MHEEN II Policy Briefing 4

Shifting care from hospital to the community in Europe: Economic challenges and opportunities

Helena Medeiros
David McDaid
Martin Knapp
and the MHEEN Group

Project supported by the European Commission, Directorate General for Health and Consumer Protection

January 2008

Copyright © the MHEEN network, 2007

Published on behalf of the MHEEN network by:
Personal Social Services Research Unit
London School of Economics and Political Science
Houghton Street
London
WC2A2AE

Designed and produced by
Sarah Moncrieff, Westminster European
westminster.european@btinternet.com

The authors would like to acknowledge the financial support of the European Commission, Directorate General for Health and Consumer Protection, and the tremendous work by partners in MHEEN.

The views here are those of the authors and not necessarily of our employing institutions or of the European Commission.

ISBN: 978-0-85328-234-1

1. Introduction

In most European countries and for many decades, large institutions dominated provision for people with severe and chronic disabilities, including people with mental health problems. Many factors contributed to the original decision to choose this model of care. One was the belief that grouping people together in large numbers with (at least some) qualified staff was the most effective way to contain or perhaps even 'cure' people. Another was the social embarrassment or stigma of having 'disturbed' relatives. Asylums were also sometimes used as instruments of social control. Finally, economic considerations came into play, particularly the belief that there economies of scale in accommodating large numbers of people together in one place.

These asylums offered mainly custodial containment to patients with a wide range of mental disorders (Thornicroft and Tansella 2003). In the 1950s, concerns were being raised with increasing frequency about the inhumane conditions within which mentally ill patients were treated (Geller 2000). A number of other factors have been suggested for the decisions in many countries to begin the process of deinstitutionalisation: the replacement of long-stay psychiatric hospitals with smaller, less isolated community-based alternatives for the care of mentally ill people (Bachrach 1997; Goodwin 1997).

It has now been more than five decades in some countries since the start of the process of shifting care and support of people with mental health problems from psychiatric institutions to community-based settings. The closure or downsizing of the asylums has had a significant effect on long-term care. There is a widely held consensus today that delivering mental health services within the community is more appropriate than offering long-stay residence in institutions. It is widely recognized that community-based services have the potential to be more effective in achieving good quality of life for people with long-term needs for support. It is also recognized that community care is not necessarily more expensive than institutional care. Community-based services make it easier to promote and protect basic human rights. Most importantly, care in community settings is generally preferred by service users.

However, the process of closing the institutions and replacing them with humane, effective, enabling alternatives is far from complete. Asylums still exist, and communities still lack adequate services and resources. This is why the European Commission has given such emphasis to changing the balance of care. As the Commission argued in its 2005 Green Paper:

> The deinstitutionalisation of mental health services and the establishment of services in primary care, community centres and general hospitals, in line with patient and family needs, can support social inclusion. Large mental hospitals or asylums can easily contribute to stigma. Within reforms of psychiatric services, many countries are moving away from the provision of mental health services through large psychiatric institutions (in some new Member States, such institutions still account for a large share of the mental health services infrastructure) towards community-based services. This goes hand in hand with instructing patients and their families as well as the staff in active participation and empowerment strategies.

The Mental Health Economics European Network (MHEEN), a partnership between Mental Health Europe, the London School of Economics and Political Science (LSE) and partners across 32 European countries, has looked at the balance of care for people with mental health problems, and particularly at the economic barriers to and opportunities for change. This policy briefing summarises what was found.

2. MHEEN data collection

MHEEN was formed in 2002, funded by the European Commission. Phase 1 of the MHEEN programme involved 17 countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, and the United Kingdom. Phase 2 began in 2004 and extended membership of the Network to 15 further countries: Bulgaria, Cyprus, Czech Republic, Estonia, Hungary Latvia, Liechtenstein, Lithuania, Malta, Poland, Romania, Slovakia, Slovenia, Switzerland, and Turkey, making 32 in total.

The initial phase of the MHEEN project identified a number of barriers and challenges to improving the mental health services, including issues related to the financing and coordination of services. Most countries in Western Europe have been moving towards a community-orientated approach to mental health service delivery, with varied success. The second phase of MHEEN explored the extent to which this successful shifting of the balance of care had continued, whether there have been any economic and organisational barriers, and how these barriers might be surmounted. Among the areas explored were the merits and challenges of an integrated (multi-sectoral) approach to the delivery of services (compared with the fragmented arrangements that dominate many countries). We also examined the incentives and disincentives to the development of community-based care, and whether sufficient resources can be transferred from institutional budgets to support alternative provision. Another topic was the transitional arrangements needed during this process of re-balancing care for people with mental health problems.

The findings in this policy briefing are based primarily on a questionnaire prepared by MHEEN members and completed for most participating countries in 2005. The aim of the questionnaire was to explore the economic barriers and incentives affecting the shift in the balance of care, to look at whether the mix of services and support provided across Europe is considered to be appropriate, based on data that would allow us to make some cross-country comparisons. Some specific information was sought – such as background data on facilities and residents (or changes in numbers) – but was not always available. We also aimed to describe policies that appeared to promote or hinder the process of closing institutions and replacing them with community-based arrangements. The availability of information was sometimes quite limited, so some caution is necessary in interpreting the findings.

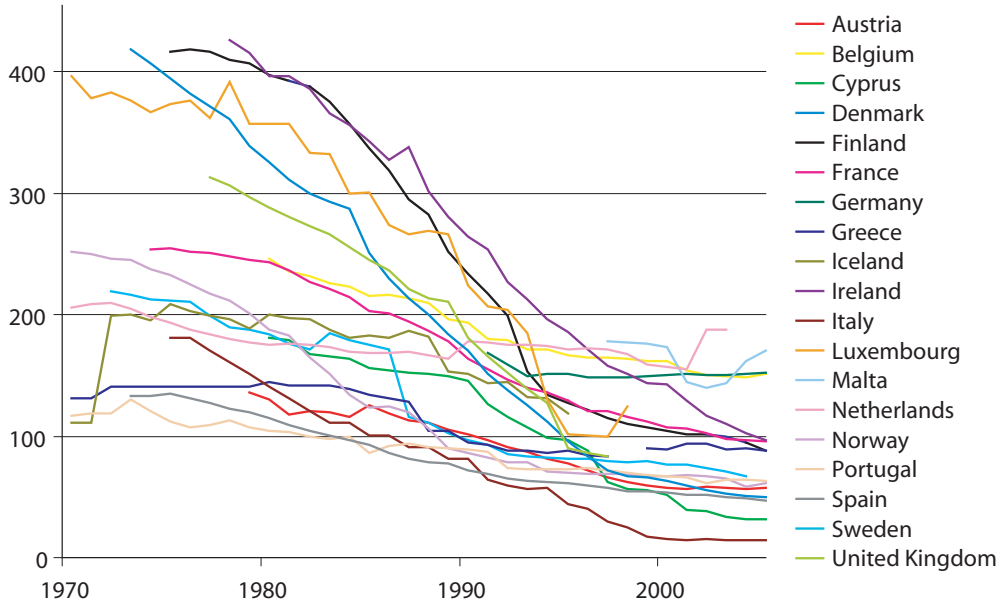
3. Trends in the balance of care across Europe

'Deinstitutionalisation' has three main components:

- the discharge or movement of individuals from hospitals into the community;
- their diversion from hospital admission;
- and the development of alternative community services (Bachrach 1976).

