowski, Adam Frączek, Janusz Grzelak, Irena Heszen-Niejodek, Brunon Hołyst, Piotr Jabłoński, Zdzisław Kapelski, Wojciech Kłosiński, Jerzy Kwaśniewski, Maria Majewska-Sokołowska, Jerzy Mellibruda, Barbara Mroziak, Irena Namysłowska, Krzysztof Ostaszewski, Stanisław Pużyński, Helena Sęk, Krzysztof Tronczyński, and Krystyna Wyrwicka.

3 Action for promotion and prevention in mental health

Availability of policies

There is an ordinance of the Cabinet on mental health promotion and mental disorders prevention activity and implementation issued in 1996 by the Prime Minister of Poland. This ordinance describes the ways in which promotion and prevention should be implemented, provides information on what types of public institutions are responsible for the implementation of mental health promotion and prevention of mental disorders, and lists the basic objectives in these two areas. The strategy components include:

1. Development of appropriate knowledge and skills in the society needed for self-development and self-actualisation, coping with stress and environmental demands.
2. Development and implementation in school educational curricula activities aimed at enhancement of the skills of solving problem situations and coping with stress.
3. Development of educational programmes on mental health promotion and their implementation in the curricula of under- and postgraduate training of professionals involved in teaching and upbringing, treatment and care provision, re-socialisation and rehabilitation, management and organization of labour.
4. Implementation of educational programmes in working places, enabling the development of healthy relationships.
5. Providing different forms of psychological, educational, marital and family counselling, vocational guidance, etc., as well as to improve service provision through existing facilities, such as child guidance clinics and social welfare organizational units.
6. Providing psychosocial support for children and adolescents at risk for mental health.
7. Organizing and promoting the development of various forms of social support, especially self-help groups, to people with mental disorders.
8. Establishing crisis intervention centres for people suffering from emotional crises and for families experiencing difficult life situations.
9. Establishing provincial and communal centres providing counselling, guidance and psychosocial support to people at risk for mental health.
10. Providing professional training for those professionals involved in mental health promotion, counselling and other psychosocial support.
11. Supporting research on psychosocial factors promoting enhancement and maintenance of mental health, and on factors detrimental to mental health.

In the field of alcohol related problems, prevention activities and strategies are organized by The National Programme of Prevention and Resolving Alcohol-Related Problems, Goals and Action Plan for the Years 2000-2005. The National Programme is a basic document of governmental administration providing the key objectives, strategies and methods of State policy regarding alcohol-related problems and specific objectives for several ministries and the district administration. The programme sets out eight objectives (e.g. to reduce alcohol consumption by teenagers, to reduce health risks caused by alcohol) and several strategies (e.g. constructing an effective legal and public control over harmful behaviour resulting from alcohol, supporting activities of self-help groups).

In the field of drug-related problems, prevention activities and strategies are structured by the National Programme for Counteracting Drug Addiction, 2002-2005. In compliance with the Law of April 24, 1997 on Counteracting Drug Addiction, the National Programme for Counteracting Drug Addiction provides the basis of activities in the scope of drug prevention. It was established by the Council of Ministers upon the motion of a minister competent in the scope of public health. The current programme gives priority to supply and demand reduction, the issues of co-ordination and flow of information. It also includes a separate area related to research and monitoring carried out in close co-operation with EU agencies.

In the field of prevention of other problem behaviours, the activities and strategies are set by the National Programme of Social Maladjustment and Delinquency Prevention Among Children and Adolescents. The Programme was developed at the initiative of the Prime Minister by a multidisciplinary Task Force in 2003. The Programme outlines the framework and directions of activities undertaken by particular ministries, local self-government agencies, and NGOs. The aims of the Programme are to prevent further increases in social maladjustment (including delinquency) among children and adolescents, and to reduce outcomes of social maladjustment, particularly those that threaten the health and life of children and adolescents. The prevention of juvenile delinquency and social maladjustment in children and adolescents includes a system

of integrated activities to eliminate risks to healthy child development by providing children with satisfactory living conditions, supportive education and upbringing, a sense of safety, acceptance, and subjectivity, as well as active participation in culture and healthy leisure time. Moreover, children's rights should be respected. There are three main components to prevent social maladjustment, targeted at various groups of recipients:

1. Anticipatory activities – education of the society as a whole, with the focus on children and adolescents, parents and teachers/educators;
2. Restraining activities targeted to at-risk groups of children and adolescents with impaired or disturbed socialization; and
3. Re-socialisation and therapeutic interventions targeted to social groups at risk for social pathology and to socially maladjusted children and juvenile offenders.

Commitment to prevention

Even from the perspective of the above mentioned legislation, mental health is not a priority in Poland as evidenced by the amount of resources put into the field during the last years and by the number of programmes implemented into real practice. The only exception is the field of substance abuse prevention (both alcohol problems and drug-related problems). The State Agency for Alcohol Related Problems Solving and partly the National Bureau for Drug Prevention are supporting the development and application of some preventive programmes. Unfortunately, these programmes are not becoming a regular part of the activities of the institutions which have implemented them during the time of agency support.

There are several areas in mental disorders prevention that are almost completely neglected, especially suicide prevention. Although there is epidemiological data available on these problems, there are no policies, practices or research to prevent them.

Programmes and policies across settings

There are some good experiences of programmes and policies across settings:

1. Some of the new programmes have been implemented in school settings over the last decade. These programmes are mostly focused on prevention of alcohol and drug-related problems and violence (e.g. school-based intervention toward a drug using student, see: www.imhpa.net/programmes-database).
2. During the early 1990s, the project of Health Promoting Schools (HPS) was implemented and tested in 14 pilot schools. The concept was gradually extended and institutionalised in the education system and is now a part of the European Network of Health Promoting Schools (ENHPS), with a national network and several local networks. It is estimated that more than 1000 schools in Poland are in the network.
3. The National Network of Health Promotion in the Workplace, co-ordinated by the Institute of Occupational Medicine in Lodz, addresses issues of traumatic events in the workplace, consequences of socio-economic changes and unemployment, stress management and smoking prevention.
4. Several National Campaigns were organized to provide mental health awareness raising activities and training e.g. "Schizophrenia – Open the door".

4 Organizations and resources for implementation

Infrastructures

The National Council on Mental Health Promotion was appointed by the Ministry of Health in 1997. The Council published a report on the mental health problems in Poland, and on the state of art of mental health promotion in Poland. The Council has also prepared the draft project of mental health promotion in Poland. Since 2001, the new Minister of Health has not supported the Council and its activities have practically

stopped. The Council is still trying to convince the Ministry of Health to adopt the programme on mental health promotion implemented as government law. During October 2005, the Conference on Mental Health Promotion in Poland was held in Warsaw as one of the instruments of convincing politicians to become involved in the field.

Various statutory bodies, for example, the National Bureau for Drug Prevention, the State Agency for Prevention of Alcohol Related Problems, the National Council for Mental Health Promotion, non-governmental organizations, for example, the ITACA, professional bodies, for example the Polish Psychological Association, some academic institutions, for example, the Institute of Psychiatry and Neurology have all played a part in the development and delivery of public mental health and mental health improvement.

Workforce for mental health

There is a poor system of providing training and education for undergraduate students in academic settings. There are many training programmes implemented among different groups of professionals to improve their skills in a broad area of mental health promotion. This is probably the largest area of activities regarding mental health promotion in Poland, but mostly limited to substance abuse prevention. There are several institutions at the national level (e.g. CMPPP- Methodical Centre of Psycho-Pedagogical Assistance, National Bureau for Drug Prevention, ETOH Foundation) that provide professional training courses for staff of educational system professionals, social workers, and NGOs' members etc. Some of these trainings were carefully planned and evaluated (e.g. school-based intervention toward a drug using student, see www.imhpa.net/infrastructures-database).

5 Monitoring and evaluation

The Mental health promotion strategy at the national level has not been evaluated. However, some elements and programmes have been evaluated (e.g. school-based alcohol primary prevention programmes: "Noah", "Second Primer", Polish adaptation of the US "Project Northland", and school-based intervention toward a drug using student, see www.imhpa.net/programmes-database).

The Health Behaviour in School-Age Children (HBSC) study, a WHO Collaborative Cross-national Study, is implemented in Poland.

6 Challenges

The key barriers to progress or the challenges facing mental health promotion and mental disorders prevention in Poland are:

- ▶ Lack of political will to implement the policies stated in governmental documents.
- ▶ Lack of higher education in mental health promotion and disorder prevention.
- ▶ Lack of co-operation between state agencies and other organizations which receive funds for mental health promotion; separate programmes are developed on alcohol and drug addiction prevention.
- ▶ Funding of research in mental health promotion does not exist in Poland. Most research in this area is supported by foreign institutions or within international projects.

7 Opportunities and advances in the field

The most significant opportunities come from existing organizations that are ready to undertake promotion and prevention activities. The Institute of Psychiatry and Neurology has proposed amendments to the Mental Health Act, which could lead to the incorporation of a National Mental Health Programme into government

policy. The crucial part is the programme of mental health promotion and prevention of mental disorders. The adoption of these amendments by the Parliament would secure financial resources for training and implementation of many existing national and international programmes. According to this draft project the role of the National Council for Mental Health Promotion could play an important role in programme implementation.

The National Bureau for Drug Prevention and the State Agency for Prevention of Alcohol Related Problems have been a great support in developing several substance abuse prevention programmes. Strengthened co-operation between them and the National Council would result in better programmes and better co-ordination of their implementation.

In some of the universities, new curricula, which include mental health promotion and mental disorder prevention, have started to develop, for example in the Academy of Special Education and in the School of Higher Education in Social Psychology.

The national conference on mental health promotion, which was recently held in October 2005, has provided the opportunity to bring together professionals and local authorities involved in the field to discuss the possibilities of collaborative work, and to identify advances that foster mental health promotion.



Portugal

Prepared by dr. Maria João Heitor dos Santos, dr. Ricardo Gusmão, dr. Sara Ferreira and dr. Marta Santos

1 Introduction

Portugal is a country with an approximate area of 92 thousand km², a population of 10 million and a sex ratio (men per hundred women) of 93. The population under the age of 15 years is 17% and above the age of 60 years is 21%. The life expectancy at birth is 73.6 years for males and 80.5 years for females and the healthy life expectancy at birth is 67 years for males and 72 years for females (WHO, 2004). Based on World Bank 2004 criteria, the country belongs to the high-income group. The health budget is 9.2% of GDP. The per capita total expenditure on health is 1618 international dollars, and the per capita government expenditure on health is 1116 international dollars (WHO, 2004).

In Portugal, policy on mental health (under the framework of mental health legislation), integrates mental health improvement (i.e., promotion and prevention), treatment (through mental health services) and psychosocial rehabilitation (with the involvement of health, social security and other sectors). The Directorate-General of Health at the Ministry of Health, (through its Psychiatry and Mental Health Department) and the five Regional Health Authorities have respectively national and regional responsibilities on the definition and implementation of mental health policies in Portugal. Under the framework of the Portuguese National Health Plan 2004-2010, mental health (including alcohol related problems) has been appointed as a top priority.

A new national mental health plan is being prepared within the context of the National Health Plan. Several other programmes namely for the elderly, children and adolescents, depression, post-traumatic stress disorder (PTSD) and alcohol related problems are also being prepared. There is a national network, involving the Ministry of Defence, the Ministry of Health and the Ministry of Labour and Social Security for PTSD and other psychological disorders of ex-combatants. A National Mental Health Referral Network and a National Network for Alcohol problems are being developed.

The Mental Health Law 36/98, dating 1998, although mainly for compulsory treatment, sets the basis of the policy. Other relevant national laws are the Law 35/99 (organization of services), the Joint Ruling 407/98 (not specific for mental health), the Order 348A/98 (social firms, not specific for mental health), the Council of Ministers Resolution 166/2000 (Alcohol Action Plan), the Law 281/2003 of Continuity Care Network and the Joint Ruling 502/2004 (PTSD network).

The country has disability benefits for persons with mental disorders. Financial incentives were introduced for disabled employees in 1982. More recently, benefits were announced with the Law 247/89.

Since 1989, community care (vocational training, employment support, day centres and residential support) has been progressively developed through co-operation between health services, social services and NGOs. Since 1998, there has been an integration of social support and continuous health care for people suffering from mental and psychiatric disorders in situations of substantial dependency (physical, mental, social) in order to provide residential and occupational programmes, financed by social security. In 1998, the Ministry of Work and Solidarity defined the framework for recognition and granting of technical and financial support to promote integration within the context of social employment market; the Institute for Employment and Vocational Training sponsored active employment.

There is a national participation in European programmes, like the 'European Community Health Indicators (ECHI-2)', in order to achieve national health indicators. The 3rd National Health Survey contains information about mental health and the 4th (in preparation) will strengthen alcohol and mental health information. There is some information about psychiatric service use obtained through the periodical National Psychiatric Census

(the latest in 2001). The Directorate-General of Health (Psychiatry and Mental Health Department) within the Ministry of Health is preparing a national system for mental health information and the first National Psychiatric Morbidity Study.

The country has specific programmes for disaster affected populations, elderly persons and children. There are separate clinics for child and adolescent psychiatry. For the elderly, there are outpatient clinics, inpatient services, home visit facilities and old people's homes. There are three child and adolescent psychiatry departments and 25 services and units (Rede de Referência em Psiquiatria e Saúde Mental, Direcção-Geral da Saúde, 2004). There are three regional alcohol treatment centres and one centre for psychiatric rehabilitation. Alcohol related problems are dealt within the context of mental health and are integrated in the general health system. In the field of illicit drugs, the country has a separate nationwide network of 45 specific care centres.

In 2000, the Resolution of the National Assembly 76/2000 and the Resolution of Council of Ministries 166/2000 directed a national policy for alcohol related problems. An update on alcohol legislation, a national programme with a new strategy in alcohol policy and a national alcohol care network are being prepared.

2 Process to prepare country story

The present Portugal country story was compiled by a work group/coalition integrating stakeholders involved in the arena of mental health and its improvement and promotion. Every individual in the coalition group for the IMHPA project was asked to complete the European Questionnaire on Mental Health Promotion and Mental Health Disorder Prevention (www.imhpa.net/questionnaire). Through shared experiences and realities in the broader field of mental health, as well as through the gathering of required document based information, these professionals drafted this document, after a consensus meeting. The consensus process was facilitated by the amount of common views on the actual status and needs for improvement of mental health in Portugal. A broader and more representative coalition group is being organised to continue these tasks and to facilitate the implementation process of mental health promotion and mental disorder prevention policies in Portugal.

Persons involved in the group/coalition:

Dr. Isabel Brito, Child and Adolescent Psychiatrist, Psychiatry and Mental Health Department, Directorate-General of Health, Ministry of Health

Dr. Teresa Cepêda, Child and Adolescent Psychiatrist, Psychiatry and Mental Health Department, Directorate-General of Health, Ministry of Health

Dr. Manuel Cruz, Psychiatrist, Regional Health Authority, Lisbon

Dr. Ricardo Gusmão, Psychiatrist, Medical Science Faculty, Lisbon

Dr. Maria João Heitor dos Santos, Psychiatrist, Director of Psychiatry and Mental Health Department, Directorate-General of Health, Ministry of Health

Professor Isabel Loureiro, Public Health Physician, National School of Public Health

Dr. Ana Cristina Trindade, Psychiatrist, Regional Health Authority, Algarve

Dr. Gregória Von Amann, Public Health Physician, Directorate-General of Health, Ministry of Health



3 Action for promotion and prevention in mental health

Availability of policies

An official governmental written policy for mental health promotion and mental disorder prevention is in preparation (National Mental Health Plan). This policy will include a national strategy on training, interventions by primary care professionals, school interventions integrated in the curriculum, interventions for groups at risk and interventions for the general public. Although still in preparation there will be strong components on:

- ▶ Training of primary care professionals and articulation with mental health teams;
- ▶ Development of guidelines for primary care professionals' interventions and for consultation-liaison psychiatry at the general hospital;
- ▶ Promotion of mental health and prevention of mental disorders in children and adolescents and in older people;
- ▶ National strategies/campaigns against stigma and discrimination of people with mental disorders and for mental health promotion for the general public.

At the national level, in the Directorate-General of Health (Psychiatry and Mental Health Department) there is an identified person that is responsible for overseeing and managing mental health including promotion and prevention strategies. Besides that, there are focal points at regional levels with a role in the implementation process.

The existing governmental funding is not specific for mental health; it is for health in general. It is available for infrastructure development, training and programme developments. Due to national budget constraints, the funding has been mainly used for infrastructure development.

There is no non-governmental written policy on the prevention of mental disorders or the promotion of mental health. Similarly, there is no non-governmental funding available for promotion and prevention in mental health.

Commitment to prevention and promotion

In Portugal, although policy or practice guidelines on mental health promotion or mental disorder prevention have not been developed yet, they are now in preparation.

Mental health does not seem to be a high priority in Portugal as evidenced by the number of references to it in speeches and policy documents by politicians and policy makers but there is interest in it. Drug problems and AIDS have been the highest priorities in health. However, there is a shift and at present the main priorities are cancer, cardiovascular diseases, AIDS and the elderly. Although mental health is slowly becoming a priority as evidenced by the increased amount of resources put into the field more recently, there have been no or little changes in resources because of the non-existence of a budget allocated especially to mental health promotion or mental disorder prevention.

Programmes and policies across settings

In Portugal, although policy or practice guidelines on mental health promotion or mental disorder prevention have not yet been developed they are in preparation. A registry or database of programmes or strategies for the promotion of mental health or the prevention of mental disorders has not yet been developed. Training programmes for health care professionals, which include promotion and prevention in mental health, have started in 2005, funded through the National Health Plan.

Programmes or strategies for the promotion of mental health and the prevention of mental disorders are partially available in schools and workplaces, and available in general/family practices. In the schools, some

training of teachers and students has been started. In workplace settings, there are some local programmes on stress management. In general/family practice settings, there are several local experiences on the liaison of mental health teams with primary health care and with representatives of the community. There is also the practice of consultation-liaison psychiatry in general and specialised hospitals.

4 Organizations and resources for implementation

Infrastructures

There is a central governmental infrastructure that creates health policies and supports their implementation, with a specific department for mental health. There is a governmental structure for the dissemination to health professionals or prevention workers of knowledge, programmes and strategies on health issues that include the prevention and promotion of mental health. National or regional training programmes for health professionals on prevention and promotion in mental health are being developed. The principal bodies involved in developing the knowledge base for mental health promotion and/or mental disorder prevention are the Directorate-General of Health (namely its Psychiatry and Mental Health Department), the National School of Public Health, the Medical Science Faculties (Lisboa, Oporto and Coimbra), the Higher Institute of Applied Psychology, the Psychology and Education Sciences Faculties (Lisboa, Oporto and Coimbra), and the Institute of Quality in Health.

