AIM Healthcare and social benefits for all

60 1958 2018

European Economic and Social Committee

The Future of Mental Health

#futureMH2018
#AIM20yearsBxl

Welcome

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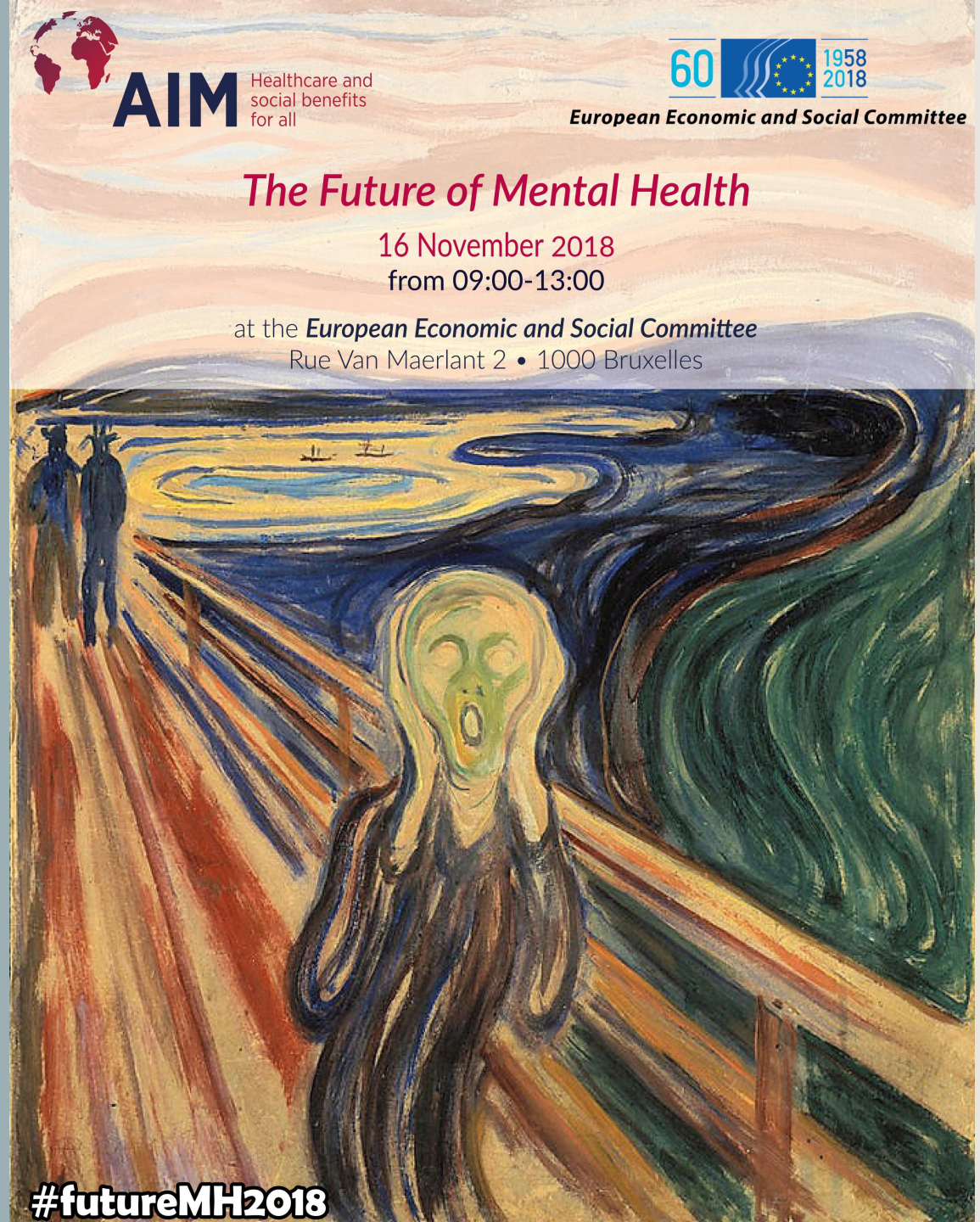

SETTING THE SCENE: THE PANORAMA OF MENTAL HEALTH IN EUROPE

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STATE OF ART

*Mental disorders are one of the top public health challenges in the WHO European Region, **affecting about 25% of the population every year**.*

In all countries, mental health problems are much more prevalent among the people who are most deprived.

Europe therefore faces diverse challenges affecting both the mental well-being of the population and the provision and quality of care for people with mental health problems.

WHO, The European Mental Health Action Plan 2013–2020 (2015)

STATE OF ART

The most common are depression and anxiety

Depressive disorder is twice as common in women as in men

About 1–2% of the population are diagnosed with psychotic disorders, men and women equally

5.6% of men and 1.3% of women have substance use disorders

The ageing population is resulting in increasing prevalence of dementia, typically 5% in people over 65 and 20% of those over 80.

STATE OF ART

Across Europe, neuropsychiatric disorders are **the second largest** contributor to the burden of disease (disability-adjusted life years – DALYs), accounting for 19% of the total.

There is considerable variation across the Region **associated with the different socio-economic conditions**.

In terms of burden of disease, mental disorder **ranks highest in many high income Western European countries**, while it takes fourth or fifth place in some low income countries due to the high prevalence of perinatal and cardio-vascular diseases.

DISEASE BURDEN IN EUROPE

DALYs by causes	%
Cardiovascular diseases	22.9
Neuropsychiatric conditions	**19.5**
Malignant neoplasms	11.4
Unintentional injuries	9.6
Digestive diseases	4.9
Respiratory diseases	4.5
Intentional injuries	4.3
Sense organ diseases	4.1
Infectious and parasitic diseases	3.8
Musculoskeletal diseases	3.7
Respiratory infections	2.1
Perinatal conditions	1.8

STATE OF ART

An important indicator of the disease burden on society and health systems is the contribution of specific groups to all chronic conditions (years lived with disability – YLDs).

Mental disorders are the most significant of the chronic conditions affecting the population of Europe, accounting for just under 40%.

Unipolar depressive disorder alone **is responsible for 13.7%** - leading chronic condition in Europe.

Alcohol-related disorders **(6.2%)** in second place,

Alzheimer's and other dementias in seventh **(3.8%)**,

Schizophrenia and bipolar disorders in eleventh and twelfth position, each responsible for **2.3%** of all YLDs.

Ranking 1st	Unipolar depressive disorders	13.7%
Ranking 2nd	Alcohol use related disorders	6.2%
Ranking 7th	Alzheimer and other dementias	3.8%
Ranking 11th	Schizophrenia	2.3%
Ranking 12th	Bipolar disorders	2.2%

Mental Health Programme

NEURO-PSYCHIATRIC CONDITIONS EUROPE: YEARS LIVED WITH DISABILITY (YLDS)

STATE OF ART

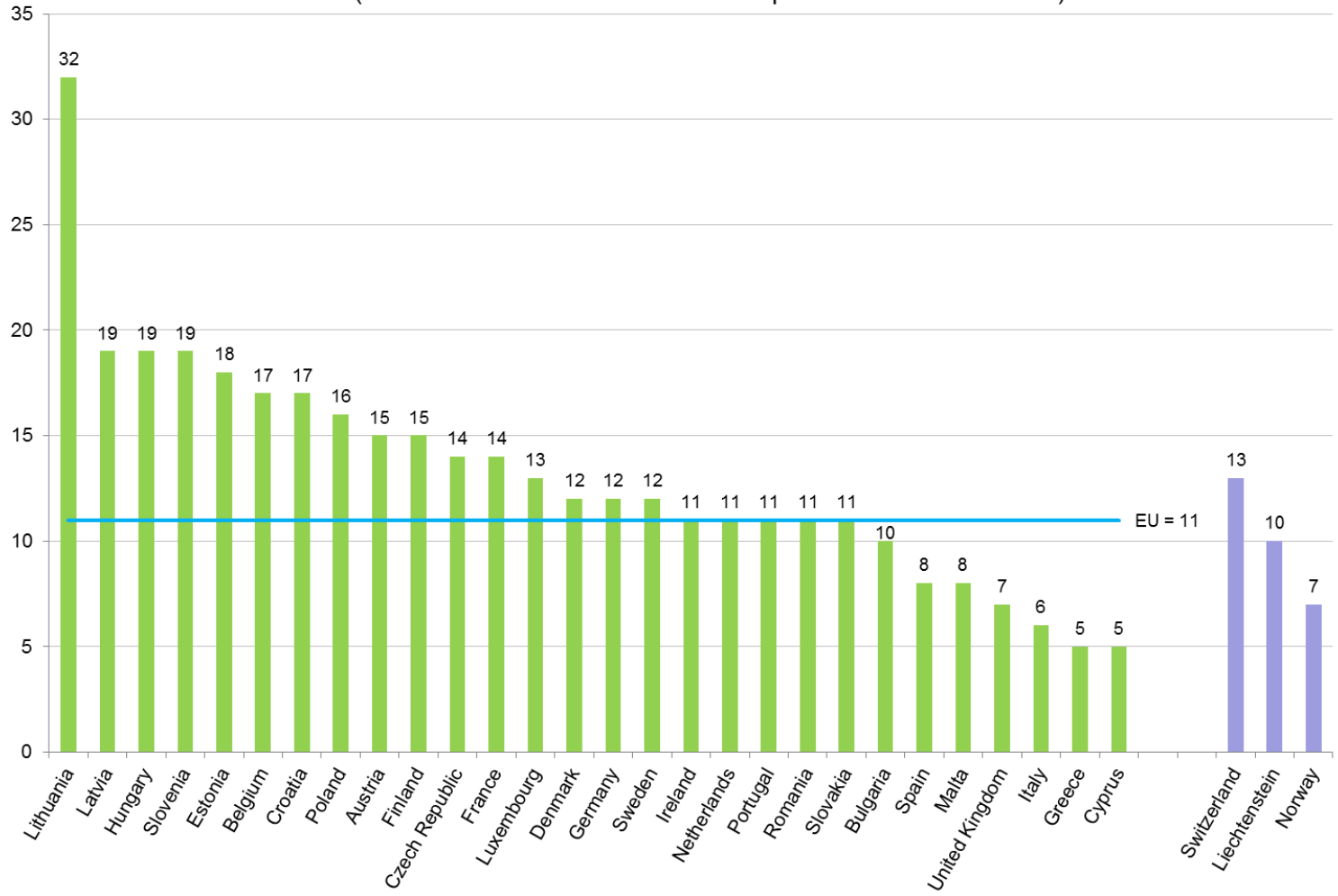
Suicide rates in the European Region are very high compared with other parts of the world.

The average annual suicide rate in the European Region is 13.9 per 100 000, but there is a wide variation.

The 9 countries with the highest suicide rates in the world are all in the European Region.

Suicide rate in the EU Member States, 2014

(number of deaths due to suicides per 100 000 inhabitants)



ec.europa.eu/eurostat

STATE OF ART

In several countries the number one cause of death of adolescents is suicide.

Men are almost 5 times more likely to commit suicide than women in Europe.

Depression, alcohol abuse, unemployment, debt and social inequality, are all risk factors and are all closely related.

Changes in suicide rates coincide with changes in unemployment and the insecurity caused by anticipating job loss.

There are some reports that suicide rates have risen since 2008, with the greatest increases in those countries most affected by the economic recession.

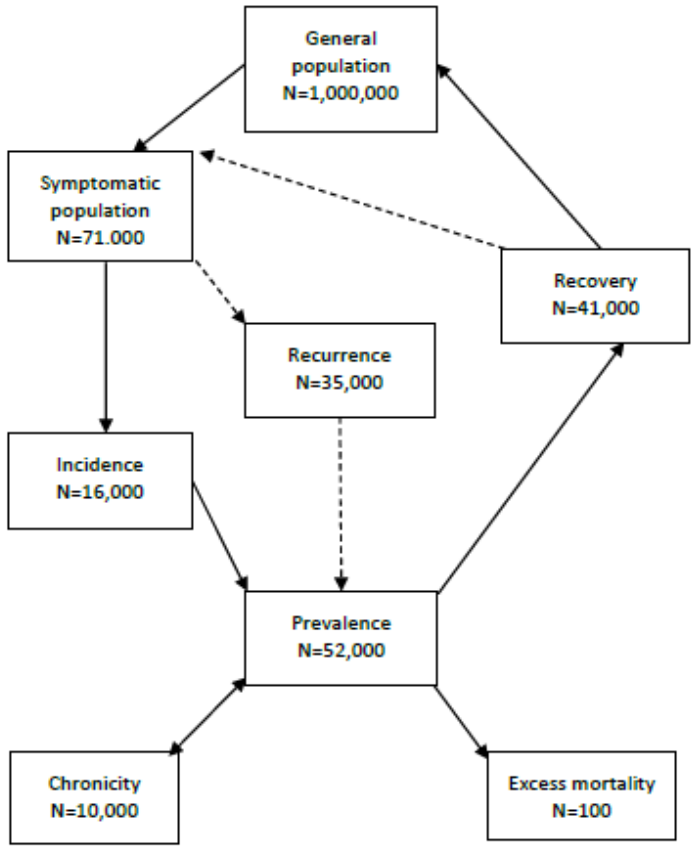


Figure 1. *The epidemiology of depression per one million people aged 18-64 years*