In most countries, this transition has been very uneven, sometimes leading to a gap between the closure of institutions and the availability of alternative services in the community. The successful implementation of a policy to change the balance of care is not simply about moving patients from asylums or psychiatric hospitals. It also imperative to ensure that adequate, appropriate and flexibly managed community care is available, and that continuity is emphasised during the process of transition. Hospital inpatient services must continue to be available for those who need admission. Another key element stressed in discussions of

Figure 1: Trends in availability of psychiatric beds in Western Europe, 1970–2005,



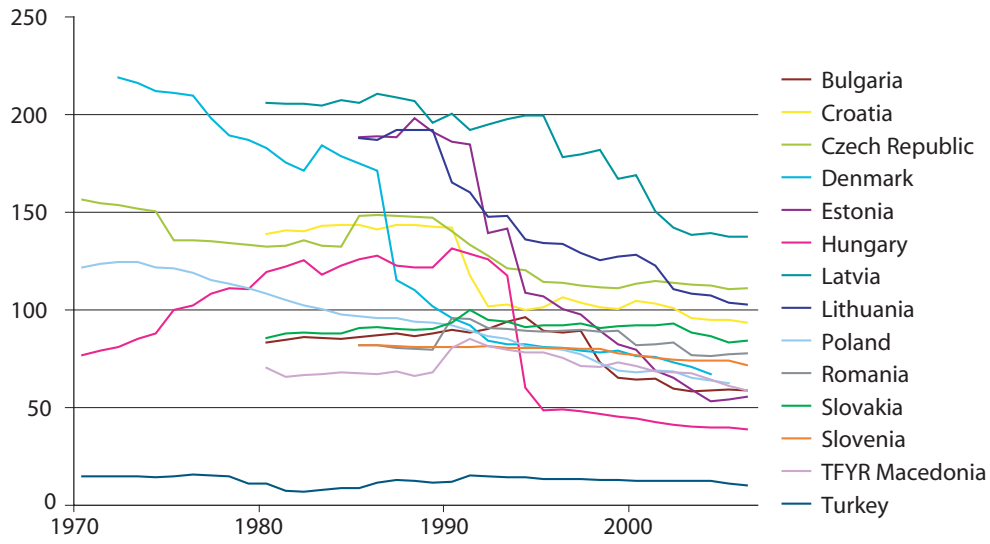
Source: European health for all database

effective community care is individualised care, in the sense of responding to individual needs, and services that are culturally relevant. Growing attention has also been paid to service user involvement and empowerment (Heinssen et al. 1995; Bachrach 1997; Mansell et al 2007). Despite the accumulation of supporting evidence in favour of community-based care arrangements, changes to the balance of care have been slow to materialise in some parts of Europe. Commitment to the closure of institutions varies according to resources, financial incentives, national traditions, and the socio-cultural context (Mechanic and Rochefort 1990; Mansell et al 2007).

Over the last four decades, in Western Europe in particular, many individuals have been able to make the transfer from long-term psychiatric hospital residence to other settings such as general hospitals, or (more commonly) to various forms of community–based living establishments (McDaid and Thornicroft 2005). Figure 1 illustrates trends in Western Europe from 1970 until 2005. Each country in Western Europe has seen bed numbers decrease markedly. In three countries – Iceland, Italy, and Sweden – there are in fact no longer psychiatric hospitals and care is provided in beds in general hospitals or in community-based facilities. There are also no psychiatric beds in Liechtenstein, but the situation there is different in that there never were psychiatric hospitals in the country and instead care had been provided in the psychiatric hospitals of neighbouring countries.

Important country reforms were initiated in this period. For example, the famous Italian Law 180 called for a gradual dismantling of all psychiatric hospitals by forbidding new admissions to these institutions. Hospitalisation, both voluntary and compulsory, henceforth had to take place in small acute psychiatric wards (no more than 15 beds each), located in general hospitals and

Figure 2: Trends in availability of psychiatric beds in Eastern Europe, 1970–2005,



Source: European health for all database

administratively part of local Community Mental Health Services. Since 1980, therefore, all admissions to state mental hospitals in Italy were stopped, and psychiatric hospitals were expected to close. By 1998, all of them had indeed closed.

In Central and Eastern Europe, significant progress has been made in some countries. Figure 2 illustrates the trends in bed numbers for the ten new European Union Member States from 1970 until 2005. Since the 1990s, much progress has been made in countries such as Bulgaria, Estonia and Latvia, but there has been rather less change in countries such as Slovakia and Slovenia, where bed numbers are very similar number in 2005 to what they were in 1990.

4. Changes in provision

Table 1 highlights the trends in beds, residents, admissions and discharges in psychiatric hospitals, general hospitals and social care facilities for countries in Western Europe. Table 2 provides the equivalent information for countries in Central and Eastern Europe. What do these trends tell us?

Psychiatric hospital bed numbers

The majority of the countries covered by the MHEEN survey have seen decreases in psychiatric hospital beds over recent years. However, the extent of these changes varies considerably, and – as we noted earlier –four countries do not have any such provision today. When looking at the differences in bed numbers one must keep in mind that the process of closing institutions was initiated at different times across Europe. In Western Europe, this process started as early as the 1960s in some countries. In Sweden, it started in 1967 with the devolution of responsibility for

Table 1: Bed numbers in western Europe

	Psychiatric hospitals				General hospital				Social care homes			
	Beds	Residents	Admission	Discharge	Beds	Residents	Admission	Discharge	Beds	Residents	Admission	Discharge
Austria	▼	?	?	▲	▲	?	▲	▲	?	?	?	?
Belgium	▼	▲	▼	-	▲	?	▲	?	▲	?	▲	?
Cyprus	▼	▼	▼	▲	▲	▲	▼	▲	▲	▲	▲	▼
Finland	▼	?	▼	▲	?	?	?	?	?	?	?	?
France	▼	?	▲	▲	▼	?	▲	?	?	?	?	?
Germany	▼	▼	▲	▲	▲	?	▲	?	▲	▲	?	?
Greece	▼	▼	▲	▲	▲	▲	▲	▲	▲	▲	▲	-
Iceland	none	none	none	none	▼	▼	-	▲	▼	▲	-	-
Ireland	▼	▼	▼	▼	?	?	?	?	-	-	▲	▼
Italy	none	none	none	none	-	-	-	-	▲	▲	▲	-
Liechtenstein	none	none	none	none	-	-	?	▲	▲	-	?	▲
Luxembourg	▼	?	?	?	?	?	?	?	▼	?	?	?
Malta	▼	▼	▲	▲	-	-	▼	▼	none	none	none	none
Netherlands	▲	▼	▼	▲	?	▼	▼	▲	▲	▲	▲	▲
Norway	▼	▼	▲	▲	▼	▼	▲	▲	▲	▲	▲	▲
Portugal	▲	?	▲	▲	▼	?	▲	▲	?	?	?	?
Spain	▼	?	▼	▼	▲	?	?	?	▲	▲	▲	?
Sweden	none	none	none	none	▼	▼	▲	▲	▲	▲	▲	?
Switzerland	▲	▲	▲	▲	?	?	▲	▲	none	none	none	none
England	▼	▼	▼	▲	▼	▼	▼	▼	▲	▲	▲	?
Scotland	▼	▼	▲	▼	▲	▼	▲	▼	▼	▲	▲	?
Wales	▼	▼	▼	▲	▲	▼	▼	▲	▲	▲	▲	?
Northern Ireland	▼	▼	▼	▲	▼	▼	▲	▲	▲	▼	▲	▼