Workforce for mental health

A nationwide mental health coalition is already constituted (National Council of Mental Health) with representatives of governmental, non-governmental, health professional, scientific, families and users organizations. Although this coalition also includes a strategy on mental health promotion and mental disorder prevention, a more specific coalition is being recently created for this particular purpose. Higher education on mental health promotion and/or mental health disorder prevention is available from the national School of Public Health and some Medical Faculties.

The prevention of mental disorders is integrated in the professional vocational training of general practitioners and family doctors and nurses or doctors' assistants working in general practice and it is compulsory. However it is not integrated in accredited continuing medical education. The promotion of mental health or the prevention of mental disorders is also not integrated in the professional vocational training and accredited continuing education of health care professionals working in chronic disease care, midwives/obstetric care and geriatric care.

5 Monitoring and evaluation

No evaluation studies on the effectiveness or on the cost-effectiveness of mental health promotion or mental disorder prevention programmes implemented in Portugal, have been developed or published in peer-reviewed journals or in governmental publications. There have been studies on how to increase the involvement of primary or secondary health care professionals in the prevention of mental disorders and the promotion of mental health (DepCare, secondary prevention of depression in primary health care).

6 Challenges

The key barriers to progress or challenges facing Portugal in 2004-2010 in the implementation of a country based mental health promotion and prevention strategy are lack of funding, lack and/or heterogeneity in the distribution of human resources in mental health and a decrease of compliance (poor motivation, less availability of time, etc.) among health care professionals, particularly in primary care.

7 Opportunities and advances in the field

There are some key advances that would like to be seen in Portugal in 2004-2010 in the implementation of evidence-based programmes for the promotion of mental health and the prevention of mental disorders. These would include the implementation of evidence-based programmes during pregnancy and early childhood, in schools, in health care services, for the general public and at the workplace. An advance would also be the performance of cost-effective evaluations of implemented programmes and the implementation of an adequate mental health information system, including regular utilization of a set of mental health indicators.

A mental health impact assessment project is being planned within the framework of a European project co-financed by the European Commission.

To make these advances possible some changes need to be made. These changes include the availability of resources for the implementation of the National Plan for Mental Health, which should incorporate evidence-based programmes. This could be facilitated by a change of policy priorities.

Additional Sources of Information

Directorate-General of Health (2004) National Health Plan 2004-2010.

Ministry of Health (2000) Health Determinants in the European Union: Évora Conference Proceedings.

Ministry of Health - Directorate General of Health (2002) Health Gains in Portugal.

Ministry of Health – Directorate-General of Health (2004) Statistics elements of Health/2001.



Romania

Prepared by Dr. Bogdana Tudorache, Raluca Nica, Dr. Dan Ghenea and Dr. Adina Bitfoi

1 Introduction

Romania is a country with an area of 238,000 km² in south-eastern Europe. It is divided into 41 counties or districts and the municipality of Bucharest, the capital of the country. Over 2 million people live in Bucharest, but a high proportion of the country's population (45%) lives in rural areas. In 2002, the population of Romania was 21.7 million people. The population distribution by age groups is: 0-14 years: 17.95% (male 2.0 million, female 1.96 million), 15-64 years: 68.51% (male 7.6 million, female 7.72 million), 65 years and over: 13.54% (male 1.26 million, female 1.77 million). Life expectancy is 71.19 years (67.05 for men, 74.81 for women).

One of the main aspects of the country's economy is that many people have lost the economic security they had before socio-economic transition. Therefore, transition to a market economy has been associated with dissatisfaction and disillusionment. Widespread poverty constitutes a significant psychological stressor for many people. Up until 2000, mental health promotion and mental disorder prevention have not been represented as a major priority in government policies. After the assessment of mental health in Romania made by the WHO in the year 2000, and which contained some precise recommendations, there have been some changes, with the introduction of a special section for mental health promotion in the Romanian legislation being a main change.

2 Process to prepare country story

The data used for the country story have resulted from a collaborative effort involving the following experts in mental health:

Adina Bitfoi, MD, Resident Psychiatrist, Romanian League for Mental Health

Doina Cozman, MD, Ph.D., Professor, Head of Psychiatry Department, University of Medicine and Pharmacy, Cluj

Iuliana Dobrescu, MD., Associate Professor Child and Adolescent Psychiatry and Psychology of "Carol Davila" University of Medicine and Pharmacy, Bucharest

Laura Mateescu, MD, Child and Adolescent Psychiatrist

Raluca Nica, Director of the Romanian League for Mental Health

Dan Ghenea, MD, Psychiatrist, Romanian League for Mental Health

Eugen Stefanut, MD, Executive Director of the Romanian Alzheimer Society

Marian Matei, Sociologist at Health Promotion Department, National Institute for Research and Development in Health

Bogdana Tudorache, MD, Ph.D. – President of the Romanian League for Mental Health, WHO Mental health national Counterpart

Catalina Tudose, MD, Psychiatrist, Lecturer in Psychiatry at "Carol Davila" University of Medicine and Pharmacy, Bucharest, President of the Romanian Alzheimer Society

Daniela Valceanu, Health Care Trainer and Consultant, Researcher, National Institute for Research and Development in Health

Their contribution included the completion of the IMHPA Mental Health Module Questionnaire, the Romanian data of which will be enhanced with continued inputs (www.imhpa.net/infrastructures-database).

3 Action for promotion and prevention in mental health

Availability of policies

The Mental Health Strategy of the Ministry of Health comprises a legislative module. This module sets out the norms of implementation for the mental health law, which was adopted in July 2002. It is called “The law for the promotion of mental health and the protection of persons with mental illness”, and it respects the “Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care” adopted by United Nations’ General Assembly (Resolution 46/119 of December 1991).

The Ministry of Health is now preparing the adoption of these norms in collaboration with other Ministers, local authorities, and relevant organizations. After the adoption of these norms, the Ministry of Health will be involved in the implementation process both at the level of the mental health professionals (through regional workshops, implemented with the support of the group of specialists that contributed to the development of the law and norms) and at the general population level (through mass-media campaigns). There are other legislative segments that address psychoactive substances, including alcoholic beverages, education to reduce violence through different media channels, and the judicial status of persons with psychiatric conditions that commit offences of the law.

Other laws and activities include Law 487/2002 which deals with poverty and social exclusion, the National Programme for the prevention of psychiatric and psychosocial disorders, education policies and school programmes that include mental health in the school health education curriculum, education programmes coordinated by the Ministry of Education for some special groups such as the Roma population, early education programmes, national campaigns to prevent violence and aggression, and research activity on stigma.

At the regional level, the “Alliance against suicide” plays an important role in suicide prevention in Transylvania. The Centre for Psychological Counselling at Babes-Bolyai University provides continuing training for parents, educators and health professionals in the prevention of violence and aggressive behaviour.

Commitment to prevention and promotion

As mentioned above, up until the year 2000, prevention and promotion did not represent a priority in terms of political actions and involvement. The WHO assessment revealed that most progress in mental health promotion was accomplished as a result of the involvement of NGOs. The Romanian League for Mental Health was involved in mental health promotion and developed a long-term programme to encourage change and successful projects that could become models of practice. There was a negative opinion in the population concerning people affected by mental disorders, resulting in their isolation and social deprivation and exclusion. The lack of collaboration and involvement of public administration in the mental health problems reduced the efficacy of activities for promoting and protecting mental health. There were only very few activities on mental health promotion and there was little continuity in the programmes.

There were not any strong patient or client organizations. There was no specific law for mental health promotion and protection, which was a major impediment for the improvement of mental health services and which had a negative impact on general public health.

Since the WHO assessment, there has been a change in national programmes, strategies and laws, including the Mental Health Strategy of the Ministry of Health and the National Programme for Mental Health.

The Strategy of the Ministry of Health includes three types of prevention, according to the target population:

- ▶ *General prevention* that targets the general population, and includes:
 - Mental Hygiene Programmes (psychoactive substances, insomnia prophylaxis, etc.);
 - Stress management, crisis management, conflict management, etc.;
 - Programmes addressed to parents for the education of their children on alcohol and drugs and programmes to prevent child abuse (campaigns with thematic posters, stimulation of the awareness of civil society, the involvement of parents in the educational activity in the schools);
 - Partnership programmes with the mass-media on healthy lifestyles and the role of non-governmental organizations;
 - Assistance programmes for crisis situations (disasters);
 - Partnerships with large institutions, such as the Church.
- ▶ *Selective prevention* targeting population groups with a higher risk of psychiatric conditions, including:
 - Programmes for institutionalized children;
 - Programmes addressed to children and teenagers of parents with alcohol addiction;
 - Programmes addressed to children with brain disorders;
 - Programmes of integration/protection for children with severe illnesses, including HIV/AIDS.
- ▶ *Focused prevention* that targets high-risk groups (minimal symptoms, biological markers, genetic predisposition; without fitting the international diagnostic criteria for a certain mental illness), including:
 - Programmes for children with a predisposition of affective pathology, schizophrenia, etc.;
 - Programmes regarding older people;
 - Programmes for developing networks of social support for older people;
 - Programmes addressed to children with a risk for major psychological disorder due to family or genetic vulnerability (schizophrenia, affective disorders, addictions etc.), to children of at risk families (parents with addictions, socially assisted families), and to children with behavioural disorders (violence in the school environment);
 - The foundation of counselling centres, supporting NGOs that target families at risk;
 - Programmes for disorganized families with a high risk of abuse or neglect of children, and for orphan children.

The Ministry of Health prioritises prevention modules, programmes and actions targeted at children and adolescents' mental health, including:

- ▶ The promotion of a broader concept to protect mental health that includes both the child and his or her family, at least the mother;
- ▶ Creating prenatal counselling centres;
- ▶ Creating counselling centres for families with children which are in difficulties (risk of abandonment, families with institutionalized children, one parent families, families with parents working abroad);
- ▶ Re-introducing regular screening for early diagnosis and intervention for psychomotor development;
- ▶ Stronger mental health protection for primary school students, through ongoing training of school medical personnel;
- ▶ The introduction of programmes of mental health of the schoolchild matching work demands of the school curricula with the cognitive and emotional potential of the pupils. It aims to improve school integration, the reduction of the risk of behavioural disorders and early school dropout;
- ▶ An increase in resources for health education in schools with the aim of developing a healthy lifestyle, acquiring skills of actively taking care of one's own health, forming social competencies to deal with alcohol and drug dependency, suicide and violence, and sexual education;
- ▶ Diversification of medical and educational interventions in and outside the schools to meet the special needs of children and young people with increased vulnerability (different forms of disability, social disadvantage, institutionalization, children with a risk of social inadequacy and delinquency);

- The introduction of preventive counselling programmes addressed to the child and to the family with one parent suffering from a severe physical disease.

For young people and adults, actions include the development of programmes of primary prevention (information and counselling) for addictions, offered by primary health care physicians, the development of programmes of psychological support for young delinquents who are under probation, and training programmes for probation officers.

Despite these initiatives, mental health promotion and mental disorders prevention have not yet achieved the necessary level in terms of real governmental priorities. Following endorsement of the 2005 WHO Declaration and Action Plan for Mental Health, a Twinning Light Programme has developed between the Romanian and Dutch Ministries of Health to support the implementation of the Mental Health Strategy of the Ministry of Health, including the promotion module.

Programmes and policies across settings

Although there is much room for improvement, programmes can be found in schools, protective services and hospitals and clinics. A few projects have been undertaken by the Romanian League for Mental Health, including:

- “Mental Health Problems are treatable. How do you treat people with mental health problems?” This project was targeted at teenagers, with the objectives of increasing knowledge regarding mental health problems and of improving attitudes towards people with mental health problems;
- “Now you know why you have to care” was the first national campaign on mental health developed in co-operation with four other partners: Estuar Foundation, RAMHA Brasov, Armonia Timisoara and the PR Agency “Focus Advertising”;
- “Violence in schools” developed by UNICEF and the Institute of Science and Education;
- Preventing child labour and sexual exploitation, developed by the International Labour Organization ILO-IPEC;
- Early Intervention and Education, developed by UNICEF and the Step by Step Foundation;
- Counselling and Guidance, a project co-ordinated by the Institute of Science and Education.

4 Organizations and resources for implementation

Infrastructure

The principal bodies involved in implementing intervention programmes and other actions, disseminating information, and developing the knowledge base for mental health promotion and/or mental disorder prevention include:

- **Romanian League for Mental Health**, a non-governmental, non-profit organization, founded in 1990. Its mission is to shape governmental policy and promote alternative practices in mental health in Romania;
- **National Institute for Public Health**;
- **National Institute for Research and Development in Health**;
- **Romanian Alzheimer Society**, a non-governmental and non-profit organization whose aims are to support Alzheimer patients and their families, and to increase the general information level concerning dementia issues through the mass-media, leaflets, books, lectures, etc.;
- **National Institute for Preventing and Combating Social Exclusion of Persons with Handicap**;
- **Public mental health laboratories**, which should provide community care services but in reality, probably only some 10% have an activity that is close in meaning to this purpose. The rest are in fact

simple consultation offices, based largely on a medicalized model. Their importance is that they could become a potential setting for developing and implementing prevention programmes;

- **Ministry of Health**, especially through its departments of public health in each county.

There are two main sources for the mental health budget, a budget of US\$375,000 from the Ministry of Health for a national programme for the prevention of psychiatric and psychosocial disorders, and reimbursements for medical services insured by the Romanian National Insurance House (US\$54million). In some years the resources for the national programme have arrived too late for organizing the core activities of the programme (such as training occupational therapists and general practitioners).

Workforce for mental health

Training in mental health promotion and mental disorders prevention is provided by the Universities of Medicine, Psychology and Sociology, and by the Department of Psychology of the Babes-Bolyai University.

Human resources include 908 psychiatrists (4.2/100,000 inhabitants), some 1,000 psychologists, and some 2000 nurses, many of whom have no specific training in psychiatry. A school for psychiatric nurses started in 1993, supported by NGOs from Romania and Belgium, and with now 250 graduated nurses. The profession of psychiatric nurse was officially recognised by the Ministry of Health in June 2003. The Human Resources Department of the Ministry has begun the complex task of classification and categorization of medical staff employed in the mental health services. The Department, in co-operation with medical education authorities, is trying to develop a training programme for psychiatrists.

High standards of clinical training of medical and other staff are reported, and training levels are considered to correspond to international standards. However, there is a need to update and develop the actual curricula of mental health professionals. There are very few social workers and the number of nurses and psychologists is insufficient. There is an increasing demand for training and continuous education in mental health not only for psychiatrists, but also for psychologists, social workers and nurses. There is no regular mental health training programme for primary care professionals. Hospital staff are not properly trained in mental health, often holding negative prejudices against persons with mental disorders and avoiding referral to mental health services.

Postgraduate specialized training is still dependent on biological and medical models. Even though both psychotherapy and rehabilitation therapy are included, training in these topics is not widespread. General practitioners, primary health care workers and family doctors are not involved in mental health care, due to an insufficient basic psychiatric knowledge and, sometimes, to negative attitudes.

5 Monitoring and evaluation

There is a special section on mental health within the project "Improvement of Health Status Monitoring and Evaluation Capacity in the Framework of Health Care System Reform". International organizations, including the European Commission, the European Parliament, and Amnesty International are exerting pressure to include mental health as a priority topic for the country, it being a condition for European integration. The Centre for monitoring mental disorders will be created, since it has already been approved by the Ministry of Health. Another proposal will be the initiation of a National Structure for Evaluation of mental health, working directly with the Ministry of Health.

6 Challenges

The major obstacles are the lack of human and financial resources. There is a solid background for mental health promotion and mental disorder prevention in terms of legislation and strategies. In order to achieve effective implementation of guidelines in the field, adequate training of people is essential. There is also the need for funds to support infrastructural development and implementation. Finally, funds should be spent in the most cost-effective way.

7 Opportunities and advances in the field

One of the key advances has been the Twinning Light Programme, a partnership between the Ministries of Health of Romania and the Netherlands, which has facilitated the implementation of the Mental Health Strategy of the Romanian Ministry of Health, improved the legal and regulatory framework, and improved the training programme for health professionals involved in the mental health field. Some modules of the programme refer to the implementation of the Mental Health Promotion section of the Mental Health Strategy of the Ministry of Health.

Slovakia

Prepared by Dr. Peter Breier

1 Introduction

Slovakia is a country with a population of 5.5 million. While it is undergoing the process of economic transformation, it is also adjusting to being an independent country. Although, according to opinion polls, health issues are considered important for individuals, health care has not been a priority for the political parties and governments. The health budget has been fluctuating between 4.5% and 6.5% of the GDP in the last several years, of which approximately 4% is allotted to mental health care. However, the transition period has been associated with a steep rise of the number of persons visiting psychiatrists, which doubled between the years 1990 and 2004 (121,000 in 1990, 242,000 in 2004). Most of the patients suffer from affective disorders (19% of all patients) and neuroses and conditions caused by stress (27% of all). Suicide is lower than in the 1970s and 1980s, fluctuating around 13-15/100,000, with a ratio of 5 to 6 men to 1 woman. In a 2002 epidemiological population study of depression (EPID), the 6-month prevalence of depression in Slovakia was 40.9%, with major depression representing 12.8%, minor depression 5.1% and depressive symptoms 23% (conducted by MINI).

As mental health care is not a priority of the health care policy, mental health promotion (MHP) and mental disorder prevention (MDP) have not been given appropriate attention.

2 Process to prepare country story

Information for the country story was gathered from people working in institutions dealing with mental health, non-governmental institutions, and the Internet.

Persons involved:

Dr. Katarina Hulanska, Institute of Public Health

Dr. Maria Sreterová, NGO Kontiki

Dr. Eva Tomkova, Ministry of Education

Dr. Ivan Valkovic, Ministry of Social Affairs, Labour and Family

3 Action for promotion and prevention in mental health

Availability of policies

Until recently Slovakia did not have a comprehensive mental health programme. The regulation of the Ministry of Health (MoH) "Conception of psychiatric care" organized mental health care, and did not include MHP and MDP. In the year 2004, the national government adopted the National Programme of Mental Health as a policy document with one chapter on promotion and prevention. According to this programme, mental health issues need to be included in the curricula of primary and secondary schools. The programme is now being developed into detailed multisectoral actions, with a time-frame for implementation. The detailed programme will be adopted by the government later this year.

The National Programme for the Fight against Drugs also includes preventive aspects. Prevention is considered a priority of the strategy of the programme. The National Programme to Fight against Alcohol was adopted by the government but, as it has not been supported by any finances, it only remains a paper programme. The National Programme for Health Promotion does not mention any mental health issues except harm reduction caused by alcohol, drugs and tobacco products. Mental health promotion issues are also included in the Healthy Schools Programme, supported by the MoH.