NEW CHALLENGES TO MENTAL HEALTH CARE

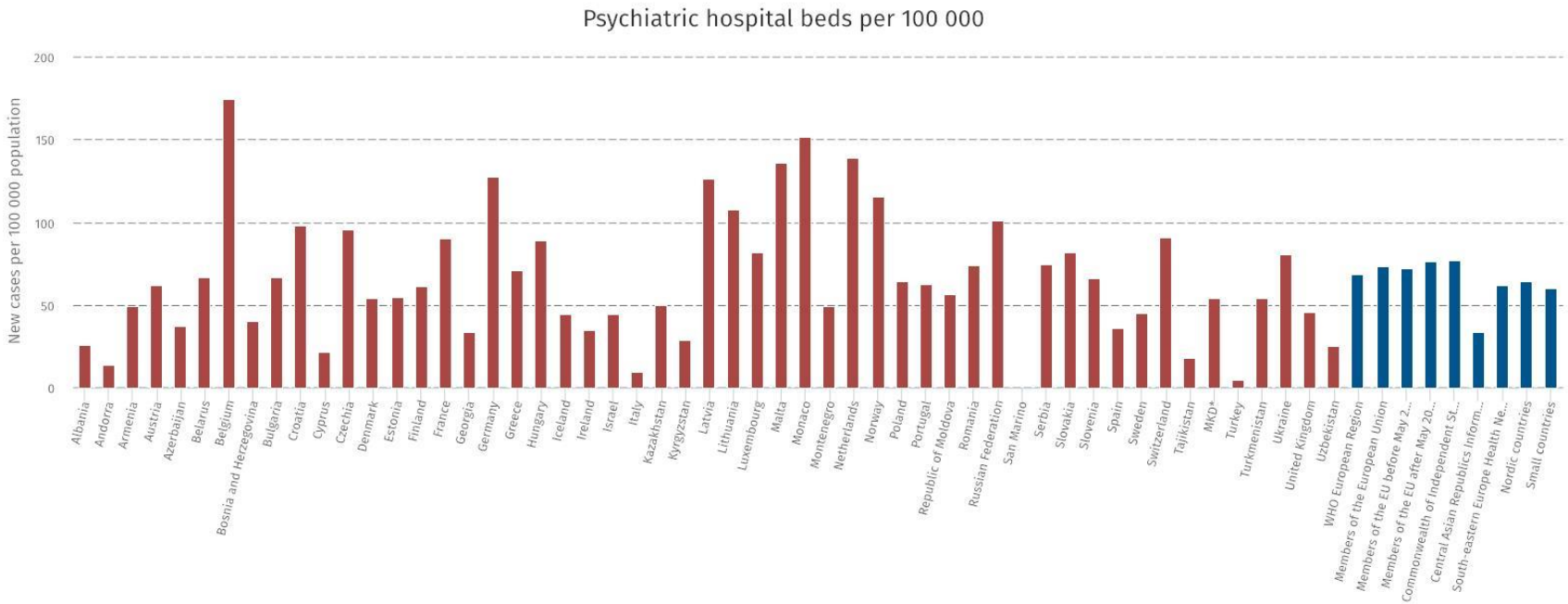
ORGANIZATION

Mental health services

The combined rate of psychiatric beds per 100 000 population in community psychiatric inpatient units, units in district general hospitals and mental hospitals ranges from 185 in Malta to 8 in Italy, with a median rate of 72.

Rates of admissions to inpatient units per 100 000 population vary from 1301 in Romania and 1240 in Germany to 87 in Albania. The median rate of admissions is 568 per 100 000 population.

The rate of visits to all outpatient facilities per 100 000 population (varies from 28 200 in Slovakia and 26 077 in Finland to 1083 in Albania and 1066 in the United Kingdom (Scotland). The median rate is 6596.



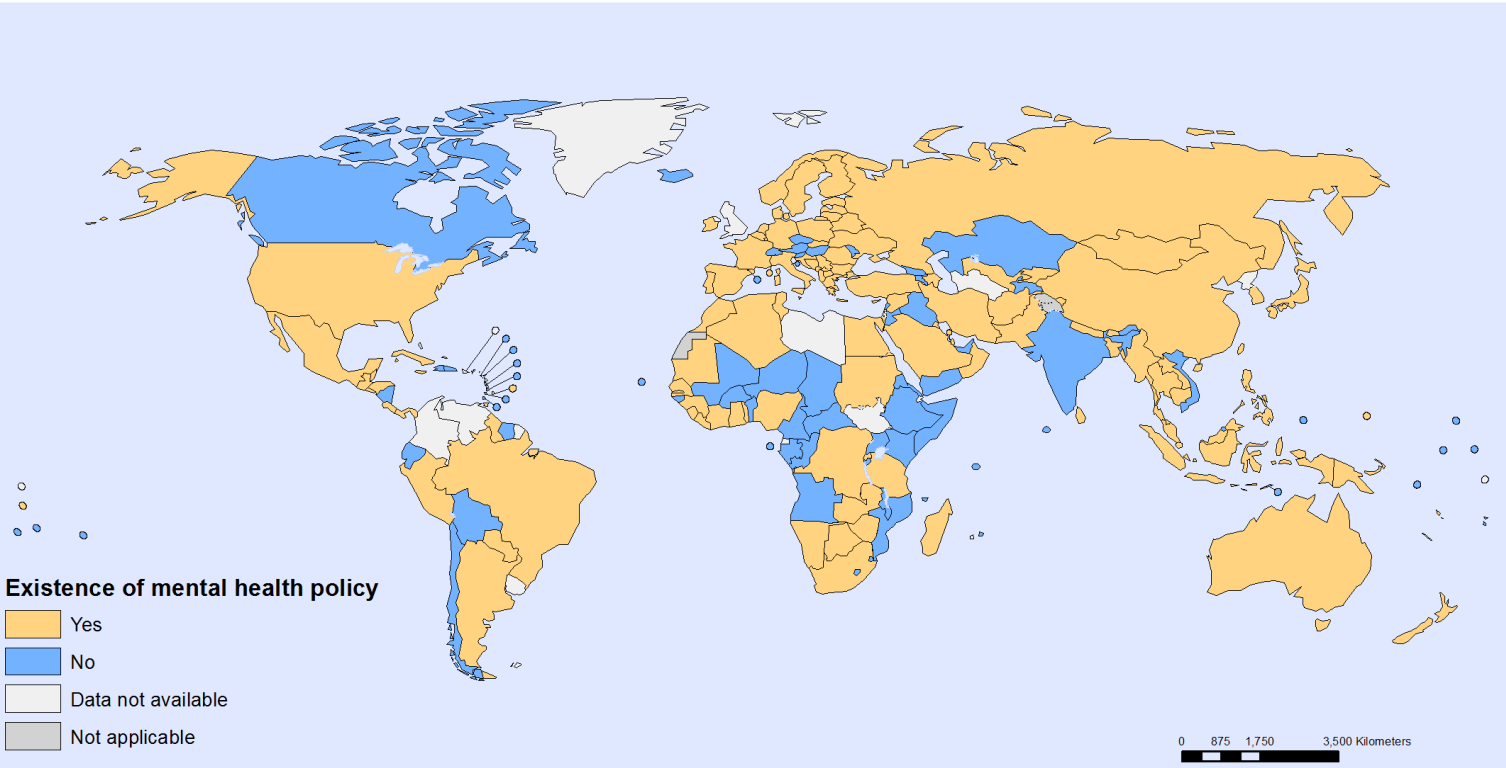
* The former Yugoslav Republic of Macedonia (MKD is an abbreviation by the International Organization for Standardization (ISO))

NEW CHALLENGES TO MENTAL HEALTH CARE

ORGANIZATION
MENTAL HEALTH WORKFORCE

- **The number of psychiatrists per 100 000 population** ranges vary widely: from 30 per 100 000 in Switzerland and 26 in Finland to 3 in Albania and 1 in Turkey. The median rate of psychiatrists per 100 000 in the 41 countries that provided information is 9.
- The median rates of psychiatrists per 100 000 population in the different parts of the WHO European Region are:
- EU15 – 12.9
- Countries joining the EU since 2004 – 8.9
- Countries in south-eastern Europe – 8
- **The rate of nurses working in mental health care** varies from 163 in Finland to 4 per 100 000 population in Bosnia and Herzegovina (Republika Srpska) and 3 in Greece. The median rate of nurses per 100 000 population is 21.7, more than twice the median rate of psychiatrists.

Existence of a mental health policy, 2011



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Health Statistics and Information Systems (HSI)
World Health Organization

World Health Organization

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NEW CHALLENGES TO MENTAL HEALTH CARE

ORGANIZATION
MENTAL HEALTH IN PRIMARY CARE

Most countries report that general practitioners (GPs) deal with common mental health problems:

- identifying and referring people with problems (95% of countries);
- diagnosing problems (86%);
- regularly treating people with common disorders (86%).
- GPs play a major role in identification, diagnosis and referral for severe mental disorders, but in most countries specialists are expected to give treatment, with GPs playing a supportive role.
- 74% of countries report that GPs identify and refer people with severe and enduring mental health problems.
- 52% report that GPs diagnose such disorders: 11 of the 15 countries belonging to the European Union (EU) before May 2004 (73%) and 5 of the 12 countries that joined the EU afterwards (42%).
- 40% report GPs give treatment; this includes no countries in south-eastern Europe or newly independent states.

ACTION PLAN

	Objective 1	Objective 2	Objective 3	Objective 4	Objective 5	Objective 6	Objective 7
Inequities and social determinants	✔	✔		✔	✔		✔
Governance			✔		✔	✔	✔
Life-course	✔		✔				
Empowerment		✔		✔		✔	
Health systems			✔	✔	✔		✔
Public health	✔				✔	✔	✔

ACTION PLAN

THE FOUR CORE OBJECTIVES ARE:

1. everyone has an **equal opportunity** to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk;
2. people with mental health problems are citizens whose **human rights** are fully valued, protected and promoted;
3. mental health services are **accessible and affordable**, available in the community according to need;
4. people are entitled to **respectful, safe and effective treatment**.

THE THREE CROSS-CUTTING OBJECTIVES ARE:

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

ACTION PLAN- OBJECTIVE I

Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk

a) strengthen awareness of the impact of the social determinants of health on mental health, the importance of mental health as an intermediary determinant, and the contribution of population mental health to public health;

b) identify interventions and develop care pathways for prevention of and early intervention in harmful stress and its consequences at individual and population levels;

c) support the promotion and dissemination of sound educational programmes, covering suicide prevention, stigma and discrimination, alcohol and drug use and dementia; and

d) disseminate evidence of effective workplace interventions to Member States

ACTION PLAN- OBJECTIVE II

People with mental health problems are citizens whose human rights are fully valued, respected and promoted

a) work with intergovernmental partners to guarantee **human rights and social justice** for people with mental health problems;

b) disseminate **good practice examples** of services and systems that support and promote recovery and social inclusion; and

c) implement policies that promote **recovery and social inclusion**, and address inequalities and discrimination.

ACTION PLAN- OBJECTIVE III

Mental health services are accessible, competent and affordable, available in the community according to need

a) produce guidelines for the above actions applying the evidence base and experience, in partnership with professional associations;

b) identify and disseminate good service models around the Region;

c) bring together countries at subregional level on the basis of culture, resources and stage of development, and coordinate assessments, knowledge exchange and shared implementation;

d) coordinate technical support to Member States to develop policies and implement services; and

e) develop guidance on good management practices in mental health care.

ACTION PLAN- OBJECTIVE IV

People are entitled to respectful, safe and effective treatment

a) development and dissemination of curricula for primary care staff, incorporating principles of recovery;

b) support the competencies and harmonization of postgraduate training and continuous medical education.

ACTION PLAN- OBJECTIVE V

Health systems provide good physical and mental health care for all

a) development of good practice guidelines for physical health assessments in mental health services;

b) development of good practice guidelines for mental health assessments in physical health services; and

ACTION PLAN- OBJECTIVE VI

Mental health systems work in well coordinated partnership with other sectors

a) disseminate effective policies and practices

ACTION PLAN- OBJECTIVE VI

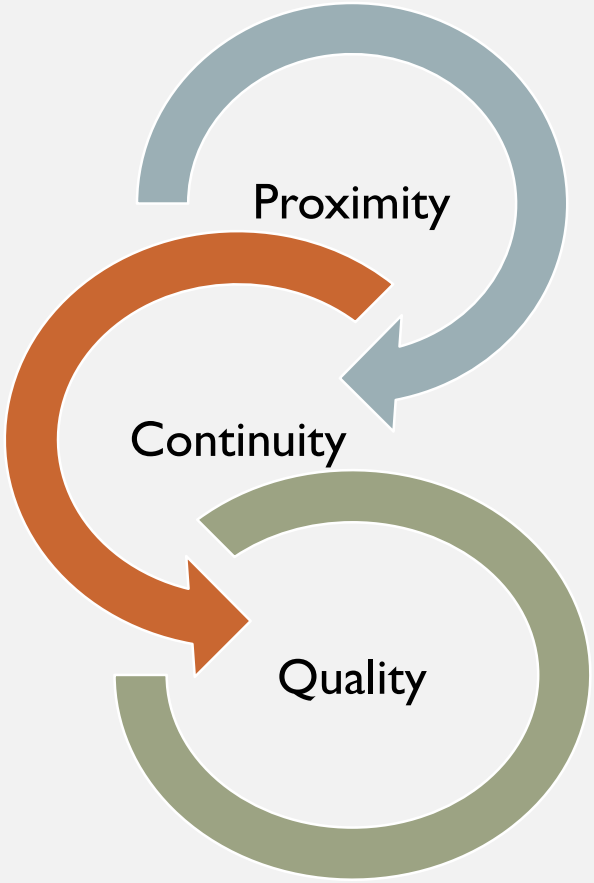
Mental health systems work in well coordinated partnership with other sectors

a) develop and publish a set of definitions of mental health terms in partnership with stakeholders; and

b) monitor involvement of service users and their families.