Legend: ▲ (increase) ▼ (decrease) - (stable) ? (Information not available)

Table 2: Psychiatric beds in central and eastern Europe

	Psychiatric hospitals				General hospital				Social care			
	Beds	Residents	Admission	Discharge	Beds	Residents	Admission	Discharge	Beds	Residents	Admission	Discharge
Bulgaria	▲	-	?	-	▲	▼	?	▲	-	▲	▲	▼
Czech Republic	▼	?	?	?	▲	?	?	?	?	?	?	?
Estonia	▼	▼	▲	▲	▼	▼	▲	▲	▲	▲	▲	▲
Hungary	-	▲	▲	▲	▼	▲	▲	▲	-	-	-	-
Lithuania	▼	?	▲	▲	▼	?	▼	▲	▼	▲	?	?
Poland	▲	▲	▲	▲	▲	▲	▲	▲	▼	▲	▲	▲
Romania	▲	▲	▲	▲	?	▲	?	?	?	?	?	?
Slovakia	▼	?	▲	▲	▲	?	▲	▲	?	?	▼	?
Slovenia	▼	▲	▲	▲	-	?	?	?	▲	▲	▲	?
Turkey	-	▲	▲	-	▲	?	?	?	none	none	none	none

Legend: ▲ (increase) ▼ (decrease) - (stable) ? (Information not available)

psychiatric care to county councils. In Germany, the process started in 1975 with the introduction of the national mental health policy. Probably the best-known initiative was the aforementioned Law 180 passed in Italy in 1978.

Many countries in Western Europe reduced bed provision in psychiatric hospitals very substantially. In France, for instance, there were 81,225 beds in 1990, but this number had decreased to 44,311 by 2004. In Germany, the number fell from 45,000 to 33,033 beds between 1990 and 2000.

For some countries in Central and Eastern Europe, although there has been significant progress towards closing institutions over the last 15 years and consequently decreases in bed numbers, the changes are generally less marked than in Western Europe. Countries where bed numbers have fallen considerably include Estonia, Poland, Lithuania, Cyprus and the Czech Republic. For example, bed numbers in the Czech Republic decreased from 15,000 to 11,591 between 1990 and 2004. In Estonia, there were 14,377 beds in 1993 but only 8,088 by 2002; over the same period the number of psychiatric hospitals fell from 115 to 51. In Poland, beds numbers decreased from 31,558 in 1990 to 19,966 in 2003. In contrast, there has been little change in countries such as Bulgaria, Hungary, Slovakia and Slovenia. In Turkey, although psychiatric care is almost entirely provided in nine psychiatric hospitals and there are virtually no social care homes or community-based services, there has also been a slight decrease from 4140 beds in 1990 to 3777 in 2004. In some parts of Eastern and Central Europe, it was reported that, instead of seeing the development of alternative modes of care such as community-based facilities, in fact new psychiatric hospital have been opened. A case in point is Poland: there were 34 psychiatric hospitals in 1970, but the number had increased to 47 by 1990 and to 53 by 2003.

One important difference between Western and Central/Eastern Europe needs to be noted. As can be seen from a comparison of the vertical scales in Figures 1 and 2, Central and Eastern European countries actually started the period with rather lower levels of provision per 100,000 population than most West European countries. In other words, there may have been less of a pressing need to close beds. On the other hand, the quality of provision was often extremely poor in some of the institutions of Central and Eastern Europe. However many individuals in Central and Eastern Europe may reside in very poor quality social care homes; data on these facilities are not readily available (see section below).

General hospital bed numbers

The picture is somewhat different for general hospitals. Some countries witnessed an increase, while in almost an equal number of countries the trend was in the opposite direction. Numbers have remained stable in Italy, Liechtenstein and Malta. The majority of Eastern and Central European countries have seen increases in general hospital bed numbers, but there have been decreases in Estonia, Hungary and Lithuania. In Hungary, the decrease in the number of psychiatric beds in general hospitals was due to general bed closures in all specialities (not just psychiatry) in an attempt to cut costs, and had nothing to do with a planned movement towards deinstitutionalisation in mental health care. In Turkey, there are now some beds available in psychiatric wards in general hospitals but figures are difficult to obtain and the only data available are for 2003 when there were 1876 beds, and for 2004 when there were 2467 beds.

Social care homes

It proved particularly difficult to obtain data on the provision of psychiatric beds in social care homes in some countries, as social care services are often regional or municipal responsibilities, and national statistics are not compiled. Where it was possible to find the necessary information, it was more common to find that the numbers of social care home beds have increased rather than decreased. One must also keep in mind that social care facilities are not available in all countries – there are virtually none in Turkey, for example, and in most cantons in Switzerland there are no such facilities. In Malta, as well, there are social care homes for older people that do admit people with mental health problems, but there are no earmarked psychiatric beds in such homes. In Greece there are no social care homes, instead there are facilities known as hostels, boarding houses and sheltered flats. In Hungary there was no significant change in the availability of social care home facilities.

Changes in overall resident numbers

Not surprisingly given what we have just seen in relation to the numbers of beds, in most West European countries there has been a fall in the number of residents in psychiatric hospitals (Table 1). Similarly, it was common to find a fall in the number of psychiatric residents in general hospitals. With respect to social care homes, in contrast, there was a strong tendency for an increase in residents with mental health problems.

In Central and Eastern Europe, the most common trend was an increase in the number of residents in psychiatric hospitals and in social care homes (Table 2). The picture for residents in general hospitals varied quite a lot, and most countries were unable to provide information. Bulgaria and Estonia saw decreases in residents, while Poland and Romania witnessed increases. In Slovenia, there is only one psychiatric ward in a general hospital (in Maribor) but this is in fact a clinical department for psychiatry and is only formally part of a general hospital for administrative reasons.