Commitment to prevention and promotion

Besides the field of drug prevention, MHP and MDP are not part of the policies of health care. On the other hand, more programmes and activities were included into the responsibilities of the Ministry of Education. Although Slovakia signed the 2005 WHO Mental Health Declaration for Europe in Helsinki, support for mental health remains more on the verbal than on the practical level.

Programmes and policies across settings

There are no special programmes devoted to MHP and MDP in the health care field in Slovakia. State or public health institutions have dealt only with illicit drug issues during the last years and programmes were oriented mainly towards school children. They were financed through the Fund against Drugs (governmental agency), which, in 2004, supported 148 projects organized by schools and school organizations. These projects are mainly carried out by the Pedagogical and Psychological Counselling Centres (PPCC), which are located in all 80 districts and 8 regional centres (they employ about 350 psychologists, special educationalists and other professionals) and by Educational and Psychological Prevention Centres (EPPC). These centres were, until now, directed by the Ministry of Education and they co-operate with the Research Institute of Psychology and Pathopsychology in projects aimed at reducing socially mal-adaptive behaviour, truancy, bullying, drug abuse, gambling and violent behaviour. They have also supported personality growth projects. One example is a project "The Road to Emotional Maturity" for 12-15 years old students, which was implemented in more than 600 schools for 30,000–50,000 children annually. PPCCs also individually deal with school problems and they carry out preventive programmes that target a healthy way of life, that increase information about mental health, as well as peer group programmes (in 2003 there were 542 activities for 85,751 students, mainly 6-15 years old).

The WHO programme Healthy Schools is implemented in 2082 schools (as of December 2003), mainly in nursery schools (31% of all nursery schools in Slovakia) and in primary schools (40.5% of all primary schools in Slovakia).

The Institute of Public Health has undergone a transition during recent years, and opened Health Centres in all 80 districts. While they provide information and counselling, in the field of mental health, it is limited to tobacco and alcohol use disorders.

The Ministry of Social Affairs, Labour and Family directs Centres of Counselling and Psychological Services. They are located in most of the districts (60) and they are mostly oriented to marital problems. 180 employees serve approximately 10,000 cases annually with 15,000 clients.

An important role in MHP and MDP is played by non-governmental organizations. While they have been in existence for only about 10 to 15 years, they provide many activities which the public sector is not willing to do. Centres for Violence Victims are available in all 8 regions and are spreading to new settings and smaller districts. A destigmatisation programme for people suffering with schizophrenia, Open Hearts, organizes campaigns, starting with discussions for school children. The League for Mental Health is an umbrella organization for organizations dealing with mental health issues. It brings together professionals (Slovak Psychiatric Association, Slovak Psychotherapeutic Association, Slovak Psychological Association) with volunteers' groups, and consumer and family members' associations, as well as organizations dealing with

human rights of minorities. It organizes two main media campaigns each year (spring, autumn), with open concerts with music stars and giving the opportunity for NGOs to present their work. For the World Mental Health Day, it organizes a Mental Health Week with activities in more than 50 towns in Slovakia. It co-operates with the media and organizes press conferences 8-10 times a year, focusing on current topics of mental health. The discussions about mental health and mental disorders for lay audiences are organised every week in Bratislava and they are also starting in other towns. Further, since spring 2005, every fortnight there are discussions about early childhood development oriented mostly towards young parents. It has also opened a gallery exhibiting the works of mentally ill persons and runs a 24 hours hot-line, which takes approximately 15,000 calls each year. The League is also trying to influence mental health policy with information meetings for the members of the parliament and is co-operating in the preparation of the National Programme of Mental Health. UNICEF runs a hot-line for children. There are three more hot-lines running 24 hours a day and six hot-lines opened during working hours with professionals on the phone.

4 Organizations and resources for implementation

Infrastructure

The Ministry of Health funds the activities of the Institute of Public Health. As it deals with mental health issues only marginally (alcohol and tobacco), it can be said that only a very tiny proportion of the budget is devoted to MHP and MDP. NGOs are financed mainly by donors and some of them by grants given by regional authorities. Counselling centres are financed by their constituent ministries but their budget is shrinking.

Workforce for mental health

Today, nearly 600 psychiatrists, 200 clinical psychologists, 120 professionals in counselling centres, 400 school psychologists (working in centres or independently at schools) are working in Slovakia. There are 300 licensed psychotherapists and 600 other members of the psychotherapeutic association (mostly psychiatrists and psychologists). The League for Mental Health unites over 30 NGOs, some of them being national, with their own regional organizations.

5 Monitoring and evaluation

Mental health is not monitored by population surveys or epidemiological research. The only information is about treated mental disorders and the numbers of staff and psychiatric beds, which is collected by the Institute of Health Statistics and Information (www.uzis.sk).

The programmes run by the Ministry of Education are evaluated by the institutes working for the Ministry (Institute of Information and School Prognoses - www.uips.sk). The drug prevention programmes are monitored by the General Secretariat of the Board of Ministers for Drug Dependencies and Drug Control.

6 Challenges

For the near future, the main task is the transformation of the institutionally oriented mental health care to community and patient oriented care. This is a difficult task in the period of health care transformation with a lack of resources. It will require a complete change of attitudes to mental health not only from politicians, but mainly from the professionals themselves. A substantial change in the system of undergraduate and postgraduate education is also necessary.

7 Opportunities and advances in the field

The creation of the National Programme of Mental Health presents an opportunity to bring together groups of experts from all involved sectors and consumers. These groups should not only prepare the programme, which will stress the importance of MHP and MDP, but should also start its implementation. The very first steps have been taken, and there has been some level of support from the appropriate ministries.

Slovenia

Prepared by Dr. Tanja Kamin, Dr. Andrej Marusic and Maja Zorko

1 Introduction

Mental health problems, such as depression, bipolar disorders, anxiety, schizophrenia, eating disorders, and deliberate self-harm are well monitored in accordance with the Healthcare Databases Act (2000)¹. To the experts, at least, mental health is visible, since the disorders are significantly expressed in numbers. However, speaking from the mental health promotion point of view, mental health, as a public issue, is rather under-represented in Slovenia.

Mental health literacy, including both the negative and positive sides of health is rather poor amongst both the general public, as well as amongst experts and professionals. Furthermore, everything in relation to mental health, yet alone mental disorders, is negatively labelled. Stigmatization of mental health is therefore one of the biggest underlying public mental health problems in the country.

There are many actions by non-governmental organizations offering programmes that include day centres for socializing and other daily activities, an information and advisory bureau, a centre for social and work integration, and for rehabilitation of the disabled, clubs for carers, clubs for volunteers, self-help groups, educational programmes, prevention programmes and internet advisory programmes and institutional psychiatry to place mental disorder prevention and mental health promotion on the public agenda and to improve the social status of mental health in general².

Nevertheless, much effort and energy is lost due to the lack of a strategic national programme on mental health promotion, resulting in poor networking, inefficient resource allocation and lack of a common goal. It should be noted, however, that, although not synchronized and primarily not under the mental health policy umbrella, many actions have been undertaken in this area.

To improve the current situation, Slovenia needs to overcome its lack of vision and to define its mission for mental health promotion. It needs to establish a national action plan, and to harmonize the activities and actions at different levels among different social and political actors, to avoid overlaps and to improve effectiveness.

2 Process to prepare country story

The country story for Slovenia has been formed as a result of discussion with representatives of key stakeholders in mental health. These include the Institute of Public Health, Regional Public Health centres, NGOs, academic institutions, mental health practitioners and public health experts.

Using a snow ball approach, people working in the field of mental health were distributed the European Questionnaire on Mental Health Promotion and Mental Disorder Prevention (www.imhpa.net/questionnaire). They were asked to complete the questionnaire and were invited to comment on the questionnaire itself, and suggest the important themes for further discussion. The key people were then brought together for a meeting in order to find agreement on Slovenian's response to the questionnaire and to reach consensus on the more subjective issues.

¹ http://zakonodaja.gov.si/rpsi/r09/predpis_ZAKO1419.html (30.6.2005)

² Marusic and Turcin. 2004. Mental Health Reforms in Slovenia Awaited; in Mental health reforms: 18-20.

It was anticipated that consensus would not be easily reached, knowing that different stakeholders in mental health share different and even contradictory views on the current state of public mental health in Slovenia. Different views, statements and attitudes also appear because mental health reforms are still ongoing, and the National Mental Health Programme is still awaited.

After the meeting the co-ordinator completed the questionnaire (www.imhpa.net/infrastructures-database), before submission to IMHPA. The questionnaire responses and the discussion afterwards form the basis of this country story.

3 Action for promotion and prevention in mental health

Availability of policies

Mental health promotion and mental disorder prevention in Slovenia still has not got its own national programme that would include and organize other policy areas, such as public health; education and sport; labour, family and social affairs; special planning; education and sport; higher education; social justice and social inclusion etc. around mental health issues under its own policy umbrella. However, the new National Public Health Prevention Programme is in the stage of preparation, which will set in more detail the Slovene public health priorities and their relations to other policy areas.

The old National Programme for Public Health Prevention, which was operative until 2004³, did not specifically include mental health priorities and prevention and promotion actions. The forthcoming National Programme for Public Health Prevention will be the starting base for interdisciplinary and cross-sectional establishment of the National Mental Health Promotion and Mental Disease Prevention Programme of Slovenia. It is already in the process of preparation.

Existing acts from the mental health area or related to the mental health area are:

- Act Concerning Social Care of Mentally and Physically Handicapped Persons⁴,
- Social Security Act⁵,
- Health Care and Health Insurance Act⁶,
- Patient Advocacy Act and Protection of Right of Mental Patient (in procedure),
- Mental Health Law (in procedure),
- National Action Plan on Social Inclusion (NGO)⁷.

The Council for Mental Health is the governmental body in the field of mental health. It acts as an advisory body, and comprises 28 members, including representatives from non-governmental organizations, users and carers⁸.

Commitment to prevention and promotion

Consistent with WHO directions, commitments to promotion and prevention are increasing in Slovenian public health policy. Commitment is clearly evidenced by the establishment of a National Programme for Public Health Prevention until 2004⁹, and the allocation of significant funding to public health communication interventions for improving and increasing health of the Slovenian population¹⁰. Although mental health has not received any attention among those interventions, a range of programmes related to mental health can

³ NPVZ until 2004 http://www2.gov.si/zak/Akt_vel.nsf/0/c12565e2005e8311c12568f000306144?OpenDocument (28.06.2005)

⁴ http://zakonodaja.gov.si/rpsi/r06/predpis_ZAKO1866.html (28.06.2005)

⁵ http://zakonodaja.gov.si/rpsi/r09/predpis_ZAKO869.html (28.06.2005)

⁶ http://zakonodaja.gov.si/rpsi/r03/predpis_ZAKO213.html (28.06.2005)

⁷ <http://www.cnvos.si/mreza/clankil?id=24&pid=13> (28.06.2005)

⁸ <http://e-uprava.gov.si/ispo/delovnatelesa/podrobno.ispo?komisijaid=872> (28.06.2005)

⁹ http://www2.gov.si/zak/Akt_vel.nsf/0/c12565e2005e8311c12568f000306144?OpenDocument (28.06.2005)

¹⁰ Kamin, T. 2004. Health Promotion and The Myth of Citizens Empowerment. Doctoral thesis. University of Ljubljana, Faculty of Social Sciences: Ljubljana.

be identified across different settings in Slovenia. For example, many schools in Slovenia are included in the “European Network of Health Promoting Schools”¹¹, for which an important part of the programme deals with positive mental health issues.

Among NGOs, there are many organizations that increasingly develop and implement interdisciplinary mental health promotion programmes across different settings. Some organizations deal with positive mental health (for example, Society for Prevention¹²) more than others. There are more organizations that focus more on issues related to mental disorders. For example, the organization Sožitje has, among other activities, a rich publishing history on mental disorders¹³, particularly about how to live with mental disorders.

Programmes and policies across settings

In the area of suicide and depression, the one and a half year programme under the European Alliance Against Depression Network¹⁴ aims to prevent depression and suicidal behaviour in the Slovene regions, Celje and Koroška, which have the highest suicide rates. This project includes an educational programme about treatment of depression and suicide prevention with general practitioners and medical nurses. In addition, an educational programme about prevention of depression and suicide has been implemented with some professionals including police officers, social workers and priests. The project has been completed and will be evaluated by comparison of the prescription of medications by GPs, comparison of the regional suicide rates, comparison of the attitudes toward depression before and after the education, and a public opinion survey.

The project “THAT IS ME - health promotion among youth” was launched in 2000 as an example of primary prevention aimed at adolescents in Celje region in Slovenia. In the first phase of the project an epidemiological study was conducted among 1000 adolescent aged between 13 and 17 years. Results showed that adolescents’ biggest problems are lack of self-confidence and optimism, no self-respect, fear of drug addiction, fear of failure and the feeling that life is meaningless. In relation to communication channels the research showed that 90% of adolescents in Celje region preferred using the internet as a communication tool to learn and to discuss about the above problems. Accordingly, the website *That is me*¹⁵ has been developed. It has two main aims: first, to provide adolescents with information regarding their health and well-being in general, and consequently to influence their views and values about their health and well-being in general; and, secondly, to prevent risk behaviour and to help adolescents solve their problems by getting advice from counsellors and peers.

The website is intended for adolescents (primary target group), their parents, teachers, school psychologists and others working with adolescents. The website is also intended for use in teaching curriculum during class periods. A team of 30 experts is continuously available to answer adolescents’ questions. The website has approximately 6500 visits per month, 200 users each day and 7360 expert advices from April 2001 to May 2004. The authors conclude that there are at least three reasons why the website is successful: first, suitability of the topics; second, discretion and anonymity of users; and third, the possibility of direct communication with experts and peers without being exposed.

Some bigger national and international research projects in this area that Slovenia is organizing or is part of include:

- The Slovene “Gotland” Study: An attempt of suicide prevention in Slovenia,
- GENDEP (GENome-based therapeutic drugs for DEPRESSION)¹⁶,
- GLOBAL (Suicide in Slovenia: a global view on development of suicidal behaviour risks),

¹¹ http://www.ivz.si/ivz/novica.php?ivz_id=127 (28.06.2005)

¹² <http://www.drustvo-dpd.si/> (28.06.2005)

¹³ <http://www.zveza-sozitie.si> (28.06.2005)

¹⁴ www.eaad.net (28.06.2005)

¹⁵ www.tosemjaz.net

¹⁶ <http://gendep.iop.kcl.ac.uk/> (28.06.2005)

- MINDFUL (Mental Health Information and Determinants for the European Level),
- POMONA 2.

4 Organizations and resources for implementation

Infrastructure

The infrastructure is summarized as follows:

Governmental level

- Ministry of Health
- Council for Mental Health at the Government of Republic of Slovenia (acts as an advisory body, consists of 28 members including representatives from non-governmental organizations, users and carers)¹⁷

The Institute of Public Health of the Republic of Slovenia

- Department of Health Promotion
- Section for Mental Health Improvement (in process of establishment)

9 Regional Institutes for Public Health Prevention

Institution of Psychiatry

NGOs

- Centre for social and work integration
- Associations for volunteers
- Self-help groups, etc.

Workforce for mental health

In Slovenia the workforce involved in mental health activities is drawn from a diversity of settings and sectors including: the National Health Service, The Institute of Public Health, Regional Institutes for Public Health Prevention, NGOs, and the wider public and voluntary sector e.g. community workers, academics, teachers, human resource officers, etc.

5 Monitoring and evaluation

Data on which the mental health of the Slovenian population can be monitored are, until now, more system related and data related to morbidity and mortality. A national initiative¹⁸ has begun to create a core set of sustainable mental health and well-being indicators for Slovenia.

Mental health promotion evaluation can be seen only with some projects, primarily at the local level. For this, they use items of a broad range of tools to collect qualitative and quantitative data, primarily self-completion questionnaires pre- and post- group work, counselling and befriending.

¹⁷ <http://e-uprava.gov.si/ispo/delovnatelesa/podrobno.ispo?komisijaid=872> (28.06.2005)

¹⁸ related to MINDFUL subproject

6 Challenges, opportunities and advances in the field

The biggest challenge facing Slovenia at the moment in the area of mental health promotion and mental disorder prevention is poor mental health literacy amongst both the general public, as well as amongst experts and professionals. Special campaigns at the national level are needed to challenge stigma and discrimination around mental disorders in Slovenia.

Although actions have been undertaken for mental health promotion, priorities should be explicitly delineated and placed in a wider context. We have to build a strong network of experts and institutions that are responsible in the field of mental health promotion and prevention. To intensify effects and to avoid overlaps, there is a need to harmonize programmes with a long term vision, making them concrete through actions across different settings, at different levels, pointed to different target groups.

We initiated this process by organizing the first national conference and workshops on mental health promotion and mental disease prevention: a step forward towards a national programme, which was held in Ljubljana, October 2005.



Spain, Catalonia

Prepared by Dr. Joan Colom, Lidia Segura and Dr. Antoni Gual

1 Introduction

Catalonia is one of the 17 autonomous communities in Spain with an area of 32,000 km² and is organized in 40 counties. By the end of 2002, the Catalan population was 6.7 million, of whom 51% were females and 4.8% legal foreign residents. The age distribution in the population was: 14% under 15 years, 68.7% between 15 and 64 years old and 17.3% over 65 years old. The active population is 3 million, and the unemployment rate was 9.2% (6.8% among males and 12.7% among females and 18.6% among those under 25 years). Life expectancy at birth is 76.9 for males and 83.4 for females.

The Generalitat is the institution in which the self-government of Catalonia is politically organised since democracy was restored in 1977. The government of Catalonia is divided into 13 Departments and the Health Department is responsible for health. In 2003 its budget was 34.2% of the total expenditure of the Government. The Catalan Parliament is authorized to legislate on all aspects of health. The Catalan health care model was established in 1990 under the LOSC (the Health Care Organisation in Catalonia Act). The LOSC created the Catalan Health Service (CatSalut) consolidated a mixed health system, organized all the areas of health care products and health services and integrated in a single network the public use of all health resources (hospitals, primary health care, mental health, etc.). The Catalan health system is a publicly-funded system with comprehensive coverage and which all the citizens of Catalonia are able to access.

Primary Health Care (PHC) is the citizens' first level of access to the health care system and there are 347 PHC centres spread throughout the territory. PHC centres are composed of multidisciplinary teams and integrate health promotion strategies with preventive and curative interventions.