ACTION PLAN

PREVENTION



TREATMENT

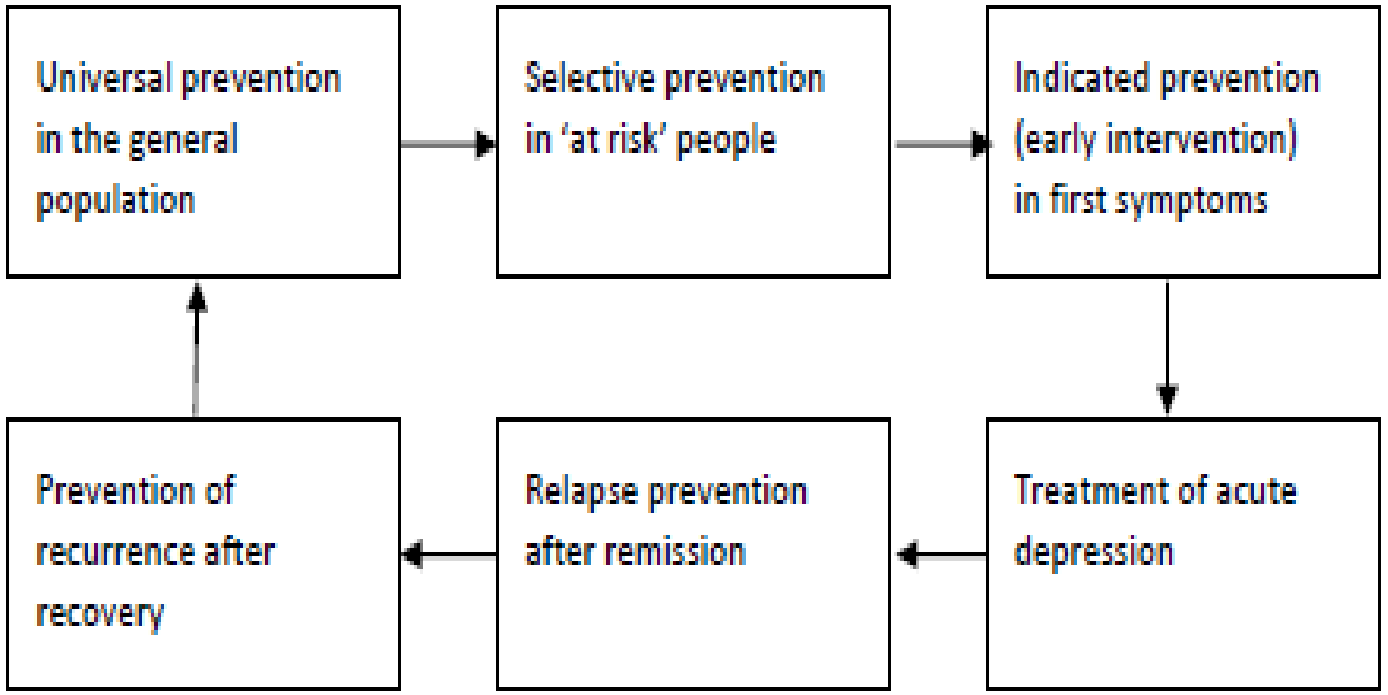


Figure 2. *Types of prevention to sustain population health (adapted after Beekman et al., 2004)*

Special Scenarios

Mental health at school

Mental health at workplace

Mental health and transculturality / cultural competencies

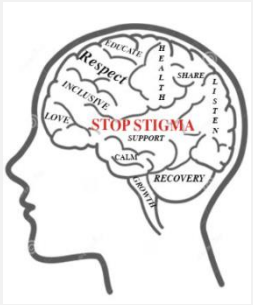
Mental health and migrations and minorities

Mental health on continuity care

Mental health and new medications

Stigma and discrimination

“The black dog – Depression and suicide”



SOME IMAGES…

10 Things you should know about Mental Health

M·H·E Mental Health Europe

Each of us has mental health. We all have ups and downs and may all experience mental distress at some point. It can happen to anyone.

30% of people with mental health problems do not have access to mental health care.

People with severe mental health problems have an average reduced life expectancy of between **10 to 25 years.**

This is why investing in prevention and early interventions can make a real difference to people's lives.

100%

Possibility of Recovery

for everyone. With the right support, recovery from mental ill health can happen. Recovery means living with and managing mental health problems, while having control over your own life.

€523.2 billion

Annual economic cost of mental ill health in Europe. Strategic investment in mental wellbeing can generate enormous economic and social returns.

9 of the 10 countries with the highest rates of suicide in the world are in the European Region.

Per centage of the EU Commission Health budget for 2008-2013 allocated to mental health according to our analysis:

Mental Health: 2,8% Overall budget

*estimate based on publicly available data and data provided by Chafea

Adolescence is a time of great growth and development but for some this can bring significant challenges.

One in five

adolescents in Europe is affected by at least 1 psychological problem in any given year.

Good work

is positive for mental health. For many people employment is the solution not the problem.

© Mental Health Europe 2017

Sources: JAMHB, CHAFEA, WHO, OECD, ILO, Eurostat

www.mhe-sme.org

Depression

Every year, about **1 out of 15** people suffer from major depression in the WHO European Region

If anxiety and all forms of depression are included, nearly **4 out of 15** people are affected

www.euro.who.int/mentalhealth

© WHO 09/2013

World Health Organization
REGIONAL OFFICE FOR Europe

In the WHO European Region,

3 out of 4 people suffering from major depression

do not receive adequate treatment.

04/2017

World Health Organization
Europe

Return on investment of treating depression in the WHO European Region

Every

US$ 1

invested in treating depression with therapy or antidepressants

leads to a return of

US$ 4

in better health outcomes and work ability.

04/2017

World Health Organization
REGIONAL OFFICE FOR Europe

DEPRESSION

350 million

people globally suffer from depression.

Globally, depression accounts for 41% of all the years spent living with mental or behavioral disorders.

41%	15%	11%	10%	7%
depression	anxiety	drug-use disorders	alcohol-use disorders	schizophrenia

Twice as many women typically develop depression than men, although in richer countries, three times as many men die by suicide than women.

SOURCES: Global Burden of Diseases, Injuries, and Risk Factors Study 2013; World Health Organization

Antidepressants

USA

11% of Americans 12 years and over report taking antidepressants.

In 2010, antidepressants were the **second most commonly prescribed medication** in the USA (after drugs to lower cholesterol).

In the USA, about **254 million prescriptions** were written for antidepressants in 2010.

Antidepressant consumption

(selected industrialized countries, 2011)
*Defined daily dose/1,000 people

*Defined daily dose is the assumed average maintenance dose per day for a drug used for its main indication in adults.

SOURCES: U.S. National Institute of Mental Health and OECD Health Statistics

Suicide

Globally, more than
800,000 people
die by suicide every year.

Suicide is the **second leading cause of death** among 15-29 year olds, after road accidents.

Globally, suicide rates are **highest in people aged 70 years** and over.

Regionally, **East Africa** and **Eastern Europe** have the highest rates.

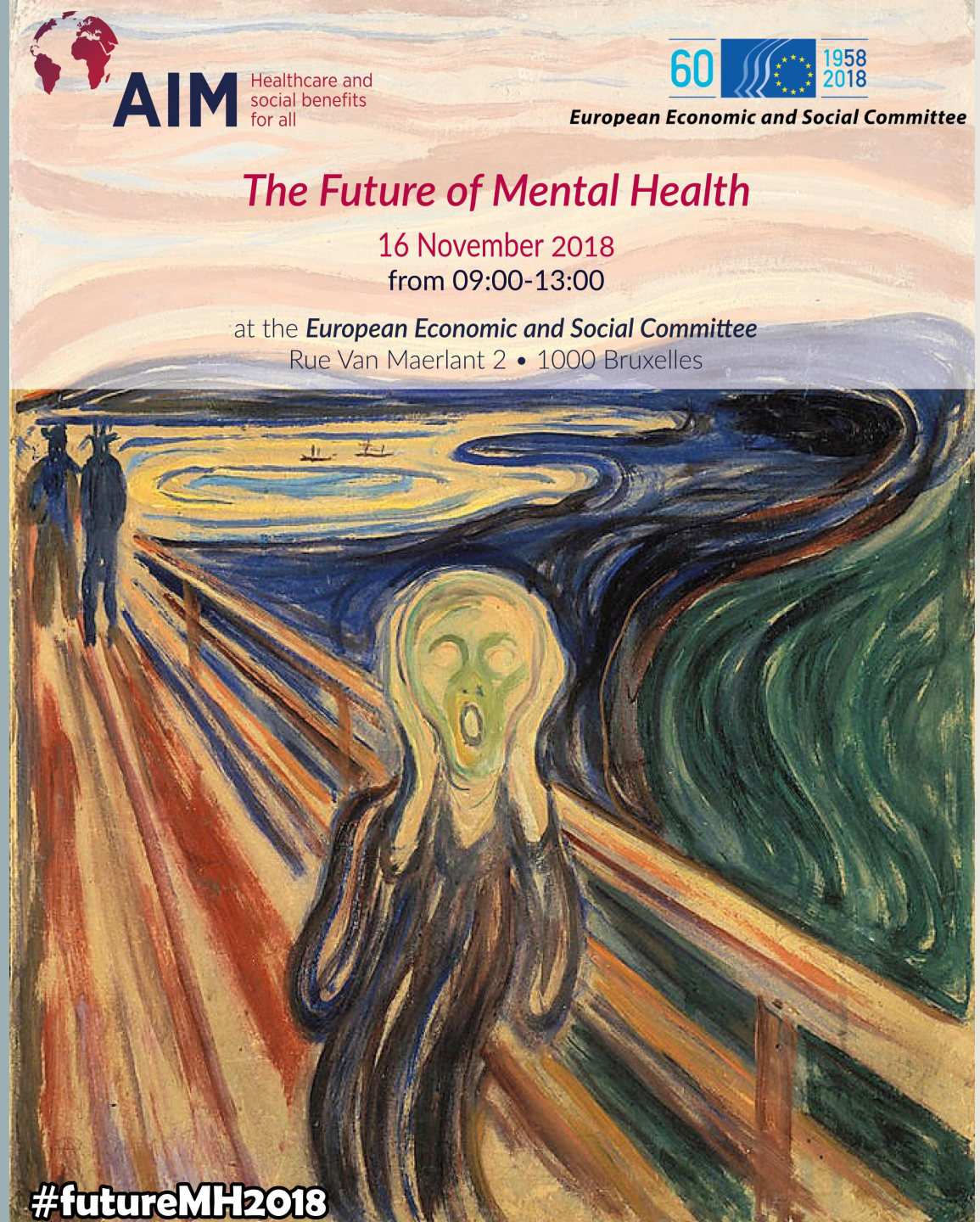
SOURCE: World Health Organization

DEMENTIA

A public health priority

Dementia is one of the major causes of disability and dependency among older people

World Health Organization



SETTING THE SCENE: THE PANORAMA OF MENTAL HEALTH IN EUROPE

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Zooming in: Some European Best Practices

- *GET.ON, a German online training for improving mental health*
- *The mental health care reform in Belgium: an overview*
- *The Netherlands: Flexible Assertive Community Treatment*

My health.

My way with GET.ON

GET.ON Institute for Online Health Trainings

Dr. Elena Heber

https://geton-institut.de

The treatment of mental health problems is often not appropriate, delayed or too expensive.

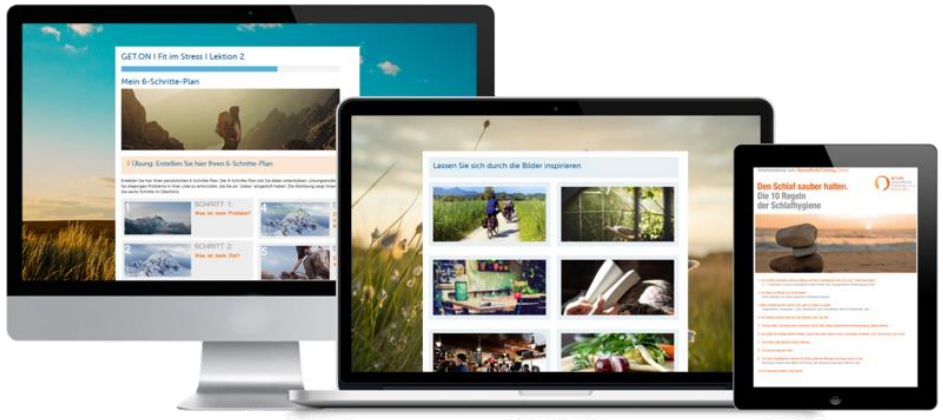
Affected individuals frequently do not access treatment due to stigma or because they want to solve their problems independently.

GET.ON wants to reach people much earlier in this process and therefore offers effective help *online*.

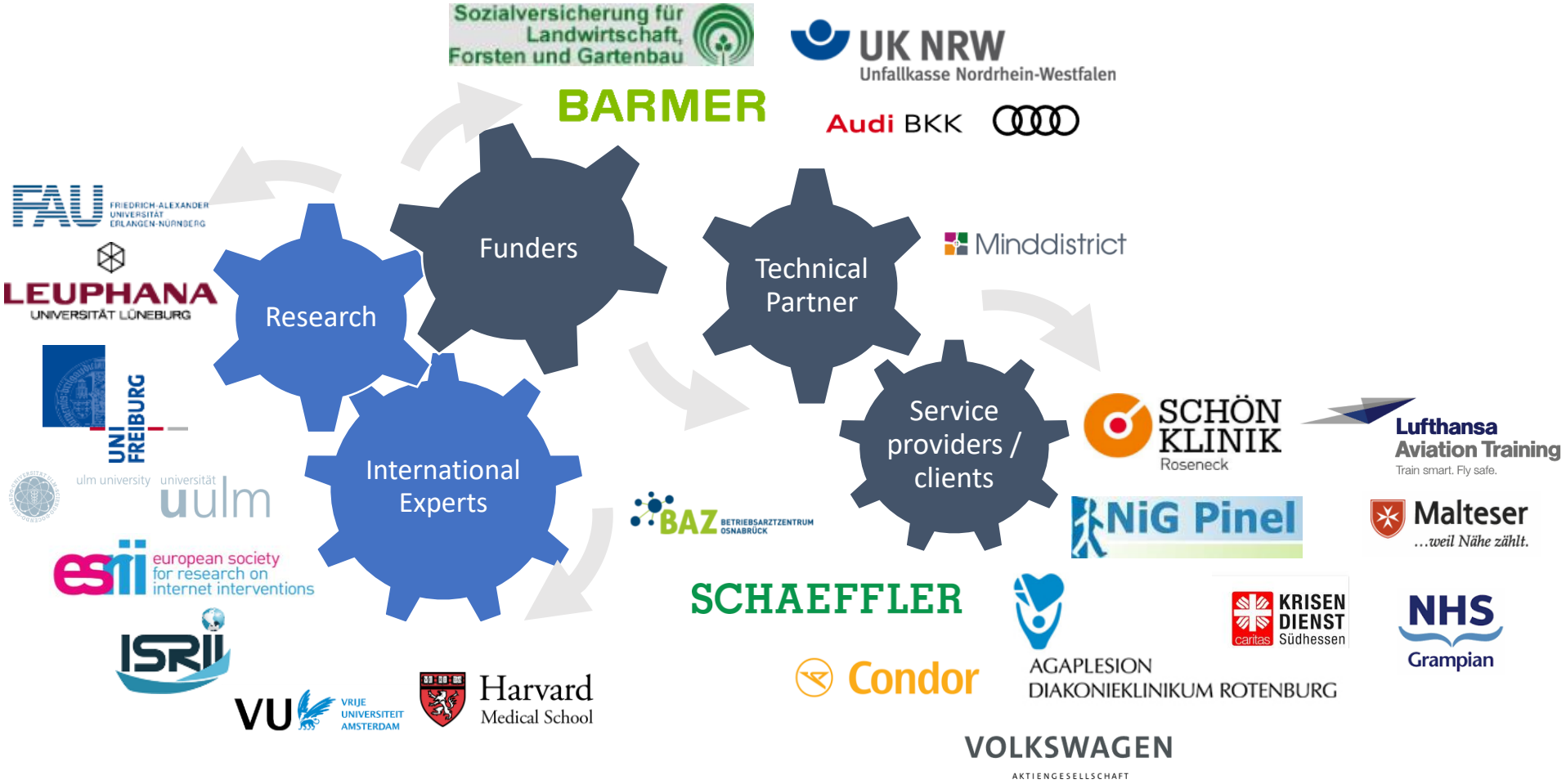
GET.ON Institute

Online Health Trainings – individual, flexible, effective

- University spin-off (EU funded research, 2011-2015)
- Head office: Hamburg; sites in Berlin & Erlangen
- founded 2015 by internationally renowned E-Mental Health experts
- Only evidence-based and effective interventions are being implemented
- > 10 years of experience in the development of E-Mental health products
- 14 employees, > 20 Online-Coaches / Therapists
- Some trainings in English, Spanish, Hebrew, Dutch



Our partners



Principles of all GET.ON Interventions

International Best-Practice – often established – optimised on an ongoing basis.