Admissions and discharges

The patterns of admission and discharge bear some similarities to the patterns of resident numbers, but differ where countries have been trying to alter the typical length of stay. In eight West European countries within the MHEEN sample there have been increases in admissions to psychiatric hospitals, and there have been decreases in another nine (Table 1). Admissions of patients with mental health problems to general hospitals increased in eleven countries, fell in five, and remained stable in two. Admissions to social care homes were generally reported to have grown. For all Central and Eastern European countries where we were able to obtain figures, there were increases in psychiatric hospital admissions (Table 2). For general hospitals, three countries saw increases and only one witnessed a decrease. However, the majority of countries were unable to provide information. In social care facilities, there were increases in admissions in four countries and a decrease in one.

The majority of West European countries reported an increase in discharges from psychiatric hospitals and only three reported a decrease. Similarly, in many countries there were increases in general hospital discharges, and a fall in only three countries. The data we obtained suggested that there were decreases in discharges from social care homes in three countries, increases an another three, and no change in a further three. Data were not available for others. In countries such as Spain, admission and discharge patterns vary from one region to another.

In most Central and Eastern European countries, discharge rates from psychiatric and general hospitals increased, while for social care facilities the picture is again varied.

Length of stay

The great majority of countries for which we were able to extract data reported that the average length of stay in psychiatric hospitals had shortened. In most cases, the decrease has been quite considerable, with the typical inpatient stay lasting only half as long as was the case ten years earlier. Almost all countries, with the exception of Switzerland also reported a decrease in the length of stay in general hospitals; in one, it has remained stable. As with the trend in psychiatric hospitals, most countries have seen a marked shortening in the average length of stay in general hospitals. A good example is Norway where the length of stay was 114 days in 1991 but had fallen to 41 days by 2003. In Estonia, the average stay fell from 61 days in 1993 to 19 days in 2002.

5. Policies to develop community care and the allocation of resources

Obviously, an important influence on bed and resident numbers is likely to be national or regional policies. A country's mental health policy establishes the framework within which care is delivered, and often channels the funding that pays for institutional and community care. However, in several MHEEN countries there is still no formal policy on mental health care, or on community care development. Tables 3 and 4 summarise the information obtained by the MHEEN partners regarding the presence or otherwise of a mental health policy, a community care policy, whether community care is available, and whether additional resources have been injected into the mental health system to support the development of community care.

In Central and Eastern Europe, although the majority of countries have a mental health policy (see Table 3), many plans are outdated and do not abide by international or European Union standards. In all West European countries, some form of community care is available, and in the majority, it is relatively well developed and widely available (Table 4). There are exceptions, however, most notably Belgium which remains highly institutionalised. However, in a few countries it was reported that community care has become over-stretched, due to the high demand for services that has followed from an apparent increasing in the prevalence or referral of mental health needs, and also due to closure of psychiatric and general hospital beds. In Central and Eastern Europe, community care typically is severely limited or in some cases not available at all (Table 4).

Paper policies alone will be insufficient; the development of community care is greatly assisted by the allocation of resources and the injection of additional funds to help build new services whilst maintaining existing services during a transitional period. Most countries in the old European Union have provided additional resources to help in rebalancing care, although there are exceptions, for example in Italy where families have had to provide much support. In most of the new Member States, although some additional resources to establish community care have been made available, often there has had to be a reliance on funding from overseas governmental donors, NGOs and more recently the European Union itself. This has obvious implications for the long-term sustainability of community care initiatives. Another barrier to the rebalancing of care is the economic dependence of isolated communities on long-stay institutions; careful thought is needed to economic regeneration as part of any reform process targeted on changing the balance of care by closing institutions.

Table 3: Community care policy and development in western Europe

	Mental health policy	Community care policy	Community care available	Injection of additional resources for community care
Austria	Absent	No	Widely	No
Belgium	Present	Yes	Widely	No
Cyprus	Present	Yes	Widely	Yes
Finland	Present	Yes	Widely	No
France	Present	No	Limited	No
Germany	Present	Yes	Limited	Yes
Greece	Present	Yes	Limited	Yes
Iceland	Absent	No	Limited	No
Ireland	Present	Yes	Limited	Yes
Italy	Present	Yes	Widely	No
Liechtenstein	Absent	Yes	Widely	Yes
Luxembourg	Absent	Yes	Widely	Yes
Malta	Present	Yes	Very limited	No
Netherlands	Present	No	Widely	Yes
Norway	Present	Yes	Widely	Yes
Portugal	Present	Yes	Limited	Limited
Spain	Absent	Yes	Limited	Limited
Sweden	Absent	Yes	Widely	Yes
Switzerland	Absent	No	Very limited	Yes
England	Present	Yes	Widely	Yes
Scotland	Present	Yes	Widely	Yes
Wales	Present	Yes	Widely	Yes
Northern Ireland	Present	Yes	Widely	Yes

Table 4: Community care policy and development in central and eastern Europe

	Mental health policy	Community care policy	Community care available	Injection of additional resources for community care
Bulgaria	Yes	Yes	Very limited	Yes
Czech Republic	Yes	Yes	Very limited	Yes
Estonia	Yes	No	Very limited	No
Hungary	No	Partial	Very limited	Limited
Lithuania	Yes	Yes	Very limited	Yes
Poland	Yes	No	Very limited	Yes
Romania	Yes	No	No	No
Slovakia	Yes	Yes	No	No
Slovenia	No	No	Very limited	Yes
Turkey	Yes	Yes	No	No

6. Challenges

As we have seen, there has been varying progress towards altering the balance of care away from institutions by developing community care in the MHEEN countries. There are, of course, many barriers to such a fundamental change, some ideological, some political, some attitudinal and some economic.

MHEEN partners identified a number of challenges for the process of deinstitutionalisation, including:

- Insufficient and unspecified budget allocations for mental health
- Rigid funding systems that make the reallocation of resources difficult and lead to inadequate funding of community care
- Lack of protection or 'ring-fencing' of funds, particularly when hospitals close
- Lack of parallel funding for the development of community care while hospitals run down to eventual closure
- Changes in reimbursement systems (for example, to diagnostic-related groups) that have altered incentives
- Fragmented systems of decision making because of existence of multiple budgets to provide the support needed by people with mental health problems living outside institutions
- A variety of national and local organisational and financial incentives to maintain institutions
- Shortages of suitably trained staff to provide good quality care in the community
- Shortages of appropriate community and primary care services to support people leaving hospital
- Poor co-ordination and planning of services
- Opposition from the psychiatric profession and the community

We now consider each of these challenges in turn.

Insufficient and unspecified budget allocations

Each of the countries included in our study noted either the absence of a specified budget for mental health or a budget of insufficient size as a barrier to the movement of people with mental health problems from psychiatric hospitals to the community. The quantitative information obtained by the MHEEN partners is summarised in Table 5, but some of should be interpreted with caution, as some of the figures are only estimates and it was often difficult to obtain precise data. The table provides estimates of expenditure on mental health as a percentage of total public spending on health care and as a percentage of gross domestic product (GDP). Figures could not be obtained for some countries. The highest percentages were reported for Switzerland and the constituent parts of the United Kingdom, and the lowest percentages for Bulgaria. Most countries allocate between 5% and 10% of their total public health budget to mental health, and only five countries allocate more than 10%. Seven countries allocate less than 5%.