2 Process to prepare country story

Persons involved:

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Joan Colom, Substance Abuse Programme, Health Department
Pilar Duro, Substance Abuse Programme, Health Department
Jose Garcia, Institut Pere Mata
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Lluís Lalucat, CSMA Les Corts
Cristina Molina, Mental Health Programme, Health Department
Josep Ramos, Mental Health Services of the Sant Joan de Deu Hospital
Mercè Saperas, CASD Mollet
Lidia Segura, Substance Abuse Programme, Health Department

3 Action for promotion and prevention in mental health

Health model

In the last decade a lot of efforts have been made to develop new communitarian and rehabilitation services and to convert the old psychiatric hospitals to centres capable of meeting the new needs of the population regarding mental health. In Catalonia, a health model based on multidisciplinary, interdepartmental teams has been promoted, based on de-institutionalizing patients and on the involvement of the community. In addition, there has been a diversification of health services: child and juvenile mental health centres, adult mental health centres, hospitals, medium and long-term stay centres, day hospitals for adolescents and adults, and day centres, currently being converted to community rehabilitation services. Psychiatric and mental health care follows an integrated interdisciplinary and intersectorial model with the participation of the health, social and education services. The community insertion is promoted and patients' and their families' needs are taken into consideration. Patients are treated at the Mental Health Network, which offers specialized treatment, support to the primary health care centres, and hospital attention at different levels of intensity (day hospitals and community rehabilitation services). The mental health teams are multidisciplinary and composed of psychiatrist, psychologist, social workers, nurses and other professionals.

Together with all the treatment initiatives, in the current year much more attention is being paid to the development of a regional strategy on mental health promotion and mental disorder prevention in the framework of a global reorganisation of the public health policies and resources. It is planned to launch the Catalan Public Health Agency by the end of 2006, which will be in charge of the formulation and implementation of policies that incorporate in a centralised manner effective strategies of health promotion, prevention and protection with the aid of epidemiology, monitoring and research¹.

“Director Plan” on Mental Health and Addictions

Mental disorders and their care and prevention have always been considered a major public health problem and a priority by the Catalan Health Strategy with the inclusion of a chapter devoted to tackling the mental health problems in all the Health Plans for Catalonia².

The current government is encouraging the development of a specific and integrated Mental Health Strategy to be launched in 2006 to increase the commitment of the networks specializing in health promotion and the prevention of mental disorders and addictions, and to focus and increase the efforts of the network of mental health and addictions in order to improve the competency and the capacity of PHC in the treatment of people with mental disorders and addictions, in all areas of healthcare action, from health promotion to rehabilitation.

For this reason during 2005 a Director Plan on Mental Health and Addictions (DPMHA) together with a Map of Health and Social Services and an Integrated Governmental Plan for Caring for People with Mental Health Problems (IGPMH) has been prepared.

In the current Health Plan, the priority interventions in mental health are aimed at improving the detection, care and rehabilitation of people with mental disorders, support for their families and respect for the fundamental rights of patients, and mental health promotion in the community. Prevention priorities include fostering the capacity and skills of primary health care professionals in the early detection and care of the most-frequent mental health problems; improving the detection and treatment of emergent pathologies and in

¹ The reform of the Public Health in Catalonia. Available from: URL: <http://www.gencat.net/salut/depsan/units/sanitat/html/ca/dir446/index.html>

² Health Plan for Catalonia 2002-2005. Departament de Sanitat i Seguretat Social. Generalitat de Catalunya 2003. [Online]. Available from: URL: <http://www.gencat.net/sanitat/depsan/units/sanitat/html/ca/plasalut/index.html>

people with learning disabilities; reinforcing cross-sector work, especially with the departments of Education, Welfare and the Family, Justice and Presidency, on the prevention and care of mental disorders; supporting and collaborating with family support groups and voluntary associations; and overcoming the social stigma carried by mental disorders by strategies of increased awareness, information and education. Additional activities include the preparation of a guide on mental health promotion and the detection of risk situations in childhood and adolescence, aimed at teachers; the training of professionals to encourage the early detection and adequate treatment of mental disorders, especially in primary health care; community work to encourage social integration and the overcoming of the stigma carried by mental disorders; and improvement of information systems on the incidence and prevalence of mental disorders.

A wide range of activities to promote the mental health of the population are being endorsed, including strategies to overcome the stigma that mental disorders still carry and to achieve greater awareness and involvement of the public and the idea that mental disorders can be prevented and effectively treated is promoted. Actions include projecting a positive image of people with mental disorders and advances in care through mass media; encouraging support, recognition and positive values with respect to all persons in schools and workplaces; and giving support to families from social and health services.

More general measures fall within the political and economic areas, such as those aimed at reducing inequalities, creating healthy urban settings, guaranteeing respect for rights, access to services and occupational and social integration.

During 2005, the Health Department in collaboration with professional and scientific associations, service provision institutions, and associations of patients developed an ambitious Mental Health Policy Strategy “the Director Plan on Mental Health and Addictions (DPMHA)”. Intervention priorities in promotion/prevention include:

- Implementing strategies on mental health promotion and mental disorder prevention (including addictions). A school based programme entitled School and Health is being implemented.
- Promoting the role of PHC in the prevention and treatment of the most prevalent mental and addiction disorders.
- Promoting co-operation with the Family and Well-being Department with the elaboration of a common map of social and sanitary services and resources.
- Promoting awareness and education actions oriented to reduce the stigma associated with mental health and addiction in collaboration with mass media and other social agents.
- Improving the accessibility of data on mental health prevalence and to promote the research on epidemiology.
- Preventing problems associated with drug consumption in schools, the workplace, and the community.
- Increasing community involvement and the role of municipalities.

Since mental health promotion and mental disorder prevention are a matter for all, the Catalan Government launched a Plan in 2004, with the aim of an integrated governmental approach on mental health, involving the following institutions:

- Government of Catalonia (GENCAT; www.gencat.net) and the following ministries: Presidential, Health, Education, Justice, Employment and Industry, Environment and Housing and Trade, Tourism and Consumer Affairs.
- Institutions including Institut Català de la Salut (ICS; www.gencat.net/ics/), Unió Catalana d'Hospitals (UCH; www.uch.es), Consorci Hospitalari de Catalunya (CHC; www.chc.es), Fòrum de Salut Mental, (ACES; www.aces.es).
- Professional associations including Fundació Congrés Català de Salut Mental (FCCSM; www.fccsm.net) and Asociación Española de Neuropsiquiatría- Catalunya (AEN; www.asoc-aen.es).

- Federació Catalana d'Associacions de familiars de Malalts Mentals (FECAFAMM).
- Associació de malalts mentals (ADEM).
- Organizations of local administration: Associació Catalana de Municipis i Comarques (ACM; www.associacio.net) i Federació de Municipis de Catalunya (FMC; www.fmcnet.org).

For specific groups (0-5 years, 6-12 years, adolescents, adults and old people), cross sector projects have to be identified specifying the actions and organisational models, resources, co-ordination strategies, and the involvement of each Ministry to assure the integrated approach.

Programmes and policies across settings

There are not many programmes for mental health promotion and mental disorder prevention already running in Catalonia and those that exist are not widely available.

Children: The Seguiment del Nen Sa³ Programme – Mental Health Protocol is aimed at providing paediatric primary health professionals with early detection tools and intervention tools to intervene with at-risk groups.

Adolescents: The Health and School Programme (Programa Salut i Escola) aimed at improving adolescents' mental health through the implementation in the school of health promotion actions, prevention in at-risk situations or groups and early detection of mental health (eating disorders, anxiety disorders and depression) and addiction problems is being implemented by nurses of the primary health care centres in collaboration with the municipal health services and other community resources. A guide has been produced for primary health care on preventive activities among adolescents⁴.

A plan addressing eating disorders has recently been launched, building on previous research⁵, publications on eating disorders prevention^{6,7} and on previous initiatives (Pla Interdepartamental on eating disorders⁸). The plan, which has been implemented in Girona during 2005, stresses the need to increase resources aimed at improving health promotion and the early detection strategies throughout all health and education facilities.

Other actions/programmes that include to some extent objectives on mental health promotion and mental disorder prevention are:

- The launch of the Agency for Dependency aimed at promoting health and guaranteeing care for elder people, with a special focus on dementia.
- The penitentiary health model will stress the need to intervene with the at-risk prison population to prevent mental disorders.
- The programme on psychiatric and psychological attention to post-traumatic stress disorder.
- The commission on gambling prevention.
- The European project against depression (2004-2006).

³ Generalitat de Catalunya. Protocol de salut mental infantil i juvenil. Programa de seguiment del nen sa. <http://www.gencat.net/salut/depsan/units/sanitat/html/ca/professionals/spnensa.htm>

⁴ Preventive activities among adolescents. A guide for the Primary Health Care. Generalitat de Catalunya. 2005. Available at: <http://www.gencat.net/salut/depsan/units/sanitat/html/ca/infantil/doc8832.html>

⁵ Tizón JL, Buitrago F, Ciurana R, Chocrón L, Fernández C, García J, Montón C, Redondo MJ. Prevención de los trastornos de salud mental desde la Atención Primaria de Salud. Aten Primaria vol. 28. Suplemento 2, Noviembre 2001.

⁶ Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. Servei Catala de la Salut. Trastorns del comportament alimentari. Guia per l'atenció primària de salut. Setembre 2003.

⁷ Generalitat de Catalunya. Guia per educadors i educadores en la prevenció dels trastorns del comportament alimentari. Març 2001. Accesible online a: <http://www.xtec.es/recursos/salut/anorexia/anorexia.pdf>

⁸ Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. Servei Catala de la Salut. Pla Interdepartamental relatiu als trastorns de comportament alimentari (anorexia i bulímia). November 2000. Accesible online a: http://www10.gencat.net/catsalut/cat/publicacions_fitxa_242.htm

- The Primary Health Care European Project on Alcohol (2002-2007).
- The publication by CatSalut of Mental Health Booklets that include some recommendations on mental health promotion and mental disorder prevention^{9,10,11,12,13,14,15}.

4 Organizations and resources for implementation

Funding

In the framework of the DPMHA the need to allocate specific funds in endorsing the development and maintenance of mental health promotion and mental disorder prevention programmes has been stated. Up to now, allocated public funds have been mixed in with other funds but have been mainly used in the areas of screening and early detection, health professionals' education and the organization of some symposia, conferences, etc.

Workforce for mental health

There are several university programmes providing higher education in mental health but they are mainly focused at providing clinical tools. Generally, mental health professionals do not have the training necessary to carry out mental disorder prevention programmes and there are deficiencies in the systems of qualifications and accreditations of teaching units.

Knowledge development and dissemination

Knowledge development, implementation and information dissemination for health care professionals are areas of responsibility of the Department of Health (and the future Catalan Public Health Agency) to be covered and established in the framework of the DPMHA. The Department of Health together with the professional associations and scientific societies will be involved in developing the knowledge base for mental health promotion and mental disorder prevention. The implementation of intervention programmes and other actions for mental health promotion and/or mental disorder prevention will be also a responsibility of the Health Department (and the future Catalan Public Health Agency) and the CatSalut that is the public health service cover provider in Catalonia. The information dissemination for health care professionals will be the responsibility of the Health Department together with the Health Studies Institute (IES) and all the professional associations, scientific societies and all the mental health providers of Catalonia.

⁹ Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. Servei Català de la Salut. Programa d'atenció específica als trastorns mentals severos. Quaderns de salut mental núm.1. Barcelona: CatSalut, 2003. Accessible online a: http://www10.gencat.net/catsalut/archivos/publicacions/planif_sanit/qsm/tras_severs_cat.pdf

¹⁰ Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. Servei Català de la Salut. Trastorn Límit de la Personalitat (TLP). Quaderns de salut mental. Barcelona: CatSalut, 2003. Accessible online a: http://www10.gencat.net/catsalut/archivos/publicacions/planif_sanit/qsm/tlp_cat.pdf

¹¹ Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. Servei Català de la Salut. Necessitats en salut mental en les persones amb discapacitat intel·lectual, SM-DI. Quaderns de salut mental. Barcelona: CatSalut, 2003. Accessible online a: http://www10.gencat.net/catsalut/archivos/publicacions/planif_sanit/qsm/neces_cat.pdf

¹² Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. Servei Català de la Salut. Pla de serveis individualitzat. Quaderns de salut mental núm.2. Barcelona: CatSalut, 2003. Accessible online a: http://www10.gencat.net/catsalut/archivos/publicacions/planif_sanit/qsm/psi_cat.pdf

¹³ Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. Servei Català de la Salut. Rehabilitació comunitària en salut mental. Quaderns de salut mental núm.3, Barcelona: CatSalut, 2003. http://www10.gencat.net/catsalut/archivos/publicacions/planif_sanit/qsm/rehab_comunit_cat.pdf

¹⁴ Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. Recomanacions per a l'atenció als problemes de salut mental més freqüents en l'atenció primària de salut. Servei Català de la Salut. Barcelona, 2000. Accessible online a: http://www10.gencat.net/catsalut/archivos/publicacions/planif_sanit/qsm/adp_cat.pdf

¹⁵ Generalitat de Catalunya. Departament de Sanitat i Seguretat Social. Servei Català de la Salut. Recomanacions per a l'atenció als trastorns mentals greus a la infància i adolescència. Quaderns de salut mental. Barcelona: CatSalut, 2003. Accessible online a: http://www10.gencat.net/catsalut/archivos/publicacions/planif_sanit/qsm/recom_inf_cat.pdf

5 Monitoring and evaluation

Parallel to the development of the DPMHA there is a plan to establish a set of resources and indicators that will help in the reporting and evaluation of the policies and programmes.

The Health Plan 2002-2005 has two operational targets related for mental health promotion and mental disorder prevention: by 2005, a guide for the early detection of eating disorders in primary health care should be available; and by 2005, a guide aimed at mental health promotion and detection of risk situations in childhood and adolescence, targeting the early detection of eating disorders in primary health care should be available.

Sweden

Prepared by Lars Jacobsson

1 Introduction

Sweden has a long tradition of preventive work, which is reflected in a high average length of life (for males 77.5 years and for women 82.1 years in 2001) and a low infant mortality (3.4 per 1,000 living born children). The Swedish welfare state is considered responsible for this development. National insurance systems and other publicly funded systems cover health care, social service and unemployment support, which guarantees that all persons living in Sweden should have their basic needs satisfied. This policy has also been successful in many ways.

The most comprehensive prevention project in the field of mental health in Sweden has been the alcohol policy developed at the beginning of the 20th century when alcohol consumption had increased to very high levels and resulted in serious social and medical problems. A policy was adopted including restrictions on the amount of alcohol that could be bought by individual persons (ration book – a small booklet where all quantities of alcohol bought was noted), the establishment of a monopoly in selling alcohol (Systembolaget) and the establishment of local committees that should care for those individuals who had developed alcohol dependence. These temperance committees (nykterhetsnämnd) were also responsible for supervising restaurants and bars selling alcohol in the community. In addition to this policy that aimed to reduce the total consumption of alcohol in the community and to care for those getting problems because of their alcohol dependence, increasingly high taxes on alcohol were added to reduce consumption. This policy was in action from 1917 and is still the basis for Swedish alcohol and drug policy. However, entrance into the European Union has made this policy very difficult to maintain and the Swedish government is still struggling with the European Union to ensure acceptance of the principles laid down in the policy.

During recent years there are strong indications that there has been an increase in depression and anxiety states in the population, including amongst children and adolescents.

The government has proposed eleven goals for comprehensive public health action in the country, in which mental health is considered an important issue. The parliament has supported the governmental bill.

2 Process to prepare country story

The data presented in this country story has been gathered through contacts with a number of individuals working in the field of prevention and promotion in Sweden, including governmental personnel. In March 2004, a meeting was convened with representatives from the Ministry of Health and Social Affairs, the National Board of Health and Welfare, which is a governmental body responsible for supervising the health care and social service systems in Sweden, the National Institute of Public Health, which is responsible for following and monitoring certain areas of the public health in the country, and Professor Danuta Wasserman, of the Karolinska Institute, who has one of the few academic positions related to prevention and promotion in mental health in Sweden. At this meeting, the items in the IMHPA questionnaire were discussed and it was concluded that collecting the data requested was quite demanding for several reasons.

In Sweden, the responsibility for health care lies with 24 county councils. These county councils are governed by politically elected bodies and they have the right to impose taxes in order to finance medical services in the county. The local municipalities are responsible for the care of children and the elderly, for social services in general and the education system up to university level. The counties and the local municipalities have a high degree of self determination and the government does not have a direct influence on their running.

The government in Sweden relies on a number of external governmental institutions, including the National Board of Health and Welfare, the National Institute of Public Health, and Labour force authorities, which means that the Swedish government has less experts of its own in its departments than many other governments. All of this makes it difficult to collect data on mental health in different parts of the country. There is a high degree of self determination in the local and regional communities and in the governmental authorities.

There is also a big discrepancy between the perception of the situation in these central authorities and at the governmental level and the experience of those working in the field. At the central and governmental level there are laws and policy documents which stress the necessity of prevention and promotion generally in the health field, but also in the field of mental health. But, for those working in the local communities the feeling is that prevention and promotion aspects are not prioritized in favour of the more pressing needs for treatment and care.

All this together with the lack of sufficient resources and time has resulted in a report for which the present author is personally totally responsible. In the future it would be important to have a comprehensive overview of the situation regarding prevention and promotion in the mental health field in Sweden, but this needs quite an extensive effort to achieve. Hopefully this will be made in the future, involving governmental, regional and local authorities, labour unions, NGOs involved in the field and research institutions.

3 Action for promotion and prevention in mental health

Availability of policies

The Swedish Health Care act (1982:763, 1995:835) says in §2b that the health and care system should act to prevent ill health including mental ill health.

The government has proposed to the parliament national “goals for public health”¹. In this proposition the government has proposed eleven areas for comprehensive public health work; 1) participation and influence in the community, 2) economic and social security, 3) safe and good conditions for growing up, 4) improved health in the working life, 5) sound and secure milieus and products, 6) a more health promoting health care, 7) good protection against infectious diseases, 8) secure and safe sexuality and good reproductive health, 9) increased physical activity, 10) good eating habits and safe food, 11) decreased use of tobacco and alcohol, a community free from narcotics and reduced negative effects of gambling. The parliament agreed accordingly.

This policy is directed towards factors in the community which affect public health, rather than directed towards specific disorders like cancer, cardiovascular disorders or mental disorders. The idea is that through developments in all these areas, general health will improve.

In 2000, the government also proposed to the parliament a national plan for the development of health care, which was agreed by parliament. In this plan, the mental health problems of children, adolescents and the elderly, and persons with mental disabilities should be especially targeted.