- **Effective** Efficacy of all trainings is proven in state-of-the-art research studies
- **Personal** Adaptive, experience-oriented and individualised according to needs and interests
- **Concentrated** in 6-10 sessions: step by step towards an improvement of mental health
- **Interactive** set-up, informative texts, emotional pictures, audios, videos
- **Hands-on** Practical training and visualisation of progress (e.g. diaries, real-life exercises)
- **Sustainable** change of behaviour (12 months training access)
- **Guided** Individualised guidance concepts (written, video-based, via telephone) enable effectiveness at limited costs

Numerous national and international awards, including:

HDZ NRW UKRUB Universitätsklinikum der Ruhr-Universität Bochum

Heinrich Sauer Prize 2014

dgvt

German Society of Behavioral Therapy Preis 2014

Digital Health Prize 2018

NOVARTIS

EU Compass Good Practice 2018
in Mental Health & Wellbeing

PUBLIC HEALTH

efpa European Federation of Psychologists' Associations

EFPA Comenius Preis 2017

Fachgruppe Klinische Psychologie und Psychotherapie der Deutschen Gesellschaft für Psychologie e.V. (DGPs)

German Psychological Society 2015

Wilhelm-Exner-Prize 2016

AREAS OF APPLICATION

GET.ON Interventions

for the most important indications, in all phases of health care.

Prevention

- Stress
- Insomnia
- Prevention of depression
- Problem solving
- Problematic alcohol consumption
- Gratitude (detachment & worry)
- Self-critic

Therapy

- Depression
- Insomnia
- Panic Disorder
- Chronic Pain
- Sexual disfunction in women
- Depression in chronic health disorders, e.g.
  - Diabetes
  - Chronic Pain
  - Heart disease
  - Cancer
- Anxiety disorders

After-Care

- Depression
- Transdiagnostic relapse prevention after in-patient treatment for mental health disorders

Available and proven effective

Currently in evaluation

OUR PRINCIPLE:
ONLY EFFECTIVE INTERVENTIONS ARE IMPLEMEMENTED.

LOOK INSIDE

GET.ON TRAINING FOR INSOMNIA

Look inside: GET.ON Training for insomnia.

Example characters accompany users through the training. They share success, failure and new attemps. Emotional pictures are used to support behaviour change.

Example characters

Lernen Sie Frank, Martina und Christiane kennen

Im Programm werden Sie die Beispielpersonen Frank, Martina und Christiane begleiten. Bei jeder Übung können Sie lesen, wie sie die Übung bearbeitet haben. Die Beispiele stehen immer direkt vor der Übung zum Aufklappen, etwa so:

▾ Beispiel Frank

Vielleicht können Sie sich von den Beispielen* inspirieren lassen oder ein besseres Verständnis für die Übungen gewinnen.

Lernen Sie Frank (41), Realschullehrer kennen

Ich bin Frank, 41, bin verheiratet und habe zwei Kinder.

Ich bin Realschullehrer, unterrichte Chemie und Mathematik und leite derzeit eine 9. Klasse. Bei diesem Programm angemeldet habe ich mich, weil die Belastung im Job in den letzten Jahren zugenommen hat, bzw. ich die Belastung mehr spüre.

Manchmal rasen die Tage so an mir vorbei, dass ich es gar nicht merke. Und nach zwei Wochen denke ich: Wo sind die letzten zwei Wochen hin? Bewusste Verschnaufpausen nehme ich gar nicht mehr wahr und das möchte ich nun ändern. Ich möchte mich bewusster regenerieren, mein Leben insgesamt entschleunigen.

Images activating positive emotions

Lassen Sie sich durch die Bilder inspirieren

Look inside: GET.ON Training for insomnia.

Behavioural planning is an important component

Recovery activities

Übung: Mein Erholungsrepertoire

Erstellen Sie jetzt zunächst einmal zwei Listen mit Aktivitäten. Diese Listen stellen Ihr "Erholungsrepertoire" dar, aus dem Sie dann später die Aktivitäten für die nächste Woche wählen.

▾ Beispiel Frank

Kleine Erholungsaktivitäten

Machen Sie ein Brainstorming: Welche "kleinen" Erholungsaktivitäten empfinden Sie als angenehm oder würden Sie gerne mal (wieder) ausprobieren?

Meine kleinen Erholungsaktivitäten:

Größere Erholungsaktivitäten

Machen Sie ein Brainstorming: Welche "größeren" Erholungsaktivitäten empfinden Sie als angenehm oder würden Sie gerne mal (wieder) ausprobieren?

Meine größeren Erholungsaktivitäten:

Weekly planning

Übung: Planen Sie Ihre Erholungsaktivitäten

Suchen Sie sich aus diesen Listen jetzt mindestens eine "kleine" (5-15 Minuten) Erholungsaktivität für die tägliche Regeneration und eine „große" (60-120 Minuten) Erholungsaktivität für einmal die Woche aus.

▾ Beispiel Frank

Tragen Sie pro Eintrag eine Aktivität ein und klicken Sie auf "Hinzufügen", um weitere Einträge vorzunehmen.

Wochentag	Aktivität
Dienstag	Fahrrad fahren
Mittwoch	Buch lesen

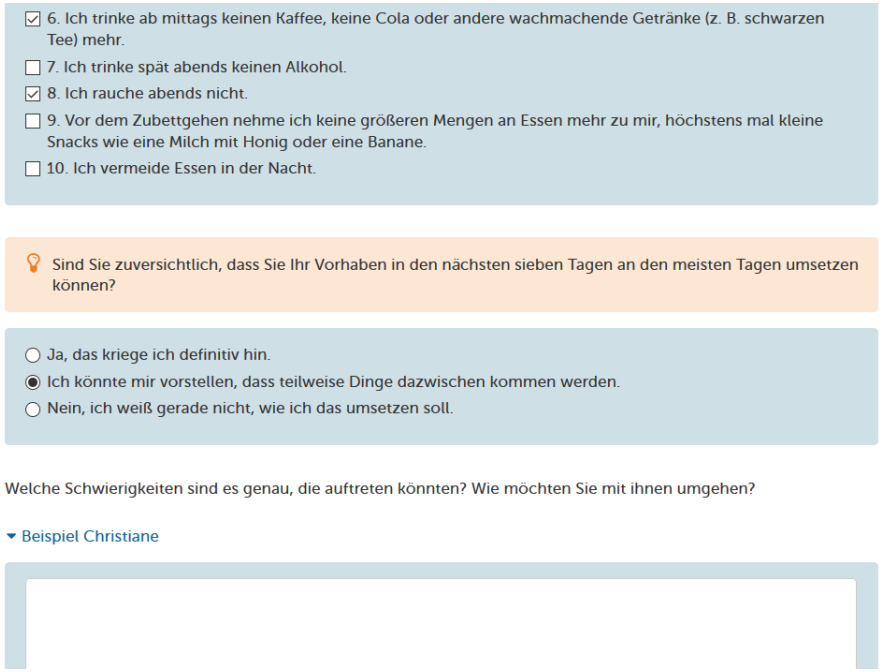
+ Hinzufügen

1. Sie können jeden Tag die gleiche(n) Aktivität(en) einplanen oder immer andere, das bleibt Ihnen überlassen.
2. Setzen Sie die Aktivität bewusst zur Regeneration ein, d. h. für das Abschalten von der Arbeit oder für besseren Schlaf.
3. Achtung Nebenwirkung! Insgesamt gilt: "Kein MEHR an Erholung ohne ein WENIGER von etwas anderem". Auszuhalten, dass Sie den Ansprüchen der anderen oder sich selbst an der ein oder anderen Stelle vielleicht nicht gerecht werden, stellt eine wichtige Form der Investition in Regeneration dar.

Look inside: GET.ON Training for insomnia.

Behaviour change is supported through goal setting, reward for achievements and self-appreciation.

Goal setting & Planning



Diaries for self-reflection

Look inside: GET.ON Training for insomnia.

Numerous short written exercises are included. Audio-files are suitable for imaginations.

Written exercises – developing helpful thoughts

Sie geben an, folgende Gedanken von sich zu kennen:

- Ich muss jeden Tag 100% fit sein!

Wählen Sie sich nun einen für Sie typischen Gedanken aus und formulieren Sie einen alternativen, entlastenden Gedanken. Er sollte kurz, prägnant, persönlich, positiv und in der Gegenwart formuliert sein.

▲ Beispiel Martina

Mein schlafschädigender Gedanke: "Die Schichtarbeit macht mich kaputt. Gesunder Schlaf ist so überhaupt nicht möglich."

Mein Gelassenheitsgedanke: "Ich brauche immer ein bis zwei Tage, um mich umzustellen. Dass diese Nächte ein wenig unruhiger sind, ist nicht so schlimm. Mein Körper holt sich das durch tieferen Schlaf in späteren Nächten wieder."

Mein schlafschädigender Gedanke:

Ich muss immer volle Leistung bringen - jeden Tag. Dafür muss ich mindestens 8 Stunden schlafen.

Mein Gelassenheitsgedanke:

Ich bringe auch mit weniger Schlaf gute Leistung. 100% ig fit ist niemand.

Audio exercises – internalising helpful thoughts

MP3 zur Atemübung:

-0:00

Die MP3 können Sie sich auch hier herunterladen und auf Ihrem PC speichern (Rechtsklick auf "Ziel speichern unter").

Look inside: GET.ON Training for insomnia.

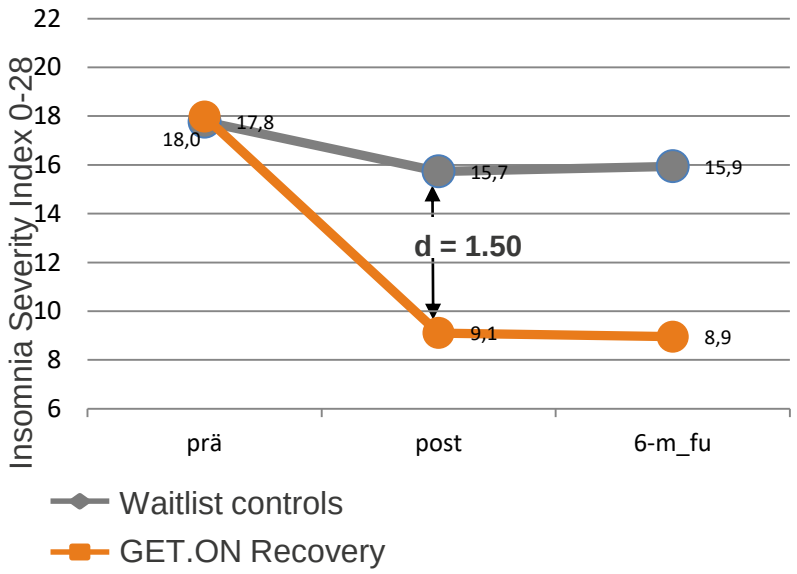
Summary and diaries as PDFs for download and print-off.

In the focus: GET.ON Training for Insomnia.

Efficacy of GET.ON Recovery for insomnia compared to a waitlist control group.

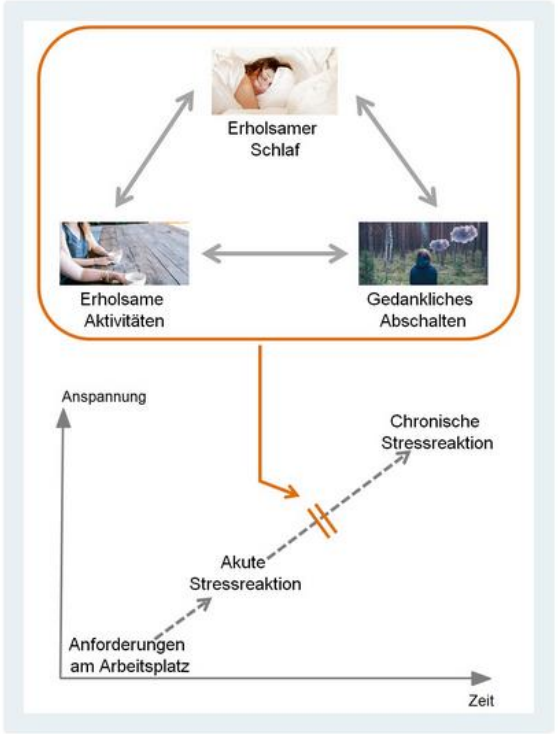
Only 1% of insomnias in Germany are treated according to state-of-the-art recommendations. Online-Interventionen can change this[1,2]

Insomnia
Intention-to-treat Analysis (N=128)



Meta-Analysis of f2f Psychotherapy: d = 0.98 [3]

Intervention
6 sessions, guided



What does recovery consist of?