Table 5: Estimates of funding in MHEEN countries

Country/Region	Source of information	% of health budget on mental health	Public expenditure on health % GDP	% GDP on mental health
Austria		Data not available		
Belgium	2005 Atlas	6.00%	7.4	0.44
Bulgaria	2005 Atlas	2.50%	4.6	0.12
Czech Republic	Czech Bureau of Statistics 2004	3.80%	6.5	0.25
Cyprus	2005 Atlas	7.00%	3.0	0.21
Denmark	2005 Atlas	8.00%	7.7	0.62
Estonia		4.60%	4.2	0.19
Finland		Data not available		
France	2005 Atlas	8.00%	8.9	0.71
Germany	2004 MHEEN	10.14%	8.1	0.82
Greece		Data not available		
Hungary	2005 Atlas	8.00%	5.7	0.46
Iceland	2005 Atlas	6.30%	7.9	0.50
Ireland	2005 Atlas	6.80%	5.8	0.39
Italy	2005 Atlas – very crude estimate as responsible for MH budgets	5.00%	6.8	0.34
Latvia	2005 Atlas	6.30%	4.0	0.25
Liechtenstein	MHEEN 2007	Data not available	5.4	
Lithuania	MHEEN 2005	9.00%	4.9	0.44
Luxembourg	2005 Atlas	13.40%	6.1	0.82
Malta	2005 Atlas	10.00%	7.2	0.72
Netherlands	2007 MHEEN	9.72%	6.0	0.58
Norway	2005	10.00%	7.6	0.76
Poland	2006 MHEEN crude estimate	3.50%	4.3	0.15
Portugal	MHEEN 2002	4.60%	7.1	0.33
Romania	2007 MHEEN	6.50%	4.0	0.26
Slovakia	2004 approximate estimate	6.00%	5.3	0.32
Spain: Catalonia	Gispert & Brosa, 2005	9.40%	5.9	0.32
Spain: Aragon	Salvador-Carulla, 2008	5.00%	5.9	0.30
Spain: Navarra		4.03%	5.9	0.27
Spain: Basque Country		7.60%	4.3	0.25
Spain:Murcia		3.40%	5.9	0.20
Sweden	2007 MHEEN	9.00%	9.0	0.81
Switzerland	Federal Office of Statistics; Jaeger M, Sobocki P and Rossler W (2008).	8.70%	11.4	1.00
Turkey		Data not available		
UK: England	2005 DH Net includes 1.5% dementia and 1.1% substance abuse	14.10%	7.2	1.02
UK: Scotland (Tayside)	2005 Scottish Parliament Report	11.70%	7.2	0.84
UK: Scotland (Greater Glasgow)	2005 Scottish Parliament Report	10.60%	7.2	0.76
UK: Scotland (Lothian)	2005 Scottish Parliament Report	9.40%	7.2	0.68
UK: Scotland (Lanarkshire)	2005 Scottish Parliament Report	8.50%	7.2	0.61

Rigid financing systems

In many countries, especially low- and middle-income countries such as Bulgaria, Estonia and Lithuania, financial resources and allocation systems act as barriers to deinstitutionalisation. Funding for mental health services in these countries tends to be directly linked to psychiatric bed occupancy, and provides little incentive for local planners to develop community-based services. Even where there is an active move towards community care, funds are not necessarily transferred to community-based services, as there sometimes appears to be the (misconceived) assumption that fewer resources are needed for such services. In many of these countries, there have been reductions in hospital bed numbers and funds, but without a corresponding transfer to community care budgets. In Lithuania, for example, the government has used the closing of an institution as an opportunity to decrease the overall level of mental health spending. Yet evidence on the cost-effectiveness of these respective services shows that community services are not necessarily less expensive, albeit quality of life and satisfaction are greatly improved (Barry and Crosby 1996; Mansell et al 2007). There is concern in all countries that policy makers use the closure of institutions as an opportunity to reduce the mental health budget, and divert some of the funds formerly allocated to the institutions away from the mental health sector.

No protection or 'ring-fencing'

It is not only limited funding than can act as a barrier, but also the lack of protection ('ring fencing') of mental health funds. It has been argued that such protection is necessary to ensure that resources are transferred from institutions to community services (McDaid and Knapp 2005). At a time when many countries are witnessing an increase in the burden of mental health problems, the available mental health budget is nevertheless actually declining. One example is Sweden, which saw an increase in community-based services, but a decrease in the mental health budget (as a proportion of total health expenditure) from 12% to 10%.

Absence of parallel funding

Parallel funding is a crucial ingredient in the successful shifting of the locus of care away from institutions. The transitional period during which an institution is closing (and this can take several years) while community-based services are being established needs adequate resources to be made available for both sets of services – the existing institutions and the new community supports. The failure of funding bodies to make such parallel funding available was reported to be a major obstacle to the implementation of community care, particularly in a number of Central and Eastern European countries. Investments must be made in both new physical capital and human resources in order to ensure the successful transfer of care from institutions to the community.

Changes in reimbursement systems

Changes in reimbursement systems (for example, to diagnostic-related groups or DRGs) have changed the incentives facing providers of hospital care, generally in favour of shorter hospital episodes, without leading to the creation of alternative services in most instances. In fact, the DRG system in some instances may lead to inappropriate shorter stays or exclusion from treatment – tariff or funds received for treating an individual with a specific diagnosis under the DRG system is crucial to the way in which the system operates. If this tariff does not cover all the costs of the average service user seen by services then there may be a tendency for service providers to be reluctant to provide treatment for those with more complex mental health problems, as was the case with the initial tariffs in Austria.

Financial arrangements that encourage the closure of long-stay institutions and social care homes, for example by moving towards a per capita funding system, need to be given wider consideration by governments. Under such systems, funding would follow the patient, regardless of where the services were received. The funds can then be used to pay for community-based services or for care in residential institutions. This would allow for greater flexibility in meeting individual needs, empowering individuals and their families and provide for independence and for choice.

In Germany a review is currently underway of its mental health funding system, with the possibility of moving from a per diem to DRG system. But while DRGs were thought to be workable in Germany, in Bulgaria this was not the case because the current DRG system of reimbursement has encouraged up-coding (or 'DRG creep'), where patients tend to be classified into more complex (and lucrative) DRGs. It was even reported that an episode of depression, for example, might be classified as schizophrenia.

Fragmented budgets

Due to the nature of most mental health problems – which can mean that many people affected need care or support from a range of services – it is common to find that funding has to be drawn from multiple ministries and budgets. This was the case in all MHEEN countries, with funding in most cases derived from health, social services, employment, housing and other ministries. In many countries, including Bulgaria and Hungary, care for the mentally ill is provided and funded separately by different institutions including hospitals, social care services, social homes and dispensaries, which fall under the jurisdiction of two separate ministries (Ministry of Health and Ministry of Labour and Social Policy). It is unlikely that a country would readily decide to allocate mental health funding entirely into a single pot, and so efforts have to be made to improve the coordination of funding across different budgets. If not, further barriers can be erected in the way of community care development.