In these documents mental health issues are mentioned and the need for prevention and promotion activities in the field of mental health is stressed. However, there are no specific actions proposed or taken by the government, for example by funding specific activities. The idea is that prevention and promotion should be an integrated part of the work that is being undertaken in the health care sector, in the schools, and at work places etc. Special money has been given to promote activities against alcohol and narcotic use.

¹ The governmental bill 2002/03:35

At the county level almost all county councils have adopted health plans in which mental ill health is noted as one of the largest public health problems. In some, there are specific measures taken to prevent mental disorders, mainly secondary preventive activities such as early detection and intervention of depression, anxiety and psychotic disorders.

Commitment to prevention and promotion

Prevention of mental disorders and promotion of mental health is mentioned in most key documents in the field of health. This includes health and care legislation, speeches and documents such as health plans and governmental bills to the parliament, and a number of parliamentary committees which have been dealing with different aspects of health and mental health. The most important recent parliamentary committees are those which considered the development of psychiatric care², child and adolescent psychiatric care³, the priority committee⁴, and public health issues, which also included mental health prevention and promotion⁵.

Generally speaking, mental health issues are not considered separate from other health issues, but are supposed to be dealt with like any other health issue. Thus there is no special national mental health plan, which has been proposed by the World Health Organization. This does not, however, mean that mental health issues are not taken care of in Sweden.

Until now, there have been no special plans to follow the WHO Declaration and Action Plan for mental health adopted at the ministerial conference in Helsinki January 2005. The idea is that this is at least partly dealt with by the health care act and the bill on goals for public health, mentioned earlier. As the government is not really executive in its function, the government and the parliament act through laws and directives to the county councils, the local communities, and to the great number of authorities under the government. Thus, mental health issues get a lot of recognition, but in reality (according to the author's opinion), the mental health issue is lost because of lack of focus. One reason for this might be the feeling that it is difficult to achieve primary prevention of mental disorders and that promotion of mental health is best achieved through strengthening the welfare state and supporting the citizens in their daily life.

Programmes and policies across settings

There are however a number of programmes developed in different fields that fit well into the concept of prevention and promotion including a "National Action Plan against alcohol and drug abuse".

There is a national programme for suicide prevention, which was established in 1995, as a collaboration between the National Board of Health and Welfare, the National Institute of Public Health, and a number of researchers interested in suicide and suicide prevention. This programme is led by Professor Danuta Wasserman at the Institute for Suicide Prevention at Karolinska Institute in Stockholm. This programme is based on seven regional networks which are in different ways trying to support suicide prevention activities all over the country. This national programme, however, has not got any special funding from the government or from the county councils, but rather depends on voluntary work in the regions. Mostly this involves people from the psychiatric services in the regions, but people from social services, schools, NGOs, and the churches are also involved. The parliament recently requested a National Plan for suicide prevention from the government.

There is a national organization of relatives of persons who have committed suicide (SPES), which supports families. They run a telephone service together with some other NGOs to support persons in a suicidal crisis.

² Psykiatrikommittén, SOU 1992:73

³ Barnpsykiatrikommittén, SOU 1998:31

⁴ Prioriteringskommittén, SOU 1995:5

⁵ SOU 2000:91

The government supports different NGOs from a public fund (Allmänna Arvsfonden) for projects to prevent mental ill health in children and adolescents.

In schools there are a number of programmes aiming at reducing bullying, alcohol and tobacco use and the adverse effects of sexual activity, unwanted pregnancy and sexually transmitted diseases. During recent years there has been an integration of all these aspects into comprehensive life skill programmes. A number of schools participate in the “Healthy Schools Programme”. There is research and experiences supporting the idea that directing activities specifically towards, for example, tobacco and alcohol and drug abuse might even be counter productive. Instead, programmes are now directed towards strengthening conflict resolution capacity and supporting emotional and personal growth. One of these programmes is developed by the Suicide Prevention Centre and is called “Love is the best kick”. Other programmes like life skills training are run in 10% of schools.

In work places, a number of programmes address stress at work. One problem is that the number of occupational health care services was reduced during the 1980s, and there is now a growing awareness that occupational health care services must be developed again. During the last five years the numbers of sick leave because of burnout syndromes and stress related depressive disorders in the labour force has increased dramatically. Some regional and local based programmes are being developed to prevent burnout and stress.

In the primary health care setting, there are special services for pregnant women and early childhood. Such services are directed towards the medical care of pregnant women and small infants, and include parenting skills. This kind of service was, however, reduced during the economic crisis of the 1990s.

In most communities there are special services for youth, Youth Health Clinics, where midwives, nurses, psychologists, social workers, paediatricians and psychiatrists deal with prevention and promotion issues. Originally these were directed towards the prevention of unwanted pregnancies and sexually transmitted diseases, but are more frequently addressing emotional problems. The system of youth health clinics is intended to support young women and men in developing and keeping good health. They offer services free of charge and are easily available often in localities central in the community. When suspected pregnant, most teenage girls in Sweden attend a youth clinic and, if pregnant, receive support from gynaecologists, midwives and/or social workers. Most young people attending these clinics are girls and young women; however, boys and young men are increasingly attending. The youth clinics offer adolescents and young people who are in health threatening situations an acceptable way to get help without being registered. There are now around 200 clinics all over Sweden.

4 Organizations and resources for implementation

Infrastructures

The major providers of health care in Sweden are the county councils. The number of private hospitals and clinics is rather limited and not directed towards prevention and promotion activities. The local communities are responsible for schools and the care of infants and elderly. They are also responsible for local policies regarding the marketing of alcohol in restaurants and bars. At work, employers are responsible by law for the rehabilitation of the workforce and many working places are connected to occupational health care organizations, which are mostly private enterprisers. Many employers, especially the larger ones have developed special programmes to prevent stress and mental distress in their co-workers. NGOs like Save the Children, the Red Cross, and a number of patient/client organizations in the field of mental health are partially active with prevention and promotion aspects.

Regarding funding, none of these institutions and organizations has a special budget for prevention and promotion as far as the author knows.

Workforce for mental health

The majority of people working in the mental health field are employed by the county councils in psychiatric and child and adolescent psychiatric services. However, the primary health care services also deal with a large number of people with mental health problems. The basic idea is that the primary health care system should be responsible for caring for the majority of the mental health problems in the population. Only cases needing specialist care should be directed to specialist clinics. In the social sector, many social workers of different occupations and training are involved in what is to be considered as prevention and promotion activities in mental health. In some of the local communities there are also health planners, whose primary task is to develop prevention and promotion activities in the community, some of which have implications for mental health. In some places, for example, they deal with suicide prevention activities.

5 Monitoring and evaluation

There are a number of governmental organizations that are responsible for supervision and evaluation of services including mental health services. The major one is the National Board of Health and Welfare, which supervises the health care system, and also partly the social service system. There are national registers of mortality where mortality due to suicide, and alcohol and drug related disorders are identifiable. Recently, the Epidemiological Centre at the National Board of Health and Welfare was requested by the government to develop a monitoring system to monitor the mental health of children. Although this is planned to be a nation wide epidemiological survey of the mental health of children and adolescents, the government has not yet taken the final decision.

Generally speaking there is no tradition of evaluation at the national level of mental health issues. As there are no specific programmes for prevention and promotion in mental health, there are no evaluations of such programmes. There has been a decrease in suicide rates over the last 10-15 years. Whether this is due to the suicide prevention programmes that have been ongoing during the same period of time is debated; some have argued that the increased prescription of antidepressants has been mainly responsible for the decrease. The National Institute of Health monitors the goals for public health set by parliament. The Epidemiological Centre at the National Health of Board and Welfare monitors public health through public health reports (Folkhälsorapporter).

6 Challenges

As the number of sick leaves and sick pensions due to mental disorders has increased dramatically during the last decade, there is an apparent need for concerted action to prevent mental disorders and to promote mental health in Sweden. The welfare state does not manage to deal with this problem by itself. The idea that mental health issues and prevention and promotion should be integrated in all activities of the health care system and social services and those of other interested parties must be supplemented with focused funding of research, development of methods, and implementation in the field of prevention and promotion.

7 Opportunities and advances in the field

There is an increased awareness in the political sphere and amongst the public at large about the importance of mental health issues. There is also an increased awareness of the problems of alcohol and drug abuse following joining the European Union, where different views on alcohol and drug policies existing in other European countries.

Hopefully a nation wide system for monitoring the mental health of children and adolescents will provide an incentive for activities geared towards prevention and promotion amongst children and adolescents. The Swedish welfare state with its emphasis on activities and measures directed towards the whole population gives a good basis for prevention and promotion activities.

The Netherlands

Prepared by Professor Clemens Hosman and Milou Leunissen

1 Introduction

The Netherlands has a long history of professional investment in mental health promotion and prevention of mental disorders, starting at the beginning of the 1970s. In that period the first group of health educators was appointed in primary care and mental health services supported by grants of the Ministry of Social Work and Well-Being. Since that early start, a comprehensive national infrastructure has been developed for health promotion and prevention.

This infrastructure includes a network of health promoters, prevention workers and trained caregivers at local and district level. At national level, several national institutes and university departments invest in the development and dissemination of new knowledge and programmes in health promotion and prevention, and in supporting local organizations in improving their quality in this field. A significant part of these national and local resources are targeted at mental health promotion and prevention of mental disorders. For instance, each of the district mental health centres and addiction clinics provide preventive services and have a team of trained prevention experts. Similarly, all district public health services provide health promotion and prevention services, that by law (Collective Prevention Act) have to include interventions targeted at mental health. These national and local activities are supported by national policy documents, a national professional association for health promotion and prevention, a national research and development programme, and a network of graduate and postgraduate training programmes for health promotion and prevention, with an explicit emphasis on mental health.

2 Process to prepare country story

This Dutch country story is based on information provided by a wide range of national governmental and non-governmental organizations and agencies involved in development, dissemination, implementation and evaluation of mental health promotion and mental disorder prevention. These organizations include: Ministry of Health, Welfare and Sport, Trimbos Institute (Netherlands Institute for Mental Health and Addiction), Netherlands Institute for Health Promotion and Disease Prevention, Netherlands Institute for Care and Welfare, Dutch Mental Health Association, Dutch Federation of Health Education and Prevention, the Netherlands Organisation for Health Research and Development, Prevention Research Centre of the Radboud University and Maastricht University. Indirect information of other relevant national organizations is included by making use of their publications and websites. Each of these organizations was represented by an expert with a long professional experience in the field. This group of experts was brought together in a meeting to complete the European Questionnaire on Mental Health Promotion and Mental Disorder Prevention (www.imhpa.net/questionnaire). The aim of the meeting was to seek agreement on the Dutch response to the questionnaire, by sharing and collating facts and pedigree documents, and to reach a consensus on the more subjective issues.

After the meeting the Dutch co-ordinator for this Country Profile completed the questionnaire and summarized the collected information and views in this Country Story. We realize that this first review of Dutch policies, activities and organizations in the field of prevention and promotion in mental health is not yet complete. We welcome any relevant information that could further complete or update this version of the country story. More detailed information and the Dutch answers to the questions of the IMHPA questionnaire, including references to relevant Dutch documents and organizations, can be found at www.imhpa.net/infrastructures-database.

Persons involved:

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3 Action for promotion and prevention in mental health

Availability of policies

Over more than 25 years, national policies for promotion and prevention in mental health can be found in documents of both governmental and non-governmental organizations, mostly as part of an overall mental health policy or health promotion and prevention policy. We refer here only to the most recent policy documents.

In 2003, the Ministry of Health, Welfare and Sport released a national policy document on prevention, 'Longer healthy Living 2004–2007'¹. The document focuses on four major health problems, mental health being one of them. In 2004, the Dutch Mental Health Association, the national organization of mental health services, published a vision document ('Joining Forces') describing their long term views and ambitions on the four core tasks of mental health services, prevention of mental disorders being one of them². In 2005, the Trimbos Institute, the Dutch National Institute for Mental Health and Addiction, published the Third Prevention Guide, aiming to support innovation of prevention policies in local mental health services, addiction clinics, primary health care and public health services as a part of public mental health strategy³. The question how the prevention of common mental disorders can become better embedded in the public mental health policy of municipalities and health districts remains an issue. Prevention of mental disorders and addictions has a lot of interfaces with municipal policies. The municipality is also pre-eminently able to stimulate co-operation between relevant organizations. In this guide insight is given to municipalities and others who are interested in the field of prevention of mental disorders and poor mental health.

The role of municipalities in health promotion, prevention and enhancing well-being is defined in two laws, the Collective Prevention Act and, from 2007, in the Social Support Act (see next section).

Other reports on, for example, parenting education and prevention for youth are discussed in the next sections.

Legislation and budgeting

Up to the present, most prevention activities in mental health have been financed under the Special Disease Costs Act, which defines several categories of health costs directly covered by a national health budgeting

¹ Langer Gezond Leven. Ministerie van Volksgezondheid, Welzijn en Sport. 's-Gravenhage. 2003

² De krachten gebundeld: ambities van de geestelijke gezondheidszorg. GGZ Nederland, Amersfoort. 2004

³ Ruiters, M., Bohlmeijer, E. & Blekman, J. Derde gids Preventie van psychische stoornissen en verslavingen. Thema openbare geestelijke gezondheidszorg. Trimbos Instituut, Utrecht. 2005

system, paid from tax money. Preventive interventions targeted at persons and groups at risk and implemented by local mental health services were covered by this national budgeting system. From 2007, a new budgeting system for mental health services will be implemented, ruled by health insurance companies. This budgeting system will be more restricted in coverage of prevention costs. The system probably will only cover evidence-based preventive services for indicated patients with beginning symptoms or at risk for relapse. However, negotiations on the final criteria for coverage are still ongoing. Under the new Social/Societal Support Act⁴ (from 2007) the financing of all other prevention and mental health promotion activities, directed at universal populations or at populations at risk, will become a responsibility of municipalities and will have to fit into their local health and social policies. Mental health services and other agencies have to direct themselves to the local government to apply for financing these services.

Since the 1980s public health services, operating under the governance and budgeting system of municipalities, are providing health education and health promotion activities. Their task in this is defined in the Collective Prevention Public Health Act, which specifies that public health services have to provide universal prevention and prevention programmes for large-scale populations at risk. These have to include a focus on mental hygiene. In addition, the public health services have been given the task to stimulate co-ordination and common policy between local health promoting agencies.

Commitment to prevention and promotion

Governmental and especially non-governmental policies reflect a commitment to mental health promotion and prevention of mental disorders, as is reflected in the above mentioned policy documents. The governmental policy document on prevention (*Longer Healthy Living*) calls for attention to prevention in mental health, although the three other discussed health problems (smoking, overweight and diabetes) have been given a higher priority. Although the Dutch mental health care has recognized prevention for over 25 years as one of its fields of action and all their out-patient services have developed specialized prevention programmes, this domain constitutes still a small part of their overall services, roughly around 5% of their capacity for out-patient services. The recent policy document 'Joining Forces', however, is advocating a higher priority for prevention in mental health by recognizing prevention as one of the four core tasks on mental health services and by advocating the doubling of their investment in preventive services. Taking these policies as a whole, prevention of mental and behavioural disorders is given a higher priority than the promotion of mental health.

It is still too early to evaluate the impact of the WHO Declaration and Action Plan for Mental Health endorsed at the WHO Ministerial Conference on Mental Health (Helsinki 2005) on Dutch governmental policy. In general, we may conclude that the need for prevention of mental disorders and mental health promotion is nationally recognized.

Programmes and policies across settings

According to a recent monitoring study the youth-directed prevention programmes provided by local mental health services are mainly targeted at the following themes and populations at risk: children and families of mentally ill parents, child abuse, conduct problems, social skills enhancement, depression, anxiety disorders and eating disorders. Programmes directed at adults and elderly are mainly targeted at: parents with a mental disorder, caregivers of chronic (mental) patients, refugees, work-related problems, depression and anxiety disorders, and social reintegration of chronic mental patients.

Prevention for children and parenting programmes are provided by a range of local agencies (e.g. public health and mental health services, parent education agencies). Municipalities are invited to develop a local preventive

⁴ Raad voor Maatschappelijke Ontwikkeling (Social Development Council). Lokalisering van maatschappelijke ondersteuning: voorwaarden voor een succesvolle Wet Maatschappelijke Ondersteuning. (Locating social support: conditions for a successful Social Support Act). Den Haag, 2005.

youth policy, as part of their responsibility for public health (see also section under legislation). Public health services have a special focus at supporting schools in developing a school-based health promotion policy and implementing prevention programmes, including a focus on mental health issues (e.g. bullying, eating disorders). The Ministry of Health and the Ministry of Justice are collaborating in stimulating and financially supporting municipalities to develop policies and action for parenting support⁵. Statistics Netherlands has provided a national report on social and mental health problems in children to support local agencies and municipalities with relevant epidemiological data⁶. The Netherlands Institute for Care and Welfare published a review in 2001 of ongoing preventive programmes on parenting support in The Netherlands and Flanders (Belgium)⁷, and a database on effective and promising prevention programmes for youth⁸.

4 Organizations and resources for implementation

Infrastructures

Most of the prevention and promotion programmes are provided by district mental health services and public health services through their prevention and health promotion teams. These local organizations each have their national organizations that support policy development and quality management among others. In addition, prevention and promotion in mental health is provided also by a range of other local organizations, such as youth care services, child protection agencies, parent education agencies, primary health care, addiction clinics, and workplace-related health agencies.

In June 2005, the Dutch Trimbos institute released a report on the organization, scope and content of preventive interventions, implemented by local mental health services⁹. The Netherlands is divided into around 50 mental health districts, each with a comprehensive system of inpatient and outpatient mental health services, including prevention. On average, district mental health services have appointed 6.2 full-time equivalent experts in their prevention team, ranging from organizations with only a few prevention experts appointed, to organizations with 36 full-time equivalents, especially in the four largest cities (Voordouw & Schaefer, 2005). It is estimated that in addition to these prevention experts district mental health services invest on average another 2.7 equivalents of their curative workforce in the implementation of prevention programmes, summing to a total average investment of around 9 full-time equivalents per mental health district. For 2004 this sums up to a national investment of 540,000 hours or almost €38million in prevention activities provided by mental health services (Voordouw & Schaefer, 2005). These figures do not include investments by other types of agencies, outside the mental health sector.

Four national institutes play a significant role in the development and dissemination of relevant knowledge (e.g. reviews), dissemination of evidence-based programmes (e.g. databases), and in enhancing the quality of local practices by providing consultation and training opportunities. These include the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ), Trimbos Institute (Netherlands Institute for Mental Health and Addiction), Netherlands Institute for Care and Welfare (NIZW), and the National Institute for Public Health and Environmental (RIVM).