- Restorative sleep
- Mental detachment
- Recovery exercises

1. Mein guter Start
2. Besser schlafen
3. Besser abschalten
4. Grübeln unter Kontrolle
5. Grübeln beenden
6. Gestärkt in die Zukunft

[1]Thiart et al 2015 Scand J Work Env Health, Ebert
[2]Thiart Lehr et al. Health Psychology 2016
[3] van Straaten et al 2018 Sleep Med Rev

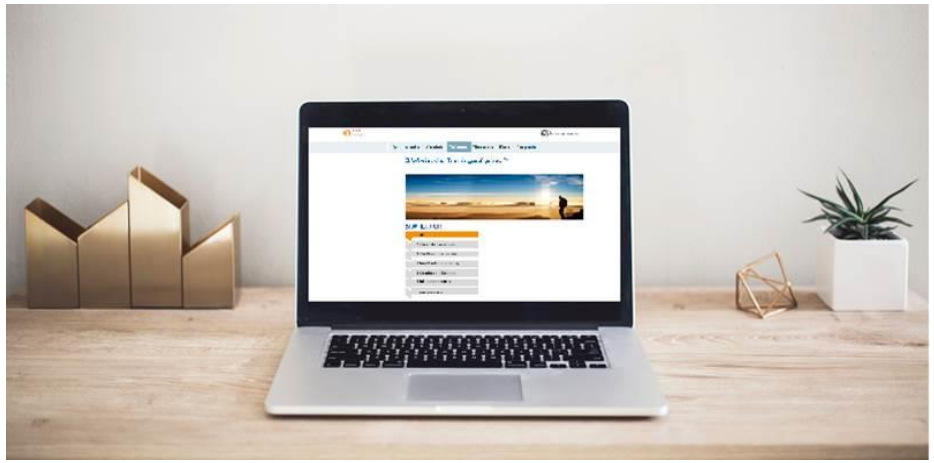
TAILORING
OF GET.ON TRAININGS

Look inside: Online Trainings for Farmers

Are all internet-based interventions effective?

Efficacy for internet-based interventions has been shown in numerous randomised controlled trials for various psychological problems.

- **But: not every online intervention is effective**
- Example: Internet-based stress management (Heber et al., 2017)
  - Overall: moderate effect (Cohen‘s d=0.43)
  - Almost half of the interventions: non-significant results



**When offering e-mental health interventions,
quality and efficacy of the interventions need to be ensured.**

Can we assume that e-mental health interventions work for everybody?

- Guided ICBT and face-to-face treatments for depression, panic, social anxiety disorder, and tinnitus (amongst others) **do not significantly differ in effectiveness** (Cuijpers & Andersson, 2014)
- **But: this does not imply that it works for everyone seeking help**
- As in other routine health care, treatment of choice needs to be taken seriously

Capitalising the possibility to receive the treatment of choice and monitor routine outcomes.

What do we need to be aware of when communicating about e-mental health?

- Communication about **validity of interventions** is key!
- Raise awareness with all parties involved
- Independent and high-quality source of information and access („**e-mental health hub**“)

Raise awareness for importance of communicating the validity of online interventions.

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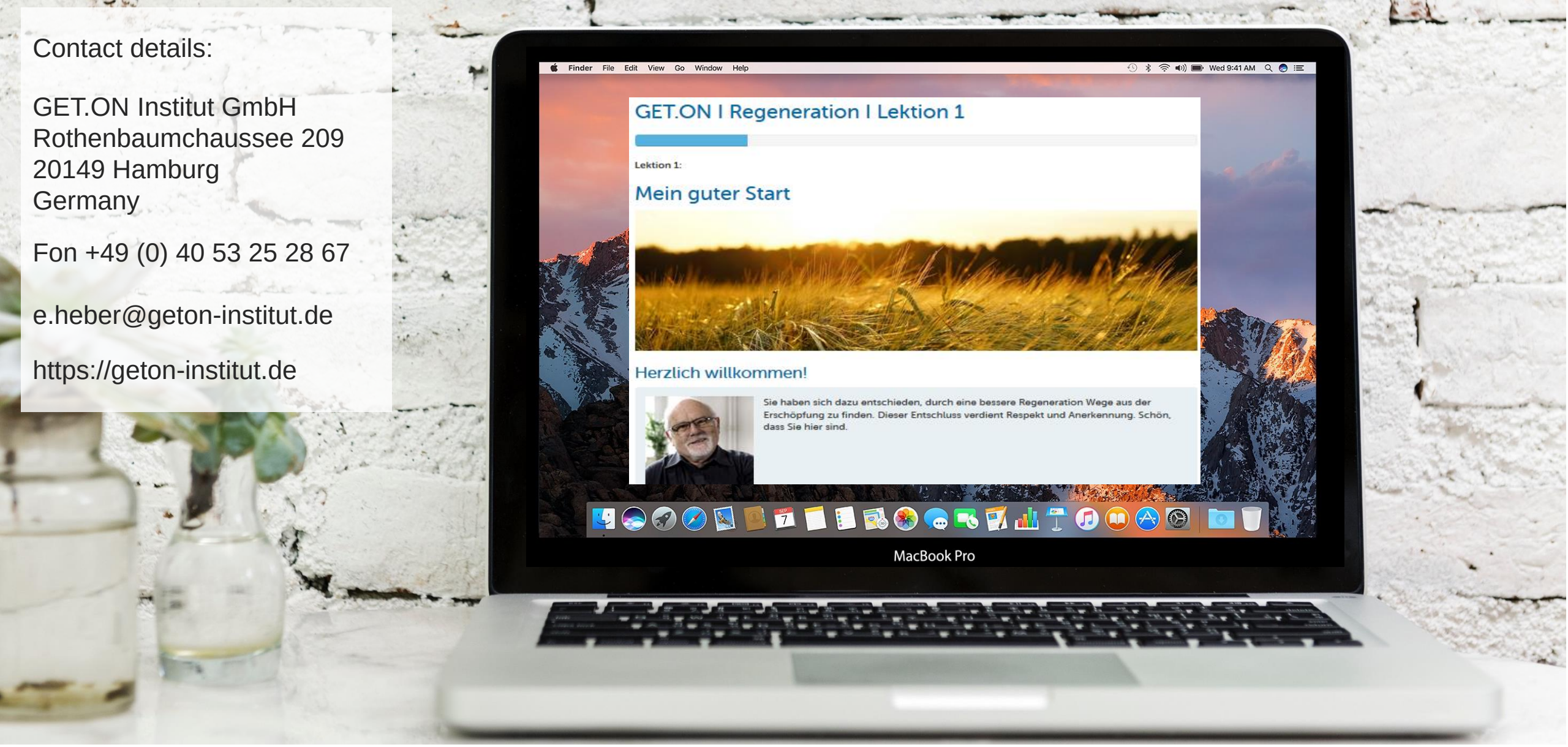


Thank you for your attention!

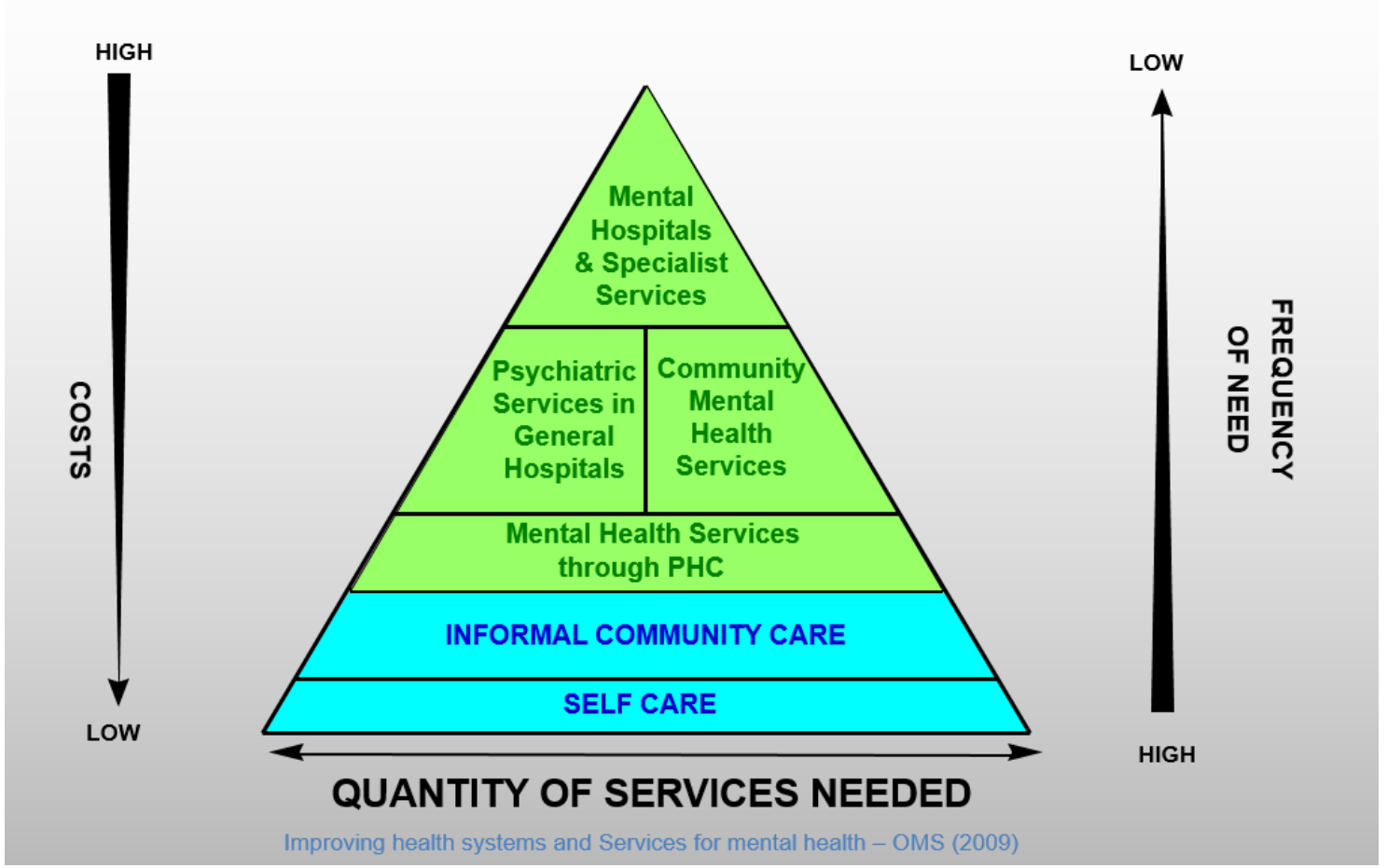
« Mental health care reforms»

VISION GLOBALE

FOUR OBJECTIVES - WHO

- STRENGTHENING LEADERSHIP AND GOVERNANCE IN THE FIELD OF MENTAL HEALTH
- PROVIDING COMPREHENSIVE, INTEGRATED AND RESPONSIVE MENTAL HEALTH AND SOCIAL CARE SERVICES IN A COMMUNITY SETTING
- IMPLEMENTING PROMOTION AND PREVENTION STRATEGIES IN THE FIELD OF MENTAL HEALTH
- STRENGTHENING INFORMATION SYSTEMS, FACTUAL BASIS AND RESEARCH IN THE FIELD OF MENTAL HEALTH

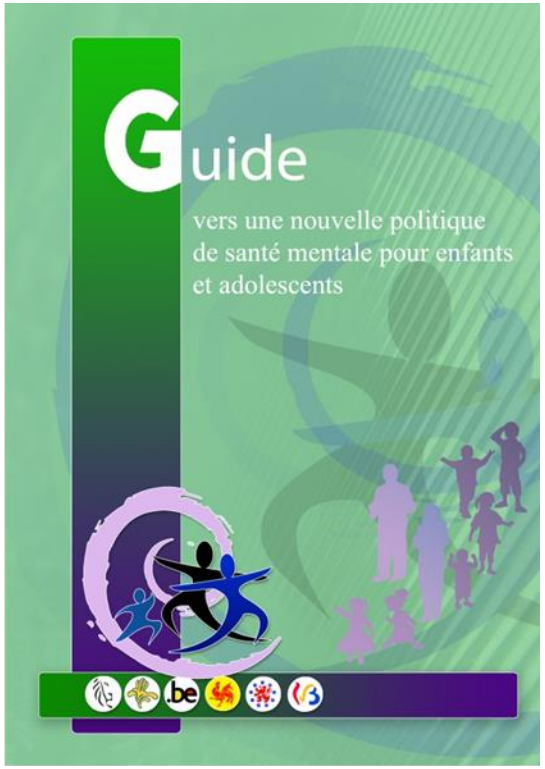
Service Organization: Optimal Mix of Services



Improving health systems and Services for mental health – OMS (2009)

GUIDELINES

Gids
naar een
betere geestelijke
gezondheidszorg
door de realisatie
van zorgcircuits en
zorgnetwerken
.be
VLAANDEREN


Guide
vers une nouvelle politique
de santé mentale pour enfants
et adolescents
.be

MISSIONS

“THE MENTAL HEALTH POLICY FOCUSES ON ALL PERSONS WHO HAVE A PSYCHOLOGICAL VULNERABILITY, AS WELL AS THEIR NATURAL AND SUPPORTIVE CONTEXT .

DE NEEDS OF THE CLIENT AND HIS/HER CONTEXT ARE CENTRAL.

CORE FUNCTIONS ARE EARLY DETECTION, SCREENING AND ORIENTATION, DIAGNOSTICS, TREATMENT, INCLUSION IN ALL AREAS OF LIFE AND EXCHANGE AND JOINT DEPLOYMENT OF EXPERTISE.

VISION: A GLOBAL (COMPREHENSIVE) AND INTEGRATED APPROACH

THERE IS CLOSE COOPERATION WITH RELEVANT SECTORS, INCLUDING HEALTH CARE AND WELFARE, AND ALL DOMAINS OF SOCIAL LIFE (EG CHILDCARE, EDUCATION, YOUTH WORK, SPORTS, CULTURE, EMPLOYMENT, LIVING ...).

VISION: A GLOBAL (COMPREHENSIVE) AND INTEGRATED APPROACH

OBJECTIVE AND DEFINITION OF A GLOBAL AND INTEGRATED POLICY

= THE INCLUSION OF ALL RELEVANT FIELDS IN A POLICY IN WHICH ALL ACTIONS COMING TOGETHER

VISION: A GLOBAL (COMPREHENSIVE) AND INTEGRATED APPROACH

« GLOBAL »:

ALL INCLUDED, COMPLETE.