Organisational and financial incentives

In the majority of countries, there are organisational and financial pressures to maintain psychiatric facilities. In countries like Bulgaria, Estonia and Lithuania, the history of relying on residential institutions for employment has meant that there is pressure to maintain these institutions, and little incentive to close them. In many areas, these facilities are the main source of employment. The directors of these institutions face pressure to preserve bed numbers, as their livelihoods depend on it (Tobis 2000). In many countries, such as Finland and Sweden, the responsibility for administering social assistance services has been transferred to municipalities, while responsibility for residential institutions generally has been transferred to regions or remained with the central government. This has created a financial incentive for municipalities to reduce their expenditure by placing people with mental health problems in residential facilities financed by other levels of government.

Shortages of staff

Mental health services are labour-intensive. Usually about 80% of total mental expenditure is accounted for by payments to staff. The development of community-based services therefore requires the education and training of appropriate personnel, including psychiatrists, social workers, psychiatric nurses and psychologists.

Table 6: Personnel per 100,000 population

Country	Psychiatrists	Psychiatric nurses	Psychologists working in mental health	Social workers working in mental health
Austria	11.8	37.8	49.0	103.4
Belgium	18.0	N/A	N/A	N/A
Bulgaria	9.0	15.0	0.9	0.3
Cyprus	5.0	45.0	19.3	25.0
Czech Republic	12.1	33.0	4.9	N/A
Denmark	16.0	59.0	85.0	7.0
Estonia	13.0	0.0	N/A	N/A
Finland	22.0	180.0	79.0	150.0
France	22.0	98.0	5.0	N/A
Germany	11.8	52.0	51.5	477
Greece	15.0	3.0	14.0	56.0
Hungary	9.0	19.0	2.0	1.0
Iceland	25.0	33.0	60.0	110.0
Ireland	6.8	136	12.7	47.7
Italy	9.8	32.9	3.2	6.4
Latvia	10.0	40.0	2.0	0.5
Liechtenstein	N/A	N/A	N/A	N/A
Lithuania	15.0	36.0	5.0	N/A
Luxembourg	12.0	35.0	28.0	35.0
Malta	4.0	102.0	2.6	3.1
Netherlands	9.0	99.0	28.0	176.0
Norway	20.0	42.0	68.0	N/A
Poland	6.0	18.4	3.4	0.6
Portugal	4.7	10.1	2.0	1.6
Romania	4.1	8.9	4.5	N/A
Slovakia	10.0	32.0	3.0	1.0
Slovenia	5.4	5.8	1.7	0.5
Spain	3.6	4.2	1.9	N/A
Sweden	20.0	32.0	76.0	N/A
Turkey	1.0	3.0	1.0	1.0
United Kingdom	11.0	104.0	9.0	58.0

Source: WHO 2005

Data from the WHO Atlas 2005 are set out in Table 6 to show the number of mental health personnel per head of population in each of the MHEEN countries, and Table 7 provides averages for countries included in Phase I of MHEEN (mostly Western European countries), new countries added in Phase II (mainly Eastern and Central European countries). It can be seen that the number of psychiatrists ranges from 1 to 25 per 100,000 population, the number of psychiatric nurses ranges from 0 to 180 for the same population, the number of psychologists ranges from 0.9 to 79, and the number of social workers from 0.3 to 477. In many countries there are acute shortages of professionals who have traditionally been at the forefront of providing assistance for people with mental health needs, including social workers and nurses.

Table 7: Personnel averages per 100,000 population

Country	Psychiatrists	Psychiatric nurses	Psychologists working in mental health	Social workers working in mental health
All MHEEN	11.4	45.3	22.2	60.0
Phase 1 MHEEN	12.9	63.0	31.7	101.6
Phase 2 MHEEN	7.9	27.5	4.1	3.6
Western Europe	13.0	61.3	33.0	897
Eastern/Central Europe	8.5	19.1	2.8	0.6

Phase 1 countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, and the United Kingdom.

Phase 2 countries: Bulgaria, Cyprus, Czech Republic, Estonia, Hungary Latvia, Liechtenstein, Lithuania, Malta, Poland Romania, Slovakia, Slovenia, and Turkey. Source WHO 2005

In many countries, particularly in Eastern and Central Europe, training programmes for social workers have been dismantled, and in some cases never introduced (Tobis 2000). In countries that have recently implemented social work educational programmes, such as Bulgaria, the profession is too new to be able to have much of an influence on provision or to influence policy. In Slovakia, there is no training of staff at the national level and even in the psychiatric centre in Michalovce, there are no social workers. There were also concerns raised that in some countries, such as Cyprus, there is a lack of psychiatrists, because the profession of psychiatry is not very popular, and medical students do not opt for psychiatry as a specialisation. At the same time, countries such as the United Kingdom are recruiting from many of the Central and Eastern European countries to address their personnel shortages, thereby further depleting resources there.

Shortages of community and primary care services

With the increasing reliance on community care, there is considerable concern that bed reductions have proceeded before the development of good community-based services, leaving both hospitals and community services under-resourced (Lamb and Bachrach 2001). A lack of community services is a worry in many countries, particularly in Central and Eastern Europe. In three countries (Romania, Slovakia and Turkey), community services are not available at all and there was a paucity in many other countries. Those surveyed in many other countries, including in Western Europe, felt that their community services were insufficient to meet the needs of patients and there were too few community residential places. Sometimes, the lack of hospital beds for patients with long-term mental health needs had led to neglect as well as to people being discharged into the community without any coordinated community care (Lamb and Bachrach 2001; Mansell et al 2007). This can lead to homelessness, and incarceration.

Countries such as Germany and England might now be starting to see a process of 're-institutionalisation', with for example a rise in then number of forensic mental health beds (Priebe et al 2005). The 'new generation' of patient who – in the previous, institution-dominated system – would have been institutionalized for long periods, is often now unable to get access to the right services, and in many cases they make use of expensive emergency room visits

(Rothbard and Kuno 2000). Many countries, particularly those of Central and Eastern Europe, have very limited, or no, community-based services for outpatient care (WHO 2001a). However, this is not just a concern for middle-income countries: in London, a review of mental health services concluded that the balance between hospital and community services was inappropriate (Goldberg 2000).

A key ingredient of a good community care system is primary care services that are able to meet the broad health needs of people with mental health problems (WHO 2001b). Access to good primary care enables faster and easier access to other services, earlier detection of disorders, and can also reduce fear and stigma. Indeed, in most European countries the majority of mental health problems will first be seen in primary care, but the detection and management of relatively common mental health problems, such as depression, often remains poor. Many of the countries surveyed indicated that the absence or inadequacy of services in primary care was a barrier to better community-based provision. In some, such as Bulgaria, Estonia, Lithuania and Romania, there was no provision for the treatment of mental health in primary, and in many others, primary care physicians are not adequately trained in – or compensated for – dealing with mental health issues.