The Trimbos Institute hosts a range of national task forces, where local prevention experts meet periodically to discuss new developments and needs, to exchange best practices and materials, to enhance programme

⁵ See for instance the report 'Opvoed- en opgroeiondersteuning: de rol van gemeenten in het licht van de Wet op de Jeugdzorg' (Parenting support and the role of municipalities). Ministry of Health, Welfare and Sport. Den Haag, 2005; and the report 'Impuls opvoed- en gezinsondersteuning' (Stimulation of parenting and family support) Ministry of Health, Welfare and Sport. Den Haag, 2004.

⁶ Zeijl, E. et al. Kinderen in Nederland (Children in The Netherlands). Statistics Netherlands and TNO. Den Haag/Leiden, 2005.

⁷ Prinsen, B. et al. Met ouders samen: opvoedingsondersteuning in de preventieve zorg in Nederland en Vlaanderen (Together with Parents: parenting support in preventive care in The Netherlands and Flanders). Utrecht. NIZW, 2001.

⁸ NIZW, Veelbelovend en Effectief. (Promising and Effective). Utrecht. NIZW, 2004.

⁹ Voordouw, I. & Schaefer, B. Ontwikkelingen in de organisatie, omvang en inhoud van de GGZ-preventie (Developments in the organisation, scope and contents of prevention in mental health care). Trimbos Institute, Utrecht. 2005.

quality and to stimulate national policy making¹⁰. This includes among others prevention taskforces on children of mentally ill parents, work and mental health, and depression and anxiety disorders. In addition, the Trimbos Institute runs effect studies on local prevention programmes, disseminates fact-sheets, enhances national standardization of prevention programmes, monitors national and local developments in prevention, advises the government, develops new opportunities for e-mental health education through the internet, and develops comprehensive, community-oriented strategies for depression prevention.

The Netherlands Institute of Health Promotion and Disease Prevention (NIGZ)¹¹, has developed a Prevention/Health Promotion Effect Management Instrument (Preffi 2.0) that is used by many health promotion and prevention teams throughout the country in order to increase the quality and effectiveness of their programmes. In addition, the NIGZ organizes among others a series of bi-annual national conferences on health promotion and prevention, co-ordinates the Dutch monitoring system of prevention and health promotion programmes throughout the country (see also section 6), stimulates the development and implementation of school-based health promotion programmes, and supports local health promotion and prevention agencies in developing successful relationships with municipalities.

The Netherlands Institute for Care and Welfare (NIZW)¹² is especially focused at health promotion and well-being for children and parents. The institute runs the national database of effective and promising programmes for children and youth. They support local non-governmental agencies through expert reports and materials. In addition, they advise governmental agencies and municipalities on youth-related issues and policies, for instance on child abuse¹³. Together with a coalition of caregivers, policymakers, representatives of parents and children they have distributed a one-page 'Proclamation on Parenting without Violence'¹⁴.

The enhancement and planning of prevention and health promotion research is co-ordinated by the Netherlands Organisation for Health Research and Development (ZonMw)¹⁵. This organization is the main grant-giving agency for prevention research in the Netherlands (see also section on evaluation).

Basic and postgraduate professional training is provided by Universities, national institutes and the National School of Public and Occupational Health (see also section on workforce)

Workforce for mental health

The development of a specialized professional workforce for health promotion and disease prevention and the improvement of its quality is the primary aim of the Dutch Federation of Health Education and Prevention (NVPG).

This association has a membership of prevention and health promotion experts from many disciplines working in national and local organizations across different public sectors, including mental health and public health. Their activities comprise the enhancing of training facilities and knowledge dissemination, quality assessment and enhancement, the organization of national conferences, and representing the professional workforce in contacts with employers, financing agencies, governmental agencies and other professional organizations. The estimated number of health promoters, health educators or prevention experts, represented by the NVPG, was 1177 in 2004. Of them 29% (N=345) were appointed in mental health services and 193 in addiction clinics. Of the remaining 639 professionals, working for instance in public health services, primary care and national institutes, a substantial proportion is, at least part-time, involved in prevention and promotion in mental health.

¹⁰ See also their website www.trimbos.nl

¹¹ See also their website www.nigz.nl

¹² See also their website www.nizw.nl

¹³ Kooyman, K. & Wolzak, A. *Verkenkende studie naar kindermishandeling*. NIZW. Utrecht, 2003.

¹⁴ Available through the NIZW, Utrecht

¹⁵ ZonMw (The Netherlands Organisation for Health Research and Development), Den Haag. See website www.zonmw.nl

Interventions aimed to promote mental health and to prevent mental disorders are delivered by two categories of professionals, those who are appointed and trained as health promoters, health educators or prevention experts, and other professionals (e.g. caregivers in primary health care and mental health services, school teachers, school counsellors, personnel officers) who contribute to the implementation of prevention or promotion activities but for whom these activities do not belong to their primary field of expertise. To the first category belong health promoters, health educators and prevention experts mainly appointed in local mental health services, addiction clinics, primary health care, youth health care, public health services, parent support agencies, child protection agencies and national health promotion agencies. These experts have a basic training in one of the following disciplines: psychology, educational sciences, health sciences, social work or nursing. Either, as part of these basic training programmes or through postgraduate programmes, these experts received a specialized science-based training in health promotion, health education or prevention. To illustrate the contributions from other professionals, an example is the involvement of outpatient mental health caregivers who, on top of their curative and rehabilitation activities, are involved in preventive programmes for, on average, 5% of their time.

Maastricht University offers a bachelor and masters programme in health education and health promotion, including a basic course in prevention of mental disorders and mental health promotion. In addition they organize international summer courses in health promotion. The Prevention Research Centre¹⁶ of the Radboud University Nijmegen provides several specialized courses on promotion and prevention in mental health as part of the Psychology bachelors and masters programmes and postgraduate training programmes, and offers international training activities on request. Postgraduate courses are also offered by the Netherlands School of Public and Occupational Health, the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ). Basic training and postgraduate training in this field are stimulated by the training policy of the Dutch Federation of Health Education and Prevention (NVPG). This includes a national accreditation system for training programmes and a professional-oriented registration system for expertise levels in prevention and health promotion, based on participation in accredited training programmes and conferences. This registration system is linked to the criteria for becoming a registered member of the NVPG.

5 Monitoring and evaluation

Mental health in the population is monitored mainly through the NEMESIS-project of the Netherlands Institute for Mental Health and Addiction (Trimbos Institute). NEMESIS is a longitudinal epidemiological survey on representative samples of the Dutch population. It assesses periodically the prevalence and incidence of mental disorders, identifies populations at risk and potential risk factors, and trends in the use of health and mental health services. In addition, several public health services and some mental health services are involved in mental health monitoring systems at the level of health districts.

Implementation of policies and programmes across the health districts and local communities are registered by several national institutes. The Trimbos Institute registers nationwide the prevention programmes provided by mental health services, while the NIGZ maintains a national database on health promotion and prevention activities in other health sectors, which may also include activities targeted at mental health. The current national QUI-project¹⁷, in which several national institutes are collaborating, aims to integrate the available databases in one national, comprehensive monitoring system for the implementation of health promotion and prevention programmes.

National institutes and University departments are running quality assessment, efficacy and effectiveness studies on these programmes and policies as part of a national Prevention Research Programme of the

¹⁶ See also their website www.preventioncentre.net

¹⁷ See also their website www.quidatabank.nl.

Netherlands Organisation for Health Research and Development (ZonMw). The Ministry of Health, Welfare and Sport provides the budget for this research programme after approval of each 5-year Research Plan. In the research plans for both the 1998-2002 and 2003-2007 periods, mental health was identified as one of the priority areas. In the first planning period, around 30% of the budget (€80Million) was spent on research projects targeted at mental health problems.

6 Challenges

Some of the major challenges for mental health promotion and prevention of mental disorders in the next decade include:

- ▶ Expanding the reach of current mental health promotion and prevention programmes in the population through expanding the capacity for programme implementation, and by using innovative intervention strategies and methods that are able to reach larger segments of the population as a whole and in particular populations at high risk.
- ▶ Increasing further insight in the effectiveness and cost-effectiveness of interventions, and systematically improving effectiveness.
- ▶ The development of a comprehensive national plan on long term development of effective mental health promotion, supported by the main national parties; a policy that includes priority areas, the development of local planning tools for co-ordinated action, a comprehensive policy on budgeting mental health promotion and prevention of mental disorders.
- ▶ Insight in the relationships between mental health, physical health and social problems, and related to these insights, effective comprehensive prevention planning strategies across mental health, public health and social policy sectors, including relations to human rights.

7 Opportunities and advances in the field

Major advances include:

- ▶ The development over the last 20 years of a comprehensive national system of local prevention and health promotion teams in public health, mental health and addiction clinics; and the availability of over 1,000 trained health promoters and prevention experts, of who approximately 50% are partly or mainly focused on issues concerning mental health.
- ▶ The development of a national research and development programme of the Netherlands Organisation for Health Research and Development (ZonMw), in which strong emphasis has been given to prevention of mental disorders.
- ▶ National collaboration between local health promoters and prevention experts in developing standardized science-based programmes.
- ▶ A national support structure of several expertise centres (Dutch National Institutes) providing updated knowledge, support and advice to local agencies, municipalities and national government.
- ▶ The countrywide availability of information through databases of effective programmes to promote mental health and to prevent mental disorders; and related to this, a national policy to prioritize the implementation of evidence-based programmes.

Turkey

Prepared by Dr. Toker Ergüder, Dr. Ebru Cengiz, Yeliz K p uk and Dr. Tahir Soydal¹

1 Introduction

The population of Turkey in 2000 was 67.8 million. Turkey has a young population structure as a result of the high fertility and growth rates of the recent past. The latest estimates (2002) put life expectancy in Turkey at 71 years for women and 67 years for men. This is well below the 1998 EU average life expectancy at birth of 80.5 years for women and 74.4 for men.

Health Expenditures in 2000 were 6.3% of GDP. Public expenditures constitute 82.6 percent of total health expenditures in Turkey, while private expenditures on health constitute the remaining 17.4 percent. Annually, Turkey spends about US\$112 per person on health (2001).

The Turkish health care system has a highly complex structure. The actors in health care in Turkey are several public, quasi-public, private and philanthropic organizations. The agencies involved in the health sector, either directly or indirectly, are grouped according to whether they are concerned with policy formulation, provision of health care, finance of health care, or whether they have administrative jurisdiction over delivery of health care.

The MoH (Ministry of Health) is the main government body responsible for health sector policy making, implementation of national health strategies through programmes and direct provision of health services. The MoH is the major provider of primary and secondary health care, maternal health services, children's and family planning services. It is essentially the only provider of preventive health services through an extensive network of health facilities (health centres and health posts) providing primary, secondary, and specialized in-patient and out-patient services. At the provincial level, provincial health directorates (for 81 provinces) are responsible for administering health services provided by the MoH.

Health services in Turkey are supplied by a multitude of public and private providers. The two key public providers are the MoH and the Universities through University hospitals. Other public Ministries, (Defence, Transport, Education), some state enterprises and municipalities also provide health services, but their capacity is quite limited. At the central level the MoH is the major government body responsible for sectoral policy making, implementation of national health strategies and programmes and provision of health services.

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Organization of mental health services in Turkey

Services related to mental health and diseases are mostly provided by mental health and state general hospitals and also university hospitals which are located in city centres or large districts. The mental health services in Turkey are basically therapy oriented. Primary level mental health services are not well developed. Mental health services in primary care include treatment services and prevention and promotion activities delivered by general practitioners. They also provide outpatient care and rehabilitative services at home. Therefore, some special training and monitoring programmes are implemented in the health centres.

In 2001, the General Directorate of Primary Health Care published “Health for All, Turkey’s Targets and Strategies”. Target 8 was “improving mental health”: “By the year 2020, improving the psychosocial well-being of the community and ensuring special care for people with mental disorders.” The sub targets were:

- ▶ By 2005, ensuring the integration of mental health services to health centres,
- ▶ By 2020, doubling the referral of people with mental problems to health institutions and counselling centres,
- ▶ By 2020, decreasing the prevalence of mental diseases like anxiety, depression, drug abuse, sleeping disorder and somatization by 20%,
- ▶ Preventing suicide attempts.

The strategies include:

- ▶ Providing support and training for physicians at primary health care to identify mental disorders
- ▶ Training of midwives and nurses at primary health care concerning psychosocial conditions
- ▶ Spreading public awareness and acceptability to seek mental health services and emphasize the link of mental health, preventive mental health with general health services in the community
- ▶ Provide psychosocial follow-up for 0-6 years age group in addition to physical health at the primary health care level
- ▶ Provide follow-up of patients with chronic mental disorders at the level of primary context with home visits
- ▶ Promote education and training of parents and teachers in the context of preventive mental health in terms of child development and health child rearing practice for early identification of children at risk for mental disorders
- ▶ Provide psychosocial follow up at day care centres, pre-schools, and all level of educational institutions (primary, secondary and high schools) in terms of psychological counselling and guidance, establish training of qualified personnel for provision of these school based services
- ▶ Develop and set up training programmes aimed at increasing coping skills of individuals.

The National Mental Health Policy Programme updating studies will be completed in January 2006, under the Marmara Earthquake Emergency Reconstruction (MEER) Project of the General Directorate of Primary Health Care – Mental Health Department of the Ministry of Health with Harvard Medical School.

2 Process to prepare country story

The country story for Turkey has been formed as a result of the efforts of employees of the department that is involved in mental health in the MoH.

There is a mental health reporting system in the country. The MoH collects this data through the medium of a special organizational structure.

For this profile people that are working in the MoH were brought together and as much relevant factual information as possible was obtained from additional contacts in order to make them available for discussion

by the group. In this study the current State policy of mental health and of mental health improvement in Turkey was discussed by participants and the involved documents were analyzed.

3 Action for promotion and prevention in mental health

The strategic direction for mental health promotion and mental disorder prevention in Turkey has evolved from a number of policy areas including: mental health, public health, social justice, education, enterprise and life long learning and arts, sports and culture.

The current mental health policy in Turkey is prevention and promotion oriented through the following aims:

- Improving the psychosocial well-being of the community and ensuring special care for people with mental disorders,
- Ensuring the integration of mental health services to health centres,
- Doubling the referral of people with mental problems to health institutions and counselling centres,
- Decreasing the prevalence of mental diseases like anxiety, depression, drug abuse, sleeping disorder and somatization by 20%,
- Preventing suicide attempts through country level trainings of involved governmental (teachers and other school staff, primary health care workers, prison officers, general physicians) staff and co-operation of non-governmental (media members) organizations.

Our National Mental Health Policy's main objectives are:

- Promote the development of community based mental health care,
- Promote the development of comprehensive mental health services integrated to primary health care,
- Stress emergency and disaster needs of the country in particular with respect to the earthquake emergency,
- Considers the needs and available resources,
- Encourage partnership between individuals, families and health providers,
- Promote the creation of a system that respects and fulfils the rights of people with mental disorders,
- Aim at utilizing evidence-based practices,
- Encourage adequate supply of trained personnel to ensure successful implementation of the policy,
- Take into account the special needs of women and children,
- Promote the reduction of tobacco and alcohol consumption and drug abuse,
- Establish parity between mental health and other health services,
- Promote monitoring and evaluation of mental health services,
- Encourage the development of a system that is responsive to the needs of vulnerable groups,
- Promote strategies for prevention and promotion,
- Encourage inter-sectoral links between mental health and other sectors.

Turkey signed the WHO Declaration and Action Plan for Mental Health in Europe in 2005. Since then, National Mental Health Policy Developmental studies are on going by the participation of academicians, national experts and members of NGOs. It was proposed to complete the studies by the end of 2005.

Programmes and policies across settings

The prevention and promotional mental health policies and programmes are available across different groups in Turkey for risk groups which are children, adolescents, older people, women, victims of a disaster and addicted people. Some examples of the programmes are:

- Provision of in-service training to health personnel on issues related to their department, organization of public information campaigns, and reproduction of training materials to be used in such campaigns,
- Integration of a psycho-social dimension into maternity care, and follow-up of 0-6 years old children at primary health care level,
- To carry out necessary studies to ensure early recognition and treatment of common mental disorders at primary health care,
- To carry out preventive mental health services for risk groups like children, the adolescent, older persons, and persons who experienced a disaster,
- To carry out follow-up, evaluation and feed-back studies in our field,
- Work for in-sector and inter-sectoral co-ordination,
- To plan, carry out and evaluate activities for special days and weeks.

In addition, there is a project about preventing suicide as part of the WHO worldwide initiative for the prevention of suicide with a focus on training care providers involved in suicide prevention, and another project supporting 0-6 year old children's psycho-social development, to be completed in 2007.

In this project, the Programme for Supporting Child Psychosocial Development (PSCPD), first level health services are basically provided through the health centres in our country. The midwives and nurses in these centres regularly monitor pregnant women and children between 0-6 years of age. We aimed to integrate the idea of supporting child development through "The Programme for Supporting Child Psychosocial Development (PSCPD)" into the existing routine services given by health centres. In this way, it is planned to support early child development and to contribute to raise physically, psychologically and socially well-developed children. A training programme and equipment to improve health staff's abilities and knowledge to support early child development was prepared. In 26 health centres serving a population of 600,000 people, pregnant women and children are monitored. With the help of the regular face to face semi-structured interviews with the parents, parents are supported and informed of the ways of supporting their children's development. Risk factors are evaluated. Risk factors such as nutritional insufficiency, extreme poverty, abuse against mother and child, parents' psychological problems, and child's developmental problems are identified earlier and possible intervention is applied. All special cases are counselled by a physician. In order to give support to those children and their families who are under risk, we work in collaboration with NGOs, government organizations and private sector representatives. In 2004, the Bursa Health Directorate decided to extend this programme to all health centres in the province, and in 2005, the Ministry of Health is considering to spread the programme throughout the country.

The MATRA supported project "Development Community based Mental Health for Schizophrenic Patients in Turkey" started on the 1st of March, 2005. The project will have a duration of three years. The project has a challenging scope, as it is envisaged to discharge a number of schizophrenic patients from an in-patient setting in a regional mental health facility at the Elazig Mental Health Hospital in the Eastern part of Turkey, and will develop sheltered home facilities in the community. This project is in collaboration with HEAP Research BV and Meerkanten GGZ (the Netherlands). The concept of sheltered homes is new to Turkey.

4 Organizations and resources for implementation

The Turkish Executive and other statutory bodies, professional bodies, academic institutes, etc. all play a part in the development and delivery of public mental health and mental health improvement. Several national infrastructures co-operate to the success of developments and implementations of national mental health policies with the MoH, including Social Services and Child Protection Agency (SHÇEK), Turkish Republic Prime Ministry Directorate General on the Status and the Problems of Women, Ministry of Justice, and Ministry of Education. In addition, the MoH collaborates with several relevant associations, such as the

Turkish Psychiatric Association, Turkish Psychological Association, the Child and Adolescent Mental Health Association, and the Turkish Public Health Specialist Association.