WORK ON ALL ASPECTS OF THE MENTAL HEALTH THEME REQUIRES AN INTEGRATED APPROACH

VISION: UNE APPROCHE GLOBALE ET INTÉGRÉE

« INTEGRATED »:

INVOLVEMENT OF ALL RELEVANT ACTORS, SERVICES AND SECTORS

A HORIZONTAL APPROACH ACROSS ALL SECTORS

A VERTICAL APPROACH AMONG ALL COMPETENCES LEVELS

A GLOBAL (COMPREHENSIVE) AND INTEGRATED APPROACH

- **BUILDING A EFFECTIVE NETWORK**
  - NETWORK COORDINATOR
  - STRATEGIC PLAN
- **A LOCAL IMPLEMENTATION**
- **INCLUDING ALL RESSOURCES**

  (5 ACTIVITIES SECTORS)

CONSTRUCTION OF A NETWORK AROUND THE USER

- ENABLING RESOURCES TO BE USED EFFICIENTLY IN LINE WITH THE NEEDS
- COMMON TOOLS (INDIVIDUALISED SERVICES PLANS)
  - REFERENCE PERSON
  - ACTION PLAN: WHO DOES WHAT WHEN
- USER'S FREE CHOICE

COOPERATIVE NETWORK AMONG STRUCTURES AND RESOURCES : SAME PURPOSE, SAME OPERATION AND COMMON OBJECTIVES : **FORMALIZATION**

- CONTINUITY OF CARE
- IMPROVING THE SUPPLY OF CARE AND THE QUALITY OF USERS MANAGEMENT

BUT EVEN MORE …

RECOVERY-ORIENTED: BUILDING ON PERSONNEL GOALS AND STRENGHTS

TO MAINTAIN, AS MUCH AS POSSIBLE, PEOPLE IN THEIR OWN LIVING ENVIRONMENT

20 NETWORKS

‘MENTAL HEALTH CARE FOR ADULTS

Netwerk GGZ
Noord West-Vlaanderen
Netwerk GGZ
Midden West-Vlaanderen
Netwerk GGZ
Zuid West-Vlaanderen
het PAKT
Netwerk
GGZ ADS
SaRA
Netwerk
GGZ Kempen
Emergo
Reling
Noolim
SaVHA
Transmurale zorg
Leuven-Tervuren
Bruxelles
Brabant Wallon
Réseau
Santé Mentale
Hainaut
Fusion Liège
RéSME
Réseau en
Santé Mentale
de la région du Centre
(+ extension)
Réseau Santé Namur
Réseau 107
Luxembourg

11 NETWORKS

MENTAL HEALTH FOR CHILDREN AND ADOLESCENTS

ANTWERPEN
PANGG 0-18
LIGANT
Région Bruxelloise
Brussels Gewest
WEST VLAANDEREN
OOST VLAANDEREN
LIMBURG
VLAAMS BRABANT
WINGG
RADAR
YUNECO
BRABANT WALLON
ARCHIPEL BW
RHÉSEAU
BRU-STARS
LIEGE
HAINAUT
REALISM 0-18
KIRIKOU
NAMUR
LUXEMBOURG
Mathilda

POINTS OF ATTENTION

- THE REFORMS ARE PART OF A GLOBAL VISION, THE RESULT OF CONSENSUS BETWEEN ALL LEVELS OF EXPERTISE, BOTH FEDERAL, REGIONAL AND COMMUNITY
- THERE IS A STRONG POLITICAL DESIRE THAT THE REFORMATION CONTINUES
- THE VISION OF MENTAL HEALTH IN THE COMMUNITY, IN THE PLACE OF LIFE SPREADS OVER THE ENTIRE TERRITORY; THE SUPPORT OF DIFFERENT LEVELS OF POWER IS OBVIOUS
- IT IS A LOCAL IMPLEMENTATION; TAKING INTO ACCOUNT THE OPINION OF THE ACTORS IN THE FIELD IS ESSENTIAL AND CONSIDERED AS A FACTOR OF SUCCESS (TOP-DOWN / BOTTOM-UP)
- THE MODEL IS DEVELOPED ON THE NETWORK CONCEPT (AN ACTION ZONE) AND IS BASED ON A GLOBAL AND INTEGRATED OFFER (VERTICAL AND HORIZONTAL APPROACH)
- NETWORK COORDINATION HAS BEEN ENTRUSTED WITH A KEY ROLE THAT AIMS TO BRING COHERENCE AND HARMONY TO THE REGION'S AVAILABLE RESOURCES.

POINTS OF ATTENTION

- THE MODEL IS BUILT BY FORMALIZING PARTNERSHIP PROCEDURES BETWEEN ACTORS INVOLVED IN THE ACTION AREA (RESULT OF GOOD GOVERNANCE)
- THE GLOBAL AND INTEGRATED APPROACH CONSIDERS ALL ACTORS: HEALTH, WELL-BEING, SCHOOL, TRAINING AND EMPLOYMENT, HOUSING, LEISURE, CULTURE, ...
- LIAISON WITH PRIMARY CARE (GENERAL PRACTITIONERS, HOME CARE, ...) IS CONSIDERED A PRIORITY
- EARLY DETECTION AND INTERVENTION ARE CONSIDERED AS A PRIORITY
- SPECIAL ATTENTION IS MADE TO HINGE AGE GROUPS
- AID AND CARE CIRCUITS ARE BUILT ON THE NEEDS OF USERS AND THEIR ENTOURAGE
- FORMALIZED CONSULTATION BETWEEN PROFESSIONALS AND USERS IS THE BASIC PHILOSOPHY AND ALLOWS FOR THE INVOLVEMENT OF REPRESENTATIVES OF USERS AND RELATIVES AT ALL LEVELS OF DECISION-MAKING (MICRO, MESO, MACRO)

POINTS OF ATTENTION

- INTERNATIONAL RECOMMENDATIONS, IN PARTICULAR FROM WHO, THE EUROPEAN UNION, THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (UN) ARE TAKEN INTO CONSIDERATION.
- RECOMMENDATIONS MADE BY REPRESENTATIVES OF USERS AND RELATIVES ARE HEARD BY THE AUTHORITIES AND INCORPORATED INTO ACTION PLANS
- IN THE FIELD, WE FIND A CONSIDERABLE NUMBER OF INNOVATIVE PRACTICES BASED ON THESE INNOVATIONS, A HANDBOOK INNOVATIVE PRACTICES HAS BEEN WRITTEN IN COLLABORATION WITH THE WORLD HEALTH ORGANIZATION.

Flexible Assertive Community Treatment

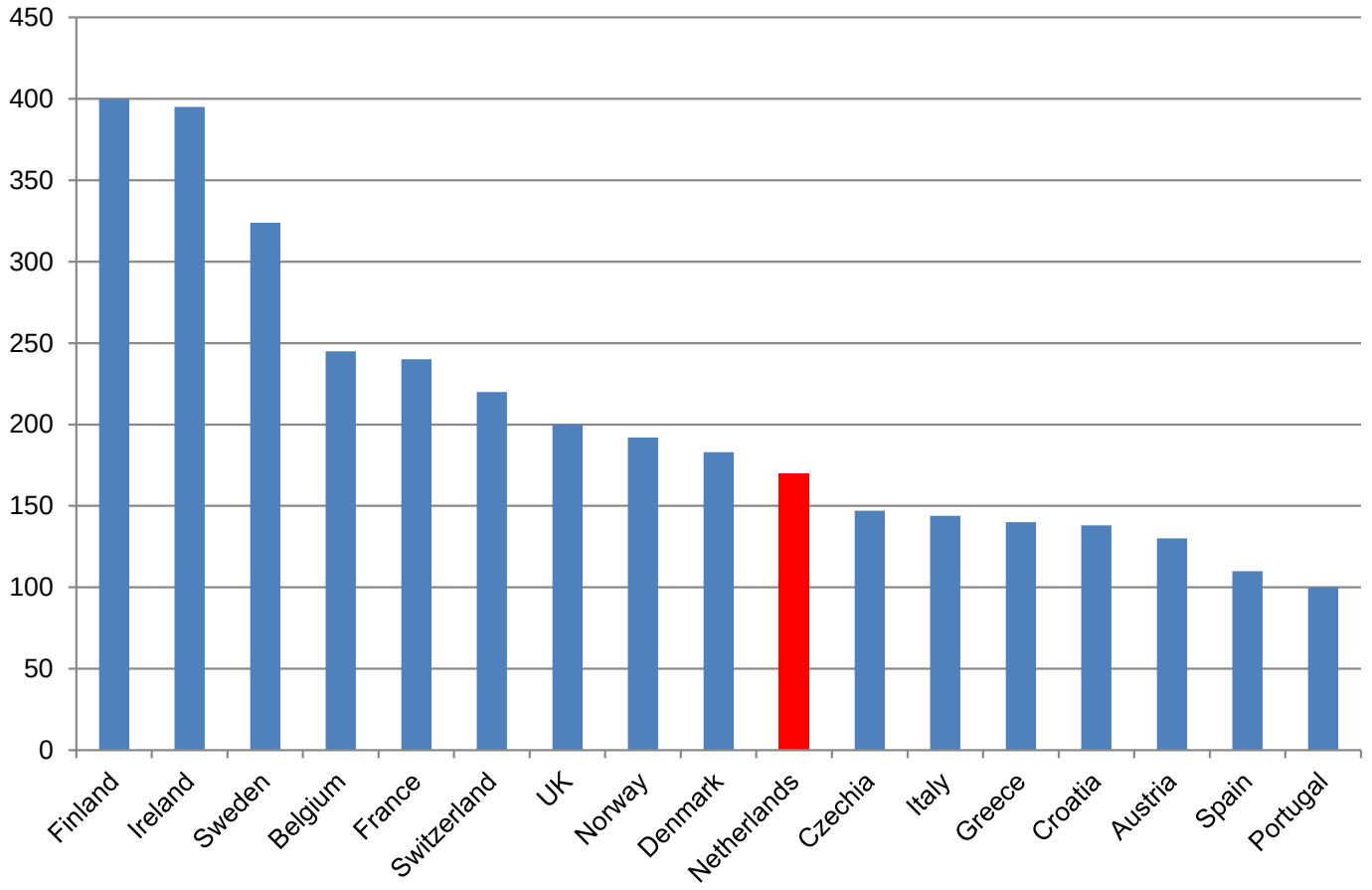
Hans Kroon

Trimbos instituut
Netherlands Institute of Mental Health and Addiction

Tilburg University

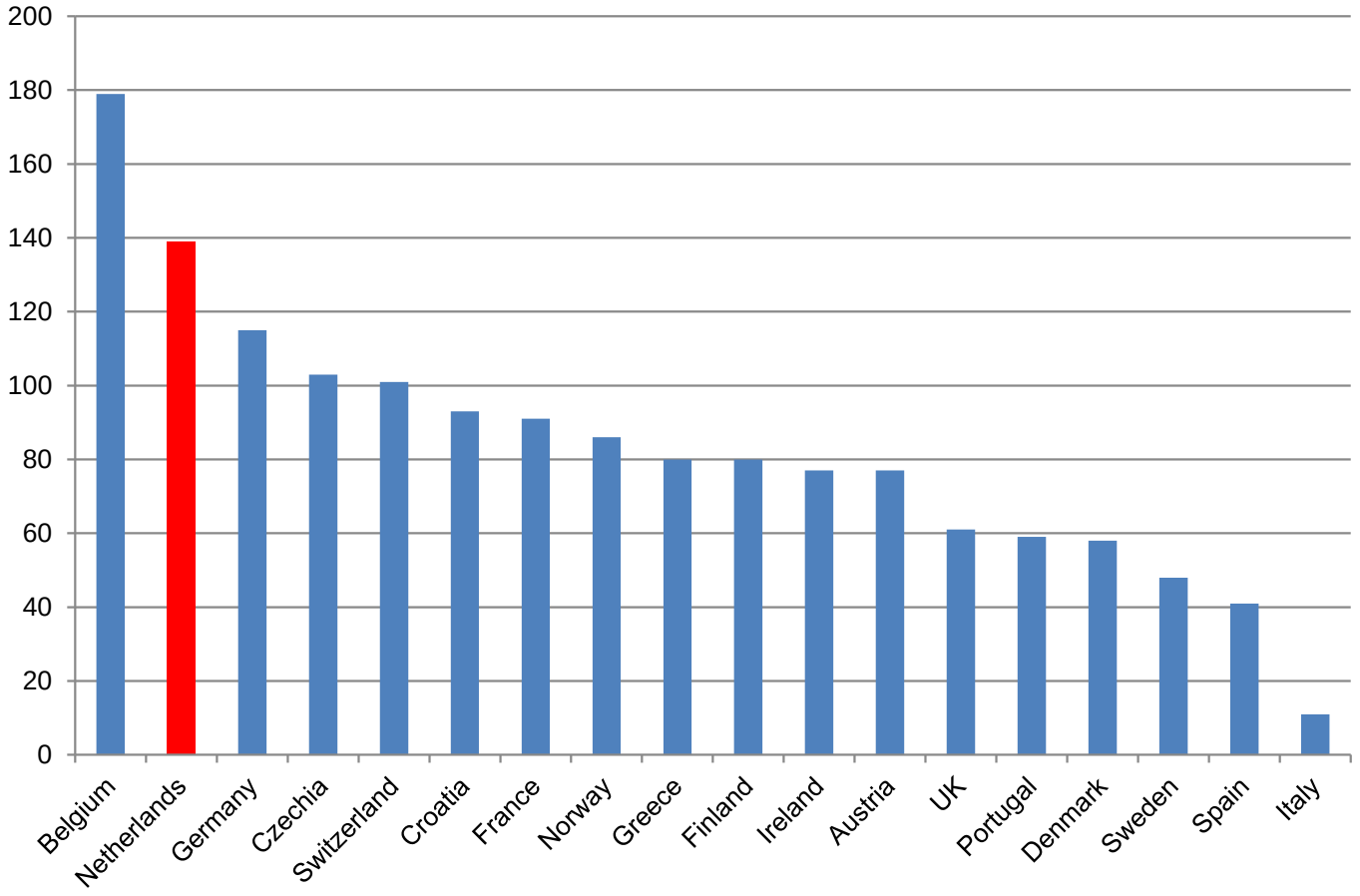
Psychiatric hospital beds in Europe
per 100.000 inhabitants