Poor coordination and planning

Coordination is essential to the process of deinstitutionalisation, and the neglected relationship between community mental health services and hospitals continues to pose a barrier to deinstitutionalisation. It has been argued by Mechanic and Rochefort (1990), for example, that this relationship requires the long-term co-operation of multiple public bodies at various levels of government, probably the implementation of some form of case management system, and the development of mental health authorities. This poses difficulties in countries where mental health services have been devolved to small municipalities, such as Finland, where there are 450 municipalities, each responsible for providing mental health care. The difficulty is that there are 'overlapping issues of territoriality, resource supply, technical capacity, and conflicting organisational objectives and styles' (Dill and Rochefort 1989). In Bulgaria, the various institutions involved and the two separate ministries (Health and Social Policy) are poorly linked and thus comprehensive care becomes very difficult, as does continuity or long-term planning. The result is substandard care, exhausted human resources, and higher costs.

Opposition from the psychiatric profession and the community

Opposition to a shift to community care from the psychiatric profession was reported to be a considerable barrier to change in many countries. In Bulgaria, it was described as the most significant barrier to deinstitutionalisation. In many Central and Eastern European countries, this opposition is rooted in the social and political background and the power of the professions. However, opposition does not stem exclusively from professionals; local communities can also be opposed to the move of people with mental health problems from hospital into their neighbourhoods. This is particularly the case when a hospital may be a major source of employment in what are often isolated communities. Attempts to build community care homes or other services are often met with resistance from the local community: discharging patients into hostile communities may affect their self-concept, mental health status, and success in adjusting to community life (Wright et al. 2000). In Cyprus, although much progress has been made in educating the community on mental health issues, stigmatisation was given as the most important barrier to deinstitutionalisation. In Luxembourg, the stigma attached to mental illness and treatment is still an important issue, to the extent that patients will opt for treatment

abroad, which was seen as less stigmatising. With the introduction of psychiatric beds in general hospitals it is hoped that the stigma will be diminished as admission to a general hospital does not create as much suspicion as opposed to admission to Ettelbruck (the psychiatric facility in Luxembourg). There are some positive signs in some countries with regards to support from the psychiatric profession. Such is the case in Hungary, where the psychiatric profession is becoming more supportive of shifting the balance of care and work towards multi-sectoral provision as indicated by the recent development of an interdisciplinary overarching National Mental Health Programme.

7. Opportunities

Although much progress has been made, there are continued opportunities to change the balance of care. The most significant is the positive environment to carry out health reforms that is visible in many countries. Health is at the top of the political agenda in many countries, and there is increasing recognition of mental health problems. In the continuing reforms, mental health legislation needs to include provision for community care.

There is also the opportunity in implementing better funding mechanisms to encourage improved care. This includes the use of personal budgets, such as in the Netherlands and England. Different funding mechanisms for community services need to be tried and there needs to be greater visibility and information on these payment mechanisms.

Although information systems in many countries have been developed, there is a need for them to be expanded to include better information on mental health services, especially community services, to allow better allocation of resources. This will also assist in developing and expanding the referral network for mental health, including referrals to community services and not just hospital-based care.

There needs to be continued cooperation and coordination across agencies and budgets, which can be assisted by the introduction and development of case management, whether or not personal budgets are to be introduced. This could greatly improve continuity of care and better coordination in the use of resources.

There needs to be increased visibility and transparency of the mental health budget, and to ensure that mental health care receives an adequate allocation. One possibility to explore would be to introduce mechanisms that would allow the budget for mental health-related activities sitting within each of a number of different ministries to be pooled into one central fund.

Funds need to be ring-fenced or protected for mental health care, at least at a time when the balance of care is shifting from institutions to the community. Earmarked funds need to be made available, as is the case in Norway, where the national mental health plan is supported by a financial arrangement consisting of earmarked unconditional grants, both to regional health authorities and to municipalities.

In many countries, seed money and pilot projects are the only sources of funding for community-based care, and although neither is an ideal arrangement (due to issues of sustainability) they can at least support the development of community services until such time as a more concerted approach is adopted by government. In Bulgaria, community mental health services are now beginning to be financed by the EU PHARE project, which plans to establish such centres in eight target municipalities. European Union subsidies and structural

funds for investment in community infrastructures continue to provide important opportunities. This is the case in Ireland, for example, where approximately €190m was invested in capital over the course of the National Development Plan between 1999 and 2003 to fund the development of acute psychiatric units in public hospitals to replace services formerly provided in psychiatric hospitals.

8. Conclusion

Although it has been half a century since the first efforts to reduce the numbers of people with mental health problems living in long-stay hospitals and other institutions, only limited research has been undertaken on progress in this area in many parts of Europe. Comparative analysis is especially difficult, as countries vary greatly in their economic and political systems as well as in the structure of their health and welfare services.

Countries in the MHEEN Network have varied experiences and challenges ahead as they continue to shift care from hospitals to the community. There is a growing consensus around the desirability of community care arrangements that aim to deliver treatments and support services tailored as far as possible to individuals' needs.

Deinstitutionalisation is of course much more than moving people from one place to another. To be successful, it requires good community placements to be available, staffed by skilled and motivated people and located in welcoming communities. It should be seen as an ongoing process and, although many countries have undertaken very positive steps, their efforts need to be sustained and increased. Many countries still need to make considerable investments in the necessary physical and human resources. Countries need to insure that mental health services are provided through primary care facilities, with appropriate secondary systems, consisting of specialist consultant services, and inpatient specialist care when needed, and that community care is seen as encompassing social care support, access to good housing, educational provision where needed, and – as far as possible – opportunities for people to obtain paid work so as to reduce the risks of poverty and social exclusion.

As the new Member States in Central and Eastern Europe continue moving towards deinstitutionalisation, they must be aware of the risks of closing beds before adequate community provision is developed. There is a pervasive concern that bed reductions too often precede the development of comprehensive community-based services, leaving both hospitals and community services under-resourced. As we know, closing an institution is easy; the challenge is to create good systems of community care.

References

Bachrach L (1976) *Deinstitutionalization: An Analytical Review and Sociological Perspective*, National Institute of Mental Health, Rockville, MD.

Bachrach L (1997) Lessons from the American experience in providing community-based services, in Leff J (ed.) *Care In the Community: Illusion or Reality?*, John Wiley and Sons, Chichester.

Barry M, Crosby C (1996) Quality of life as an evaluative measure in assessing the impact of community care on people with long-term psychiatric disorders, *British Journal of Psychiatry*, 168, 210–216.

Dill A, Rochefort D (1989) Coordination, continuity, and centralized control. A policy perspective on service strategies for the mentally ill, *Social Issues*, 45, 145–159.

Geller J (2000) The last half-century of psychiatric services as reflected in psychiatric services, *Psychiatric Services*, 51, 41–67.

Goldberg D (2000) Findings from London's mental health': A service in crisis, *Acta Psychiatria Scandinavica,* 399, Supplement, 57–60.

Goodwin S (1997) *Comparative Mental Health Policy: From Institutional to Community Care*, Sage, London.