One of the other projects is “Integration of Preventive Mental Health Services into Primary Health Care” which aims to inform the general physicians and provide them with the skills for the early recognition and treatment of common mental disorders at the primary health care level. Within the context of this project, over ten thousand general physicians have been trained by their provinces’ responsible trainers.

The MoH is financed by taxation through the general budget. In the general budget of the MoH there are no budget allocations for mental health. For programmes and projects funds are taken from the General Directorate of Primary Health Care’s general budget.

Workforce for mental health

Psychiatrists mainly work in the large cities and the Western parts of the country. Almost two-thirds are located in Istanbul, Ankara and Izmir. Most psychologists work in private clinics. Within the government set up, about two thirds of mental health staff are attached to mental health hospitals.

In Turkey the workforce involved in mental health promotion and mental disorder prevention is drawn from a diversity of settings and sectors including: entire staff of primary health care, public health experts, voluntary sector e.g. teachers, social service experts, prison officers, academics, media members, etc. Ongoing professional training and development and community based training includes “Integration of Preventive Mental Health Services into Primary Health Care”, suicide prevention training, and “Supporting the 0-6 aged children’s psycho-social development, and training of parents”.

5 Monitoring and evaluation

In Turkey monitoring of patients with mental disorders to Mental Health Hospitals are made by Provincial Mental Health Departments through Mental Health Forms. Generally there are no specific methods to collect information about the public mental health situation. Currently there are plans to develop several questionnaires for this aim.

6 Challenges

Despite recent positive developments in Turkey, there are many challenges for mental health improvement. In Turkey in the last few years, resources (budget, people, capacity, etc.) for public mental health and mental health improvement are still limited in relation to the size of the task. Although the government had allocated more funding for public services, the investment in health care, in general – and in mental health services, in particular – has been inadequate to cope with the increased demands. Although each of the 81 provinces has a mental health department within its departments of health, many have an insufficient number of staff to answer expectations. In the primary health care centres in the provinces, the general practitioner staff have typically received widely varying (but generally poor) training in mental health.

7 Opportunities and advances in the field

Historically, a strength of the health care system in Turkey, at least since the passage of the basic health law in 1961, has been the development of a primary health care grid of health care centres, administered under the MoH’s Directorate of Primary Health Care and the provincial directorates of health. The MoH also has jurisdiction over the development and dissemination of preventive services; integration of mental health and primary care; community education and identification of risk- behaviour groups; creation of counselling and guidance units; creation of psychiatric units in state hospitals; development of rehabilitation facilities; public education through the mass media; and data collection and research.

In particular, ongoing developments in national mental health policy will secure an unprecedented level of investment and activity in public mental health and mental health improvement in Turkey. Opportunities and advancements will be afforded by the establishment of this programme will include the development of new numerous programmes, projects, training initiatives, campaigns and implementations.

Furthermore, according to Turkish ancient culture the family ties are very strong. Subject to this condition there is a very small number of homeless, alone older people in our country.

8 Acknowledgements

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United Kingdom, England

Prepared by Elizabeth Gale

1 Introduction

In England mental health promotion has gained credibility in the last decade. This move has been mainly supported nationally by the National Service Framework (NSF) for Mental Health, released in 1999. This document outlines the Government's vision for mental health services, treatment, care and promotion. It followed a Government commitment to making mental health a priority, increasing budgets, supporting workforce development, enhancing the mental health estate and ensuring appropriate public and patient involvement in mental health care and programmes. It also aims to contribute to broader Government objectives such as reducing health inequalities, providing equality of opportunity, enhanced choice in health and improved access.

The NSF was the first national policy to outline the need to promote mental health in localities set out in Standard One. The National Director of Mental Health, Professor Louis Appleby, recently reviewed progress towards the standards of the National Service Framework for Mental Health, where he concluded that less had been achieved in relation to Standard One of the NSF than other standards. There is a move from rhetoric to practice and a commitment to partnership working to deliver sustainable mental health improvement in localities in England.

The NSF however, many believe, continues to locate mental health promotion within mental health service provision, although the lead organization for Standard One should be Primary Care Trusts working in partnership with local authorities and the broader community. More recently there has been a move to support far broader public mental health promotion programmes. The inclusion of mental health in the Public Health White Paper: Choosing Health has been limited but welcomed. Mental health is one of six key priorities and it is hoped that the delivery plans within localities will include far more detail on the assessment, development, delivery and evaluation of public mental health programmes. There are also an increasing number of programmes considering the development of indicators and measures for mental health and an increasing number of networks, nationally and regionally, which support those tasked with the delivery of mental health improvement.

Public mental health promotion expertise is for the first time to be represented on the Mental Health Taskforce. The Taskforce is the most senior group of mental health stakeholders advising Government. This external reference group provides advice on mental health policy development and implementation. This is another indication of the increasing credibility of the work. The National Institute for Mental Health in England (NIMHE) published a national framework for improving mental health and mental well-being in October 2005. The framework informs the next stages in the design, delivery and evaluation of mental health promotion at all levels, amongst a range of statutory and voluntary sector providers in all settings. It is the first time that an implementation framework exists for England.

2 Process to prepare country story

mentality, as the national partner in England for the IMHPA programme, collected data and opinion in a range of ways ensuring it met all the criteria outlined for the programme centrally. An external board of advisors was established representing Government, the statutory and voluntary sectors, academics and researchers, practitioners and implementers and a range of mental health and public health expertise. The advisors oversaw and reviewed the completion of the country profile and the country story. The mentality team also submitted organisational details for all advisors to this specific programme (ten), national advisors to NIMHE

on development and implementation (fourteen), details of relevant organizations (sixteen) and all reference templates (thirty in total).

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mentality also reviewed the evidence in England and identified five broad areas where models of good practice were submitted. These included parenting and home visiting programmes, healthy schools programmes, programmes which encouraged exercise and physical activity to promote mental health, volunteering programmes and programmes aiming to reduce anxiety and depression. A total of eight models were submitted to the IMHPA programme.

3 Action for promotion and prevention in mental health

Availability of policies

The strategic direction for mental health promotion and prevention in England is broad and often unconnected. There are a number of policies which outline needs or set targets and standards around mental health promotion. The National Service Framework for Mental Health (NSF) is the most significant. This framework aims to improve quality and increase the uniformity of mental health provision in England. It sets national standards and defines service models for promoting mental health and treating mental disorders. It puts in place underpinning programmes to support local delivery and establishes milestones and indicators. Standard One outlines a national commitment for health and social service departments to promote mental health and reduce the discrimination and social exclusion associated with mental health problems.

Mental health promotion also appears in other relevant health policies which is a positive step towards mainstreaming the discipline. Frameworks which make mention of it include the National Service Framework for Older People and the National Service Framework for Children, Young People and Maternity Services. Broader public health policy including that set out in *Choosing Health: Making Healthy Choices Easier* also highlights improved mental health as a key deliverable. Other broad central Government programmes such as Neighbourhood Renewal, Urban Regeneration and Social Inclusion highlight mental health improvement as a target and approved outcome for programmes supporting positive local practice, particularly in the most deprived areas. Also the Local Government Act 2000 gives local authorities the power to promote well-being among local communities.

There is also a National Suicide Prevention Strategy for England which aims to support the national target of reducing the death rate from suicide by at least 20% by 2010. The strategy seeks to be comprehensive, evidence-based, specific and subject to evaluation. Substantial progress towards this target has been achieved.

Commitment to prevention and promotion

Commitment to prevention and promotion has been limited to date. Although a number of policies state the importance of promoting public mental health there has been limited acknowledgement by ministers and officials. Budgets for mental health promotion are limited nationally, regionally and locally in comparison with other target health improvement areas, such as smoking or obesity, and other mental health advances such as assertive outreach or home treatment and crisis support teams.

Mental health promotion monies are rarely, if ever, ring-fenced and therefore, within localities, delivery can be considered to be an optional extra, rather than a definite commitment. It is hoped that the increased commitment to public health will lead to an increased commitment to public mental health in time. There has also been a call to set targets related to mental health promotion to encourage commitment and delivery.

Programmes and policies across settings

There are a range of programmes and policies to support mental health promotion and prevention throughout the lifecycle and across settings. For early years and parenting programmes there has been large investment through the Sure Start programmes, the Early Years Development and Childcare Partnerships and programmes supported by the Children's Fund and the newly appointed Children's Commissioner. In schools the investments into Healthy Schools programmes and Connexions services supporting young people through periods of transition have been appropriate, as well as policies such as Every Child Matters and the implementation that follows.

The New Deal programmes supporting people back to work and the Pathways to Work programmes have also had mental health outcomes. There are programmes supporting work-life balance and enhanced interest in programmes supporting healthy workplaces and broader corporate responsibility. In local communities, the Neighbourhood Renewal and Urban Regeneration programmes aim to improve health through enhanced participation and engagement and improved environments, structures and prospects. Community strategies and the work of Local Strategic Partnerships support enhanced well-being within localities. There is also increasing support for the health impacts of culture and the arts, physical activity and leisure and improved safety and security in communities.

4 Organizations and resources for implementation

Infrastructures

Many agencies contribute to the promotion of mental health in England. In terms of policy the leads are within the Department of Health; in terms of implementation they are within the National Institute for Mental Health in England (NIMHE), which has recently become part of the Care Services Improvement Partnership (CSIP) within the Department of Health. NIMHE has a national advisory group for mental health promotion which brings together representatives from mental health and public health organizations to advise and support effective implementation in England.

In relation to national public health organizations there are many with an increasing interest in mental health. These include the UK Public Health Association, the Institute of Health Promotion and Education, the Royal Institute of Public Health, the Royal Society for the Promotion of Health, the National Institute for Health and Clinical Excellence (NICE) and the Faculty of Public Health. The Faculty has recently established a working

group on mental health which will include programmes on mental health promotion. A Memorandum of understanding between the Faculty and NIMHE has also recently been signed.

Nationally there are a number of professional bodies and voluntary organizations who also deliver mental health promotion. **mentality** is still the only national team dedicated solely to the promotion of mental health but other organizations such as the Samaritans, Mental Health Media, Rethink, the Mental Health Foundation and the Royal College of Psychiatrists have programmes of work supporting the promotion of positive mental health and the prevention of mental disorders. Organizations also work in partnership with other agencies on specific topics; recent examples include working with English Nature on the impact of the environment, with Antidote an agency for children on emotional intelligence, and with the Work Foundation for the workplace.

Within regions, CSIP has eight regional development centres (RDC) throughout the country supporting NIMHE's programmes. In each RDC there is an individual responsible for mental health promotion and anti-stigma and discrimination work. In most areas there are also co-ordinated regional networks to inform, develop and support individuals working in localities.

Regional health structures supporting public health implementation also include Government Offices which host the Regional Directors of Public Health and their teams who are responsible for Regional Public Health Strategies; and Public Health Observatories which monitor and evaluate public health targets within regions. The National Institute (NIMHE) has pooled resources with the North East Public Health Observatory to establish a Public Mental Health Observatory.

Workforce for mental health

The workforce for mental health promotion in England is a varied one. Those leading on mental health promotion nationally, regionally and locally are generally drawn from public health, health promotion or mental health backgrounds. The broader networks of implementers in localities include health visitors, primary care professionals, teachers, governors, councillors, housing officers, community development workers, transport co-ordinators, leisure workers, social workers, police, probation officers, prison staff and colleagues in mental health services.

There are an increasing number of academic organizations including mental health promotion in more generic training, for example for mental health nurses or occupational therapists. The Open University is also including mental health promotion in broader mental health training programmes for distance learning. However this advancement is relatively ad-hoc in nature and although national training has been piloted and delivered through some NIMHE regions there is no commitment to continue to train and support those tasked with delivery.

A programme of work has begun considering competencies and capabilities required for the effective delivery of mental health promotion and the results will be due in 2006. It is hoped that this initial study and development programme will support the arguments for the continued professional development for those working in mental health promotion. There is also an independent UK wide network of mental health promoters, within health agencies. These individuals will be surveyed annually to consider workforce needs and to make recommendations to national Government and regional bodies for future investment.

5 Monitoring and evaluation

Monitoring and evaluation of mental health promotion in England is an area for further investment. Currently much data is lost by the absence of agreed definitions, frameworks and measures. There are measures such as the GHQ12 and the SF36 which are used to assess mental health but mental health promotion is generally monitored in relation to the absence of disease or illness. Individual programmes tend to be monitored with process indicators rather than outcome indicators which limit comparisons and further investment.

There has been an increasing interest in positive measurements such as the Affectometer II, which is currently being piloted by one academic institution in England. There has also been work on the development of a mental health impact assessment in one locality which is leading to further training and development across the country. Here also however progress has appeared to be uncoordinated.

6 Challenges

The main challenges for effective implementation for mental health promotion in England are outlined below: a lack of resources, leadership and commitment, conceptual ambiguity, organisational change and the stigma and discrimination which surrounds the area of mental health.

Resources for mental health promotion and mental disorder prevention have been limited. There are no ring-fenced budgets and therefore funding tends to be inconsistent and unsustainable. Resources also in relation to staff training and development and the lack of support for professionals within mental health and public health are problematic.

Although mental health promotion is the first standard of the National Service Framework for Mental Health, its implementation has been patchy and its relevance to all other standards and service provision has been largely overlooked. Nationally, the area has lacked strong leadership and commitment at all levels. Within localities implementation has often been limited to assessments rather than action.

There remains in England some conceptual ambiguity relating to mental health promotion and mental disorder prevention. This has ensured that the disciplines have continued to fall between mental health professionals and public health professionals and there has been a lack of ownership.

The health and social care economy in England is constantly changing and this tends to impede the effective implementation of national policies and programmes with long term outcomes, such as mental health promotion.

There is a high level of stigma and discrimination around mental health programmes and particularly around people who have used mental health services. The stigma that surrounds mental health often alienates the public and professionals working inside the health sector, ensuring that mental health remains sidelined and a low priority.

7 Opportunities and advances in the field

The opportunities and advances in the field of mental health promotion are outlined below: a national framework, the development of targets, indicators and tools, support for the growing evidence base and support for the mental health promotion community nationally.

There is a need for the mental health promotion community to be supported by an effective national strategy. This should outline the scope and the relevance of mental health promotion and identify key priority areas, attached to committed funding and appropriate methods of evaluation. A national framework is due for delivery imminently.

The development of appropriate indicators and challenging but achievable targets would support the national mental health promotion strategy and the community tasked with its delivery. The indicators should relate to the mental health and well-being of individuals and communities and should be easily attainable. The development of appropriate tools to assess the mental health impact of policies, procedures and programmes would support the development of mental health promotion in other sectors.

Appropriate support for the development, collation and dissemination of the evidence base for mental health promotion and mental disorder prevention would support previous stated advances. The mental health promotion community in England is disparate and often those tasked with delivery are isolated in both mental health and public health settings. The mental health promotion community requires training and support through the development of networks and forums.

United Kingdom, Scotland

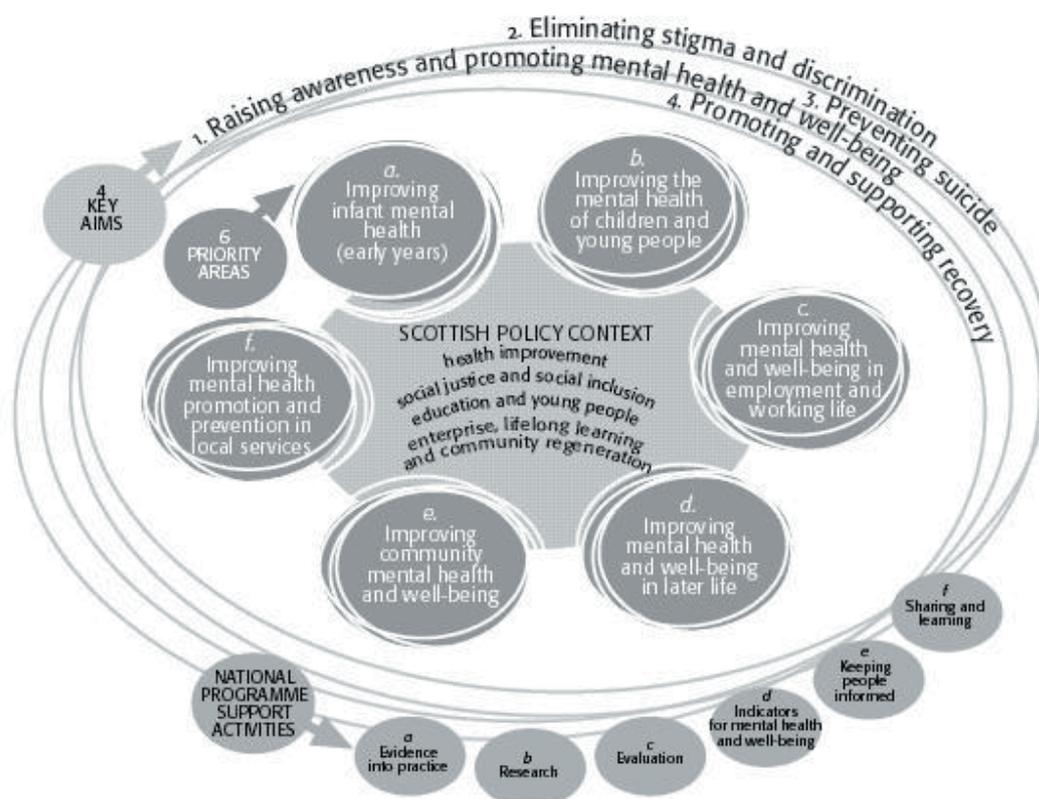
Prepared by Emma Hogg

1 Introduction

In Scotland, Government policy on mental health integrates mental health improvement (i.e. promotion and prevention) and treatment (i.e. implementation of mental health legislation and mental health services) within the Scottish Executive Health Department, under the auspices of the Mental Health Division.

The National Programme for Improving Mental Health and Well Being¹ (the 'National Programme') was launched in October 2001 to raise the profile of, and to support further action in: promoting mental health and well-being, eliminating the stigma of mental ill-health, recovery from mental illness and suicide prevention. This programme takes forward Scottish Executive policy on public mental health and mental health improvement. The work of the National Programme is at the heart of the Scottish Executive's efforts to improve health and achieve greater social justice. As such it is structured within the context of other relevant policy areas, as shown below. The diagram also shows the National Programme's four key aims and six priority areas, together with activities undertaken to support its work.