1980



Psychiatric hospital beds in Europe
per 100.000 inhabitants

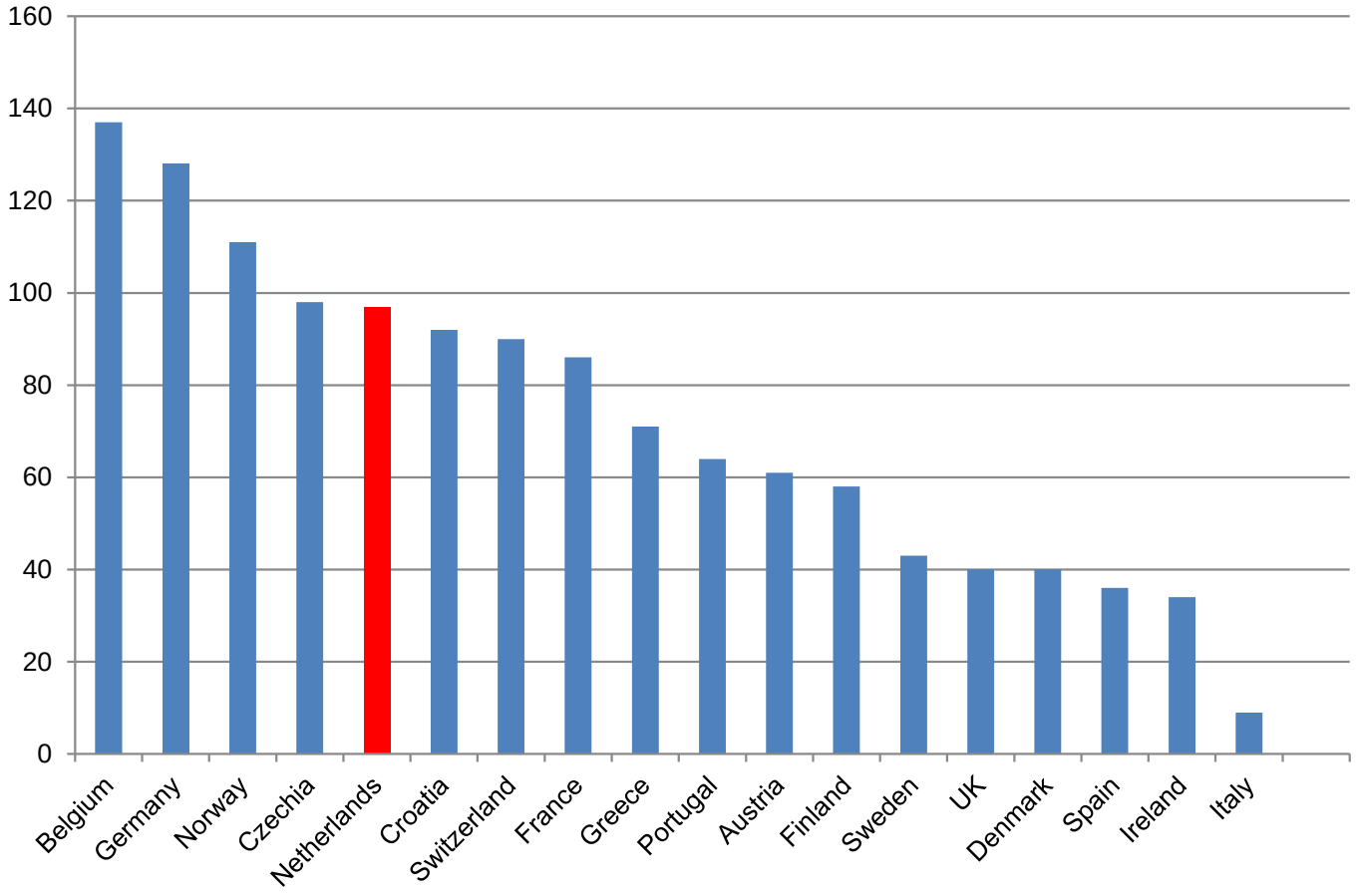
2009



Source: Eurostat

Psychiatric hospital beds in Europe
per 100.000 inhabitants

2016



Source: Eurostat

Deinstitionalization

- World-wide shift from institutions to community mental health
- High income countries 2017: 43% of mental health spending is on mental hospitals (WHO Mental Health Atlas 2017)

Deinstitutionalization

- Relative consensus about: closure, downsizing of hospitals
- Widely different solutions for: community-based services
- Many countries with poor implementation of assertive outreach across Europe

The case for integrated care

- Community is “ocean of resources”
- People with SMI suffer from interrelated mental, physical, social problems
- Even a perfect MH system with optimal prevention has sizeable numbers of long-term severely mentally ill
- Without priority these people get lost in the system, are underserved
- We need integrated care solutions on a personal, program and system level

Solutions for integrated care

From:

Adding a case manager / coordinator that provides access and monitors

(NO evidence base in psychiatry)

To:

All-in-one outreach, treatment and support (Assertive Community Treatment)

Why we developed FACT in the Netherlands

- ACT is for part of the population that needs integrated care. What about the rest?
- Smaller catchment areas to facilitate community connections (and implementation in rural areas)
- Integration of specialized evidence based treatment, recovery oriented care and basic support

Some Principles of FACT

- Assertive outreach
- Daily team meetings
- Priority mechanism to shift between individual case management and team-based care
- Treatment and support
- Flexibility in insourcing and outsourcing based on local situation
- Catchment area: 35k – 50k inhabitants

Flexible ACT team

- Caseload 1:15-20
- 200 clients (severe mental illness)
- 10-11,5 full time equivalents
- 1 psychiatrist
- 1-2 psychologists (closing the treatment gap)
- 4 (specialized) nurses
- 1-2 experiential expertise
- 1-2 vocational specialist
- 1 social worker
- Total costs: €1.300.000

Rapid spread

- First teams in 2005 in the Netherlands
- 300-400 teams in 2018
- Also specialized teams: forensic, youth, intellectual disabilities

- Facilitated by handbook, standard, national implementation projects
- Quality assurance through intercollegial certifying body (acknowledged by insurers, health inspectorate)
- Spread across Europe: Scandinavia (Denmark!), UK, Eastern Europe
- Biyearly European Assertive Outreach Conferences (Sep 5-7, 2019 in Verona)

Different ways leading to Rome: ACT in Hamburg

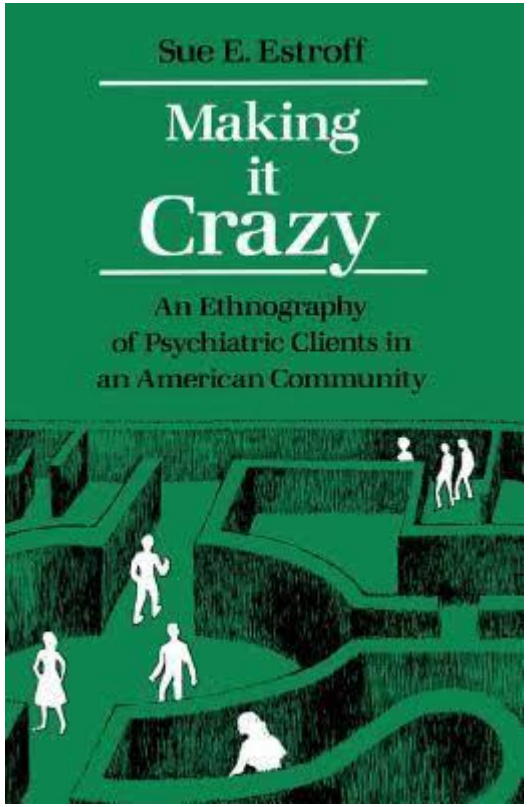
- Same intensity of services
- More input from psychiatrists and psychologists, less from nurses, experiential expertise, vocational specialist
- Partly practical reasons: cost and availability of disciplines

Challenge 1: inclusion

First ACT in Madison, Wisconsin:

Patients moved fro the hospital to an "inner psychiatric circle" within the community

→ Social inclusion, participation, overcoming stigma



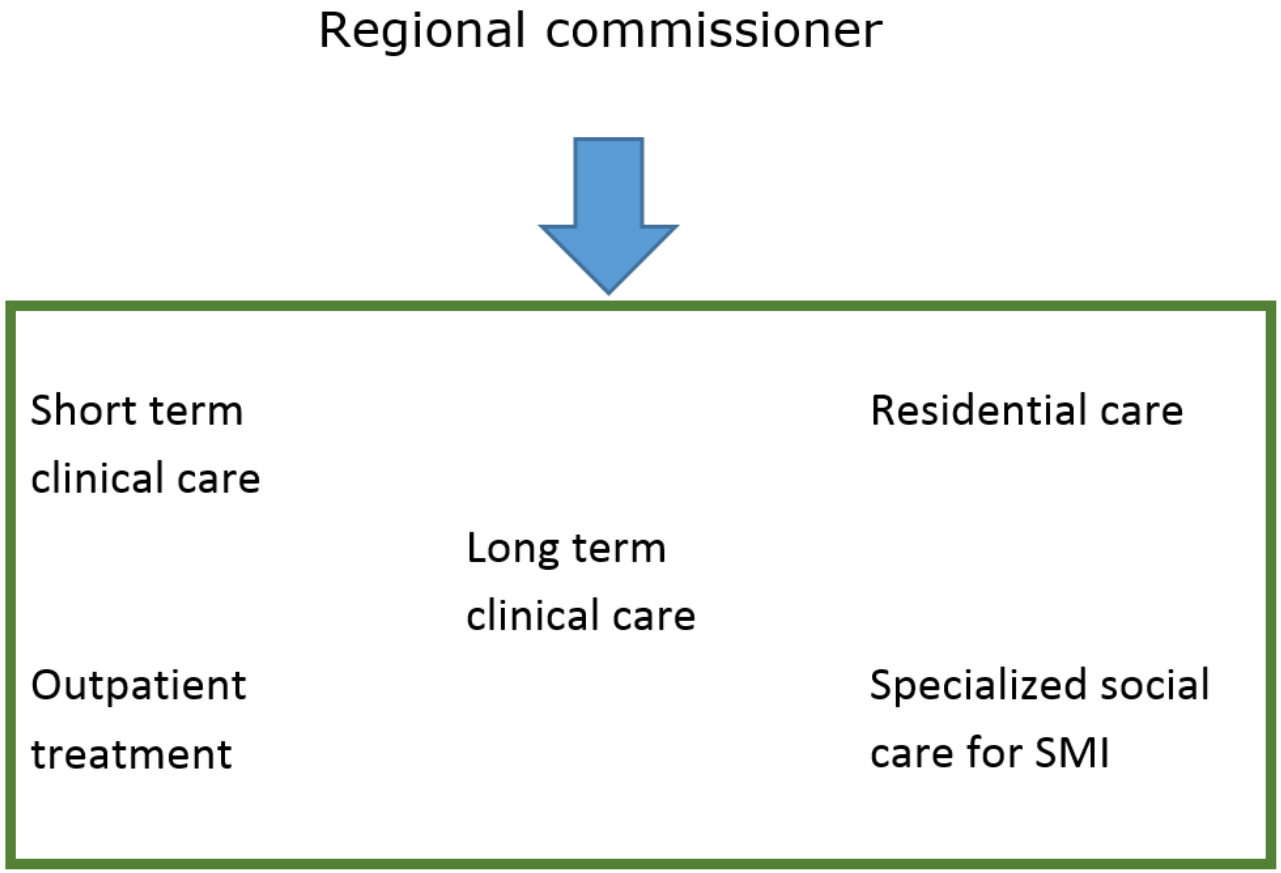
Finding the right local balance between

→ Networks of support (with risk of fragmentation and loss of priority)

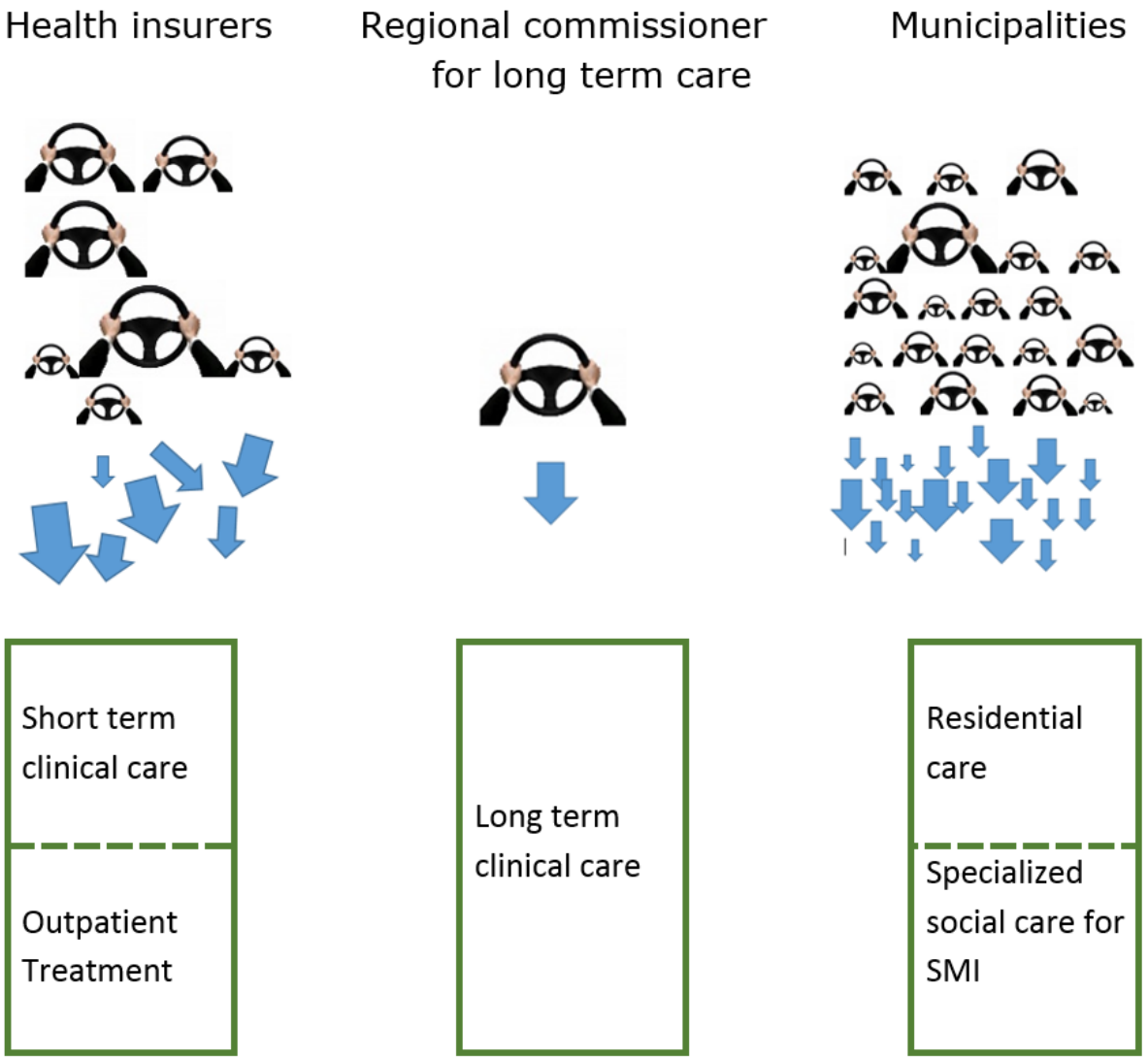
→ Integrated Mental Health teams (with the risk of a "psychiatric" bias)