Heinssen R, Levendusky P, Hunter R (1995) Client as colleague. therapeutic contracting with the seriously mentally ill, A*merican Psychologist*, 50, 522–532.

Jaeger M, Sobocki P and Rossler W (2008) Cost of disorders of the brain in Switzerland. With a focus on mental disorders, *Swiss Medical Weekly*, 138: 4–11.

Lamb H, Bachrach L (2001) Some perspectives on deinstitutionalization, *Psychiatric Services*, 52, 1039–1045.

Mansell J, Knapp M, Beadle-Brown J, Beecham J (2007) *Deinstitutionalisation and Community Living – Outcomes and Costs: Report of a European Study*, Tizard Centre, University of Kent and PSSRU, London School of Economics and Political Science.

Mcdaid D, Knapp M (2005) *Funding Mental Health in Europe. Policy Brief*, European Observatory on Health Systems and Policies.

McDaid D, Thornicroft G (2005) *Balancing Institutional and Community Care*, European Observatory on Health Systems and Policies.

Mechanic D, Rochefort D (1990) Deinstitutionalization: An appraisal of reform, *Annual Review of Sociology*, 16, 301–327.

Priebe S, Badesconyi A, Fioritti A, Hansson L, Kilian R, Torres-Gonzales F, Turner T, Wiersma D (2005) Reinstitutionalisation in mental health care: comparison of data on service provision

Rothbard A, Kuno E (2000) The success of deinstitutionalization. empirical findings from case studies on state hospital closures, *International Journal of Law and Psychiatry*, 23, 329–344.

Thornicroft G, Tansella M (2003) *What Are the Arguments for Community-based Mental Health Care?* Health Evidence Network.

Tobis D (2000) M*oving from Residential Institutions to Community-based Social Services in Central and Eastern Europe and The Former Soviet Union*, World Bank, Washington.

World Health Organisation (2005) *Mental Health Atlas 2005*, World Health Organisation, Geneva.

World Health Organisation (2001a) *Atlas Country Profiles On Mental Health Resources*, World Health Organisation, Geneva.

World Health Organisation (2001b) *World Health Report 2001. Mental Health: New Understanding*, New Hope, World Health Organisation, Geneva.

Wright E, Gronfein W, Owens T (2000) Deinstitutionalization, social rejection, and the self-esteem of former mental patients, *Journal of Health and Social Behaviour*, 41, 68–90.

About the authors

Helena Medeiros is a Research Officer within PSSRU. Helena has a BA from the University of Toronto and an MSc in Health Policy, Planning and Finance from the London School of Hygiene and Tropical Medicine and the London School of Economics. Helena's main area of interest is on mental health and deinstitutionalisation. She is currently working on the MHEEN (Mental Health Economics European Network) project.

David McDaid is Research Fellow in Health Policy and Health Economics in the Personal Social Services Research Unit and the European Observatory on Health Systems and Policies at the London School of Economics and Political Science. David's research activities focus on mental health policy predominantly, but not exclusively, in Europe. Recent research has included evaluation of the first phase of the National Suicide Prevention Strategy in Scotland, the UK-wide Healthy Living Centre Initiative, and undertaking a review of the extent to which economic evaluations have been used in public health for the Welsh Assembly Government. He has also co-authored a recent report on the Irish health care system. Other areas of current research include looking at ways of translating economic research evidence, particularly from health technology assessment, into policy and practice, valuing informal care, and in examining how economic evaluation and costing methods used in the area of health can be used in other more complex areas of social welfare, particularly related to health promotion and public health.

He has published more than 40 peer-reviewed papers, largely on the use of economics in policy making and on mental health policy. He has acted as a consultant to a variety of governments, public and voluntary agencies including the World Health Organisation, the European Commission and Amnesty International. He is co-editor of the recently published book *Mental Health Policy and Practice Across Europe*, editor of *Eurohealth* http://www.lse.ac.uk/collections/LSEHealth/documents/eurohealth.htm, associate editor of *Health Policy*, co-convenor of the joint Campbell/Cochrane Collaboration Economic Methods Group and a director of the Health Equity Network http://www.lse.ac.uk/collections/LSEHealth/researchNetworks.htm.

Martin Knapp is Professor of Social Policy and Director of the Personal Social Services Research Unit at the London School of Economics and Political Science in the UK. He also holds the position of Professor of Health Economics and Director of the Centre for the Economics of Mental Health at King's College London, Institute of Psychiatry. In addition he has an Honorary Professor at universities in Hong Kong and the Czech Republic. Martin's research activities are primarily in the mental health, long-term care and social care fields, focusing particularly on policy analysis and economic aspects of practice. He has been an advisor to many government departments and other bodies in the UK and elsewhere, and to international bodies such as the European Commission and World Health Organization. His publications include about 300 peer-reviewed journal articles, about 140 book chapters, 15 books, 4 edited books, and numerous monographs.

About MHEEN

The Mental Health Economics European Network (MHEEN I) was established in 2002 with 17 and extended in 2004 to 32 countries. The Network is coordinated by the PSSRU at the London School of Economics and Political Science and Mental Health Europe, based in Brussels, and supported with funding from the European Commission. For further information about the Network visit the MHEEN website at www.mheen.org.

The Group comprises the following partners: Martin Knapp, David McDaid, Helena Medeiros (London School of Economics, United Kingdom); Mary Van Dievel, John Henderson, Mari Fresu (Mental Health Europe, Brussels); Ingrid Zechmeister (Austria); Ronny Bruffaerts (Belgium); Hristo Dimitrov (Bulgaria); Anna Anastasiou (Cyprus); Petr Hava (Czech Republic); Taavi Lai (Estonia); Pekka Rissanen (Finland); Jean-Pierre Lépine (France); Reinhold Kilian (Germany); Athanassios Constantopoulos (Greece); Judit Simon (Hungary); Kristinn Tómasson (Iceland); Brendan Kennelly, Eamon O'Shea (Ireland); Francesco Amaddeo (Italy); Liubove Murauskiene (Lithuania); Kasia Jurczak (Luxembourg); Ray Xerry (Malta); Silvia Evers (Netherlands); Vidar Halsteinli, Solveig Ose (Norway); Katarzyna Prot-Klinger (Poland); Mónica Oliveira (Portugal); Raluca Nica (Romania); Pětr Nawka (Slovakia); Mojca Dernovsek (Slovenia); Luis Salvador-Carulla (Spain); Jenny Berg, Linus Jonnson (Sweden); Matthias Jaeger (Switzerland); Mehtap Tatar (Turkey); Sonia Johnson, Giuseppi Tibaldi, Tomasz Adamowski, Luis Salvador-Carulla, Torleif Ruud, Thomas Kallert, Petr Nawka (ESMS - European Service Mapping Schedule Network); Karl Kuhn (ENWHP – European Network for Workplace Health Promotion); Eva Jané-Llopis (IMHPA – Implementing Mental Health Promotion Action); Heinz Katschnig, Graham Meadows, Julien Mouques (Expert Advisers).