The Scottish Executive has invested £24 million (€34.3 million) in phase 1 (2003-2006) of the National Programme. Investment for phase 2 (2006 to 2008) is £18 million (€25.7 million). This funding is provided through the Health Improvement Fund. This equates to £1.78 /€2.54 per head of population per year for 2006/7 and 2007/8².



¹ See www.wellontheweb.net for further information.

² Scotland's population, as of July 2004, was 5,078,400 (www.gro-scotland.gov.uk)

2 Process to prepare country story

The country story for Scotland has been formed as a result of the efforts of a group of interested parties involved in mental health improvement.

Key people working in the field were brought together to complete the European Questionnaire on Mental Health Promotion and Mental Disorder Prevention (www.imhpa.net/questionnaire). The aim of the meeting was to seek agreement on Scotland's response to the questionnaire, by sharing and collating facts and pedigree documents, and to reach a consensus on the more subjective issues.

In advance of the meeting as much relevant factual information (e.g. names of policy documents, etc.) as possible was obtained from additional contacts, in order to make them available for discussion by the group.

It was anticipated that, while participants would share many views about the picture of mental health, they would inevitably have different experiences of policy as it translates into information, practice, training and research. An external facilitator was used to take the group through the consensus building process. Consensus was relatively easily reached with group members having similar views on the current state of public mental health and mental health improvement in Scotland

After the meeting the co-ordinator, with the support of library staff, completed the questionnaire (www.imhpa.net/infrastructures-database), before submission to IMHPA.

Overall, representatives from a variety of sources including the Scottish Executive, NGOs, academic institutions, mental health practitioners and public health experts contributed to the input to the questionnaire. The questionnaire responses form the basis of this country story.

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3 Action for promotion and prevention in mental health

Availability of policies

Strategic direction for mental health promotion and mental disorder prevention in Scotland has evolved from a number of policy areas including: mental health, public health, social justice and social inclusion, education, enterprise and life long learning and arts, sports and culture.

Current mental health policy in Scotland provides a template for comprehensive local mental health services³ and places a duty on local authorities and their partners to provide services 'designed to promote the well-being and social development' of people with mental disorder⁴.

³ A Framework for Mental Health Services in Scotland, Scottish Executive, 1997.

⁴ The Mental Health (Care and Treatment) (Scotland) Act, Scottish Executive, 2003. <http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030013.htm>.

Wider public health policy in Scotland has increasingly identified mental health as an integral part of the wider agenda for health improvement⁵. In 2000, a framework for further improvements in health and health services was established and included a commitment to a national anti stigma campaign, the promotion of positive mental health and a national framework to reduce suicides in Scotland⁶. Further emphasis on the importance of continuing efforts in these areas was given in 2003⁷ and a subsequent framework for action for health improvement⁸ in Scotland included a commitment to establishing a 3 year action plan for the National Programme between 2003 and 2006. This has now been extended into a second phase (2006-2008) with underpinning resources from the Scottish Executive Health Improvement Fund.

Scotland, as part of the United Kingdom, welcomes the WHO Declaration and Action Plan for Mental Health in Europe. The Declaration establishes a solid framework for mental health policy in Scotland to follow. Scotland will play its part in contributing to Europe wide work to help support the implementation of the Declaration and Action Plan across Europe.

Commitment to prevention and promotion

Commitment to promotion and prevention in Scotland is demonstrated in a number of ways. Commitment is clearly evidenced by the establishment of a National Programme, repeated extension and expansion of this National Programme and the allocation of significant funding to its implementation. Chairmanship of the National Programme by the Deputy Minister for Health and Community Care and several citations by key Government Ministers also demonstrate the level of commitment to mental health improvement. For example, in the National Programme's Annual Review⁹, Rhona Brankin MSP, Deputy Minister for Health and Community Care said:

"For too long, mental health issues have been misrepresented, misunderstood, ignored or delegated to others to deal with. This is no longer acceptable in modern Scotland. To be the country we want to be, we need to focus more on our emotional mental health and well-being, and on how we feel and think as a country, as organizations, as families and as individuals....we need to continue to take action on improving the mental health and well-being of everyone in Scotland, target work at the people who need it most, and make wider connections to improvements in our overall health".

Programmes and policies across settings

A range of programmes and policies are available across different settings in Scotland.

In the workplace, Scotland has a national award programme, "Scotland's Health at Work", which rewards employers who demonstrate commitment to improving the health of their workforce. A new commendation award for mental health and well-being¹⁰ has been established which requires organizations to: implement workplace mental health and well-being policies; conduct risk assessment and stress audits and produce action plans to tackle organisational issues; and provide mental health awareness raising activities and training. In the area of depression, a three-year programme¹¹ aiming to improve mental well-being for people with depressive disorders and improve access to interventions, which have an appropriate evidence base, has been established. In the prison setting extensive efforts are being made to both respond to mental illness and to promote good mental health and well-being through a range of targeted policies and actions.

⁵ Towards a Healthier Scotland, Scottish Executive, 1998. www.scotland.gov.uk/library/documents-w7/tahs-00.htm

⁶ Our National Health: a plan for action, a plan for change, Scottish Executive, 2000. <http://www.scotland.gov.uk/library3/health/onh-00.asp>

⁷ Partnerships for Care: Scotland's Health White Paper, Scottish Executive, 2003. <http://www.scotland.gov.uk/library5/health/pfcs-00.asp>

⁸ Improving Health in Scotland: The Challenge, Scottish Executive, 2003. <http://www.scotland.gov.uk/library5/health/lhis-00.asp>

⁹ National Programme for Improving Mental Health and Well Being: Annual Review 2003-2004, Scottish Executive, 2004.

¹⁰ Scotland's Health at Work Commendation Award for Mental Health and Well Being. Scotland's Health at Work 2004 (www.shaw.uk.com)

¹¹ Doing Well By People With Depression. <http://cci.scot.nhs.uk/>

4 Organizations and resources for implementation

Infrastructures

The Scottish Executive and other statutory bodies, non-governmental organizations, professional bodies, academic institutes, etc. all play a part in the development and delivery of public mental health and mental health improvement. For example, the National Programme's National Advisory Group, chaired by the Deputy Minister for Health, includes membership from a range of stakeholders across public, private and voluntary sectors and representatives from a variety of different settings (e.g. schools, prisons and the National Health Service), life stages (e.g. young people and older people) and issues (e.g. social justice). The National Programme also has an Executive Group which consists of the key national agencies responsible for supporting the implementation of public mental health policy.

In Scotland several national infrastructures exist which are well placed to take forward components of the National Programme. For example, NHS Health Scotland¹², the national body charged with leading the health improvement effort, is responsible, for turning the health improvements identified by the Scottish Executive into reality. As a special Health Board within NHS Scotland, NHS Health Scotland is 'sponsored' by the Directorate of Health Improvement within the Scottish Executive Health Department and is therefore a key implementation body for the National Programme. Examples of specific work undertaken by Health Scotland on behalf of the National Programme include a programme to establish a core set of sustainable mental health and well-being indicators for Scotland¹³ and a programme to support practice to both understand and use the evidence base in their work and to evaluate and disseminate it¹⁴. In addition to key national statutory agencies Scotland has a well established NGO sector working in mental health. For example, the Scottish Development Centre for Mental Health provides considerable research and development expertise across Scotland¹⁵.

Infrastructures have recently been established to implement specific components of the National Programme. A National Implementation Support Team and Local Co-ordinators have been established to implement the national suicide prevention strategy and action plan¹⁶ and related local level action plans. Other infrastructures have been developed for Scotland's national anti-stigma campaign¹⁷, a Recovery Network¹⁸ established to promote and support recovery for people who experience long term mental health problems and a National Project¹⁹ aimed at achieving an integrated approach to the promotion of good mental health, prevention, care and treatment of mental health problems for children and young people.

Workforce for mental health

In Scotland the workforce involved in mental health promotion and mental disorder prevention is drawn from a diversity of settings and sectors including: the National Health Service, local authorities and the wider public and voluntary sector e.g., health visitors, prison officers, teachers, social workers, community workers, academics, human resource officers, journalists, etc. In addition Scotland has a number of Health Improvement Officers with a specific remit for mental health improvement and thirty two "Choose Life" Coordinators who oversee local implementation of the national suicide prevention strategy and action plan.

A variety of multi-agency training initiatives exist or are being established in Scotland to support this workforce. Ongoing professional training and development and community based training includes mental

¹² See www.healthscotland.com for further information

¹³ See <http://www.phis.org.uk/info/mental.asp?p=bg> for further information

¹⁴ See <http://www.hebs.com/researchcentre/specialist/mhevidprog.cfm> for further information

¹⁵ See <http://www.sdcmh.org.uk/> for further information

¹⁶ See <http://www.wellontheweb.org/well/files/CHOOSE%20LIFE.pdf> for further information

¹⁷ 'See me...'. See <http://www.seemescotland.org/> for further information

¹⁸ 'Scottish Recovery Network'. See <http://www.scottishrecovery.net/> for further information

¹⁹ 'HeadsupScotland'. See <http://www.headsupscotland.com/> for further information

health literacy training²⁰, training to improve workplace practices for employers and managers²¹, mental health promotion training²², and suicide prevention training²³. Training to support the use of evidence in practice²⁴ and to support the evaluation of mental health improvement²⁵ has also been developed. A postgraduate qualification in public mental health and mental health improvement is currently being debated in Scotland.

5 Monitoring and evaluation

Scotland's monitoring systems for the mental health of the population include the use of the GHQ12 and SF12. The GHQ12 is used in several national surveys such as the 'Scottish House Condition Survey'²⁶, which looks at the physical condition of Scotland's homes as well as the experiences of householders and the 'Health Education Population Survey' which collects data on priority health topics including information on knowledge, attitudes and behaviour/health status²⁷. 'Well? What do you think?'²⁸, a biennial national survey of public attitudes to a range of mental health issues also uses the GHQ12 along with questions to establish the presence or absence of factors likely to affect respondents' mental health and well-being. The SF12 is used in the 'Scottish Health Survey'²⁹, a survey aiming to gain knowledge about the health of the population of Scotland. In addition a national programme has been established to create a core set of sustainable mental health and well-being indicators for Scotland³⁰. Approximately 10% of National Programme resources are invested in research and evaluation, both national research and evaluation work and support for local action research through an innovative annual small grants award scheme.

With regards to evaluation work, several independent evaluations of national programmes relevant to promotion and prevention have been commissioned including the evaluation of a depression project, "Doing Well by People With Depression"³¹, which examines the changes developed and required in local service systems to enhance responses to people with depression. A report that examines the main findings emerging from the evaluation will be developed to determine:

- ▶ how whole systems working regarding organization of services and care provision contribute to producing solutions that meet the needs of those with depression
- ▶ factors bearing on effectiveness of different approaches to service delivery for people with depression, with attention to issues of context, process and outcome
- ▶ the key learning points for local and national services and service systems in developing enhanced responses for people with depression.

'Choose Life', the first phase of the national strategy and action plan for preventing suicide, provides another example of the evaluation of implemented policy. This work is primarily an assessment of infrastructure and early impacts and, by synthesizing data relevant to the system for policy development and investigating

²⁰ 'Mental Health First Aid'

²¹ 'Mental Health in the Workplace' - gives a broad understanding of: best practice in improving mental health in the workplace, the business case for action, what is meant by mental health and the various mental health problems, legal obligations and practical measures to take

²² 'Promoting Mental Health – Raising Awareness' - aims to increase awareness of the importance of mental health to overall health and well-being, the many factors that contribute to it, and to the contribution which each agency makes to promoting mental health and well-being

²³ 'Asist' - a two-day intensive, interactive and practice-dominated course designed to help caregivers recognize risk and learn how to intervene to prevent the immediate risk of suicide.

²⁴ "Evidence into Practice" workshops and 'Evidence into Practice Training the Trainers' course – these courses aim to strengthen evidence based practice in the delivery of mental health improvement

²⁵ 'Mental Health Improvement Evaluation Training Plus' – aims to give participants skills the development and implementation of mental health improvement evaluation.

²⁶ See <http://www.shcs.gov.uk/> for further information.

²⁷ See <http://www.hebs.com/research/cr/crscripts/FTReportTitles.cfm?TY=HEPS&sc=survey> for further information

²⁸ 'Well? What do you think (2004) - The second national Scottish survey of public attitudes to mental health mental well-being and mental health problems' Scottish Executive Social Research, 2004.

²⁹ See <http://www.esds.ac.uk/government/shs/> for further information.

³⁰ See <http://www.phis.org.uk/info/mental.asp?p=bg> for further information

³¹ "Doing Well by People With Depression" is a three year programme aiming to: improve mental well-being for people with depressive disorders and improve access to interventions which have an appropriate evidence base.

national and local innovation, will set the template for the next phase of the strategy. There are plans to evaluate other key elements of the National Programme. At local level project evaluation also takes place to varying degrees. For example the 'Coatbridge Infant Mental Health Project'³² uses a broad range of validated tools to collect qualitative and quantitative data. External evaluation has also been carried out with self-completion questionnaires pre and post group work, counselling and befriending.

6 Challenges

Despite recent positive developments in Scotland, there are many challenges for mental health improvement (as identified by the country group outlined in section II). Compared to issues of public concern, such as reducing hospital-waiting times, promotion and prevention in mental health is not seen to be as important by the Scottish public and this has policy implications. Promotion, prevention and treatment must compete for limited resources with the need to address present suffering, with the result that treatment issues dominate the agenda. Whilst significantly increased in Scotland in the last few years, resources (budget, people, capacity, etc.) for public mental health and mental health improvement are still limited in relation to the size of the task. To address this it must be recognised that all professionals and the whole community have a role to play, and can contribute to, the mental health improvement agenda. However, gaining this wider acceptance and understanding will require significant cultural change in Scotland. Related to this is the need for more positive media coverage of both mental well-being and mental health problems, to encourage a better understanding amongst the general public. Practitioners and policy makers require increased knowledge of the existing evidence base and support to improve the evaluation and dissemination of initiatives - not only is support required to develop key skills, but other factors which influence evidence utilisation and evaluation need to be addressed, including political, organisational and economic factors. A key challenge for Scotland's National Programme in the coming years will be to build on success to date in the areas of stigma, suicide and recovery and to pay increased attention to activities focused on the promotion of well-being.

7 Opportunities and advances in the field

Opportunities and advances in public mental health and mental health improvement in Scotland are also numerous (as identified by the country group outlined in section II). In particular, the development of a National Programme has secured an unprecedented level of investment and activity in public mental health and mental health improvement in Scotland. Opportunities and advancements afforded by the establishment of this Programme include the development of numerous programmes, projects, training initiatives, networks, campaigns and implementation infrastructures noted earlier³³. In addition, the National Programme has increased workforce capacity via the development of several new national level posts in Scotland specific to mental health improvement³⁴. This increased capacity provides opportunities for further advancement of

³² The 'Coatbridge Infant Mental Health Project' aims to develop a continuum of support services to families to promote emotional, physical, social and cognitive development of the child, to provide a universal system of risk assessment within the ante and post natal period and to explore and implement evidence of best practice through multi agency service development. See <http://www.hebs.com/researchcentre/pdf/FinalReport200304RE041.pdf> for further information.

³³ Developments include: "See me...", a national anti stigma campaign (<http://www.seemescotland.org/>); "Choose Life", a national strategy and action plan for preventing suicide in Scotland (www.wellontheweb.net) and related local implementation plans with support funding for co-ordination, training and other local, community based initiatives and activities; "Breathing Space", a national telephone advice line and signposting service specifically targeting young adult men suffering low mood and depression (www.breathingspacescotland.org); a Scottish Recovery Network (<http://www.scottishrecovery.net/>); "HeadsupScotland", a national children and young peoples mental health project (<http://www.headsupscotland.com/>); a national Scottish Mental Health First Aid training programme; a national support programme for mental health in later life; a programme of work to gather and disseminate the evidence base in mental health improvement and support practice development (<http://www.hebs.com/researchcentre/specialist/mhevidprog.cfm>); a programme to establish mental health indicators for Scotland (<http://www.phis.org.uk/info/mental.asp?p=bg>); and a programme of research and evaluation to support the work of the National Programme (http://www.wellontheweb.org/well/well_MainTemplate.jsp?pContentID=470&p_applic=CCC&p_service=Content.show&)

³⁴ Examples include: a National Development Officer for Mental Health and Well Being within The Scottish Health Promoting Schools Unit (<http://www.healthpromotingschools.co.uk/>); a National Development Officer for Mental Health and Well Being within Scotland's Health at Work (www.shaw.uk.com); a Mental Health and Well Being Project Manager within the National Resource Centre for Ethnic Minority Health, a National Arts and Mental Health Worker established within the Scottish Arts Council.

mental health improvement within a range of existing infrastructures established in the areas of education, arts, workplace, etc.

Outside the National Programme a number of recent developments in Scotland have contributed to increased opportunities for the delivery and development of public mental health and mental health improvement. The recent *Local Government in Scotland Act (2003)*³⁵, for example, gives local authorities the power to advance well-being³⁶, providing significant opportunities for the improvement of mental health. This and associated guidance have put community planning in Scotland on a firm footing. The Community Planning Process (CPP) provides the overarching framework for delivering services to communities in Scotland. It is the duty of a local authority to initiate, maintain and facilitate the CPP and to ensure consultation among all public bodies responsible for providing those services, and other appropriate bodies or persons. NHS Boards working with Local Authorities, and other partners within CPPs, will develop local Joint Health Improvement Plans (JHIPS) for each Local Authority area. JHIPS set out objectives, strategies and actions for each partner organization within the CPPs, to improve health and reduce inequalities within local populations. Therefore CPPs and the JHIPS provide considerable new opportunities for advancing the public mental health and mental health improvement agenda at local level. Community Health Partnerships (CHPs) developed in Scotland will focus on integrating primary and specialist health services at local level (e.g. integrated mental health services)³⁷ and will play a pivotal role in delivering health improvement and therefore mental health improvement.

Recent legislation in relation to the new the *Mental Health (Care and Treatment) (Scotland) Act 2003*³⁸ also provides opportunities of the advancement of mental health improvement in Scotland. Section 26 of the new Act lays a duty on local authorities and their partners to provide services for people with a mental illness that are designed to promote their well-being and social development.



³⁵ See www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030001.htm for further information.

³⁶ Scottish local authorities now have the power to do anything which is considered likely to promote or improve the well-being of its area and persons within that area

³⁷ New Community Health Partnerships are key building blocks in the modernisation of the NHS and joint services in Scotland, with a vital role in partnership, integration and service development. See <http://www.scotland.gov.uk/library5/health/chpg-00.asp> for further information

³⁸ Mental Health (Care and Treatment) (Scotland) Act 2003, Scottish Executive, 2003. See <http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030013.htm> for further information.

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