Challenge 2: changes in the Dutch MH system

2006



2015: split between “treatment” and “care”



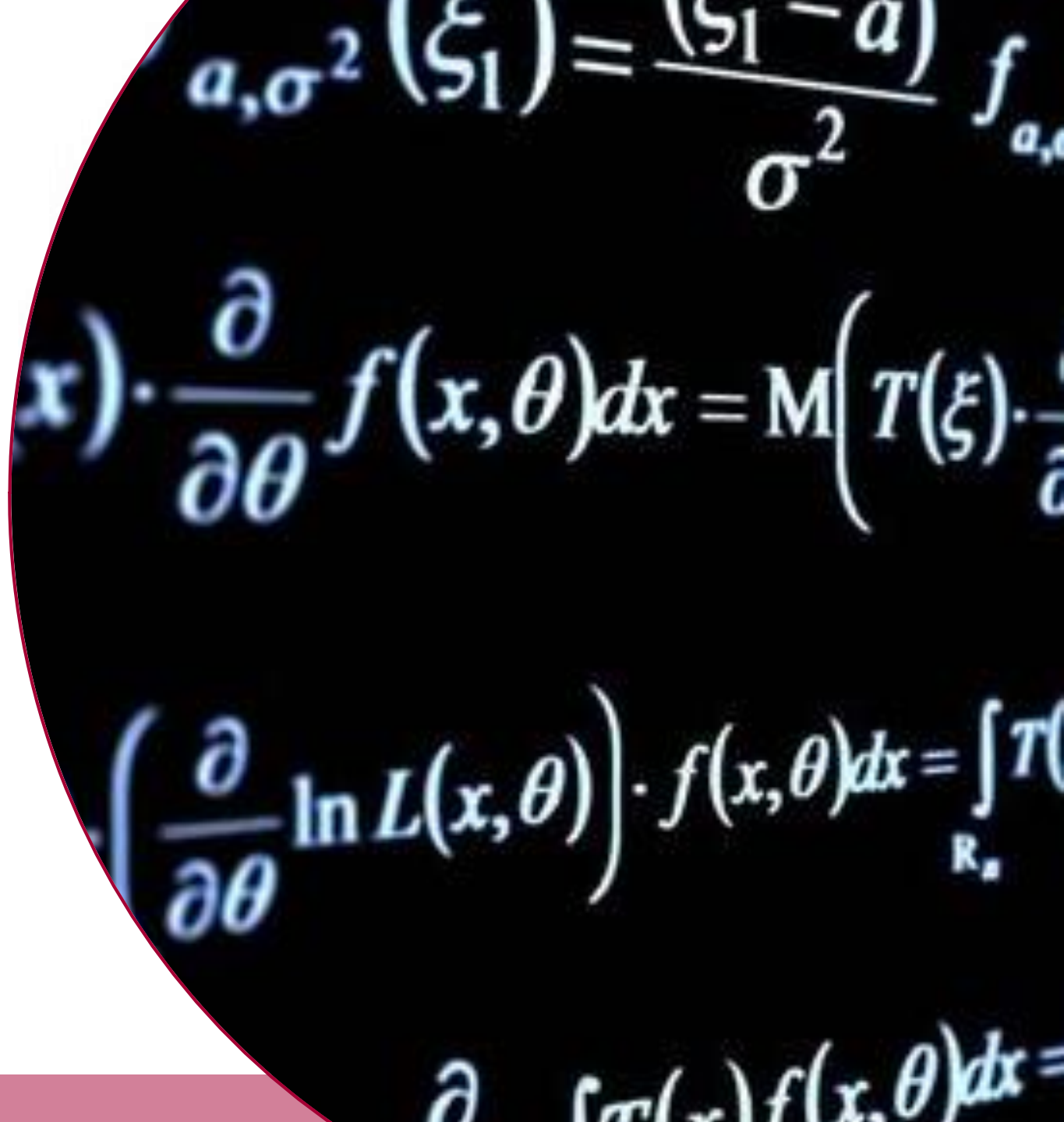
Issues in FACT

- Treatment and care are intertwined
- Insurers: what is the care part of FACT? (and should be paid by municipalities)
- Risk: services tend to be organized according to financial splits

Q&A

coffee
time

Panel Debate
Looking for the Magic Formula



Moderator: Claudia Marinetti, Director, Mental Health Europe

#futureMH2018 **#AIM20yearsBxl**

Panel Debate: Looking for the Magic Formula

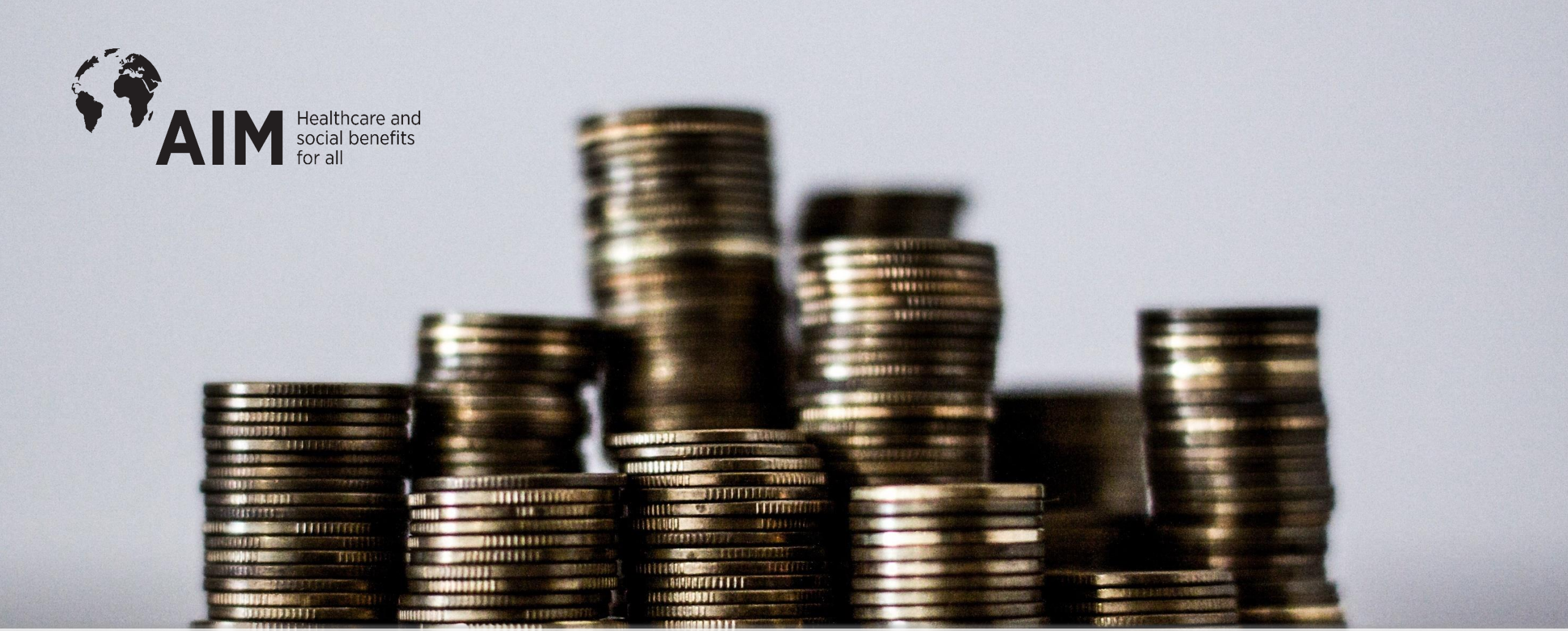
Panellists

- *Jacqueline Bowman, Policy Lead, Self-care Initiative Europe*
- *André Decraene, Board Member, European Federation of Association of Families of People with Mental Illness*
- *Pascal Garel, Chief Executive, European Hospital and Healthcare Federation*
- *Erich Koch, head of the self-administration/public relations department, Sozialversicherung für Landwirtchaft Forsten und Gartenbau (SVLFG)*
- *Annabel Seebohm, Secretary General, Standing Committee of European Doctors*

AIM Healthcare and social benefits for all

Deinstitutionalisation is being detrimental to the most vulnerable groups.

AIM Healthcare and social benefits for all



Widening the scope of reimbursed mental healthcare interventions would be financially unsustainable.

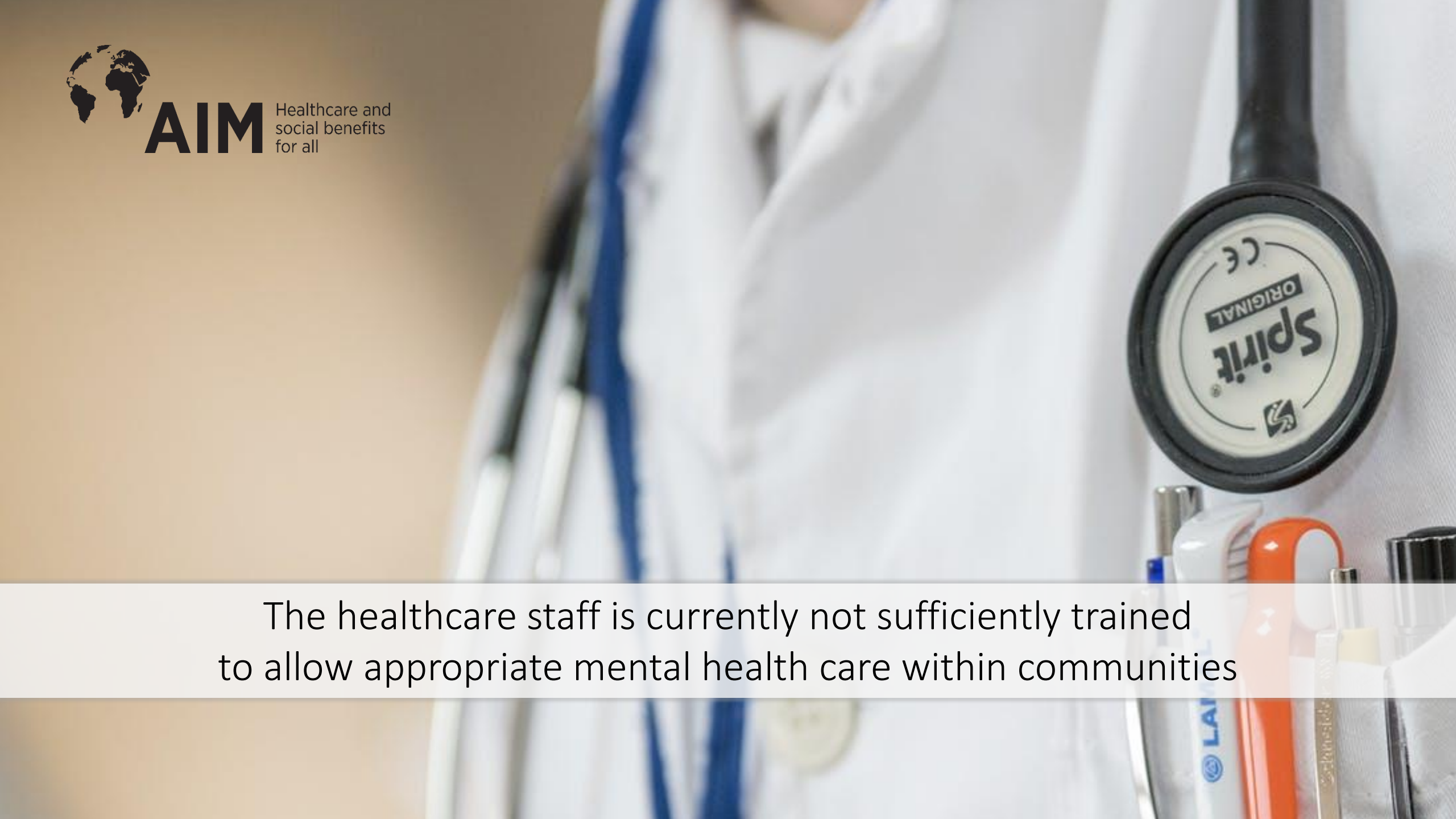
There is no such thing as mental health in all policies and there will never be.

AIM Healthcare and social benefits for all

A biomedical approach is the right way to keep treating people with mental ill health. Those diseases only require medical treatment.

The deinstitutionalisation trend has a clear negative impact on the health and well-being of informal carers.

AIM Healthcare and social benefits for all



The healthcare staff is currently not sufficiently trained to allow appropriate mental health care within communities

AIM Healthcare and social benefits for all

Investing in mental health promotion and prevention of mental ill health is a waste of resources: proof of effectiveness is unclear and it takes too long to be measured.

AIM Healthcare and social benefits for all

Healthcare payers' role, when it comes to mental healthcare, consists merely in reimbursing costs.

AIM Healthcare and social benefits for all

It is impossible to measure the quality of mental healthcare.

Conclusions

Closing remarks

Leo Blum

Chair of the AIM Health Promotion, Environmental Health and Disease Prevention Working Group

AIM Healthcare and social benefits for all

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