Mental health systems capacity in European Union Member States, Iceland and Norway
Abstract

WHO, with the support of the European Commission Directorate-General for Health and Food Safety and the Organisation for Economic Co-operation and Development, created a survey to explore the capacity of EU Member States, Iceland and Norway (29 countries) to promote mental health and prevent and manage mental health conditions. The survey also sought to identify the key challenges to and enablers of policies and health systems for improved prevention and management of mental health conditions. All countries responded to the survey. Nearly every country had a mental health policy or strategy in place, but implementation varied according to the policy area. The most common barrier to implementation was a lack of availability and coverage of the workforce, whereas the most common enablers concerned mechanisms for stakeholder cooperation and strong buy-in from said stakeholders. Recommendations for countries include scaling up capacity building for the mental health workforce and building policies with implementation in mind, including better monitoring and evaluation data.

Keywords

MENTAL HEALTH, POLICY, SURVEY, EUROPEAN UNION, ICELAND, NORWAY

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Executive summary

Mental health and well-being are directly affected by current geopolitical trends and emergent health-related events. Over the last few years, rapid technological change, a rise in living costs, the coronavirus disease (COVID-19) pandemic, the war in Ukraine and other events have underlined the importance of mental health. There is now widespread consensus that concerted, multisectoral action on mental health is needed across the WHO European Region.

Accordingly, in 2021 the WHO Regional Office for Europe proposed the European framework for action on mental health 2021–2025,1 an operational roadmap to increase knowledge sharing and collective action on transforming mental health systems through a pan-European Mental Health Coalition. The European Commission set out a comprehensive initiative to strengthen action on mental health across the European Union (EU) in 2023, including by integrating mental health into all relevant EU policies and maximizing the value of these policies at national and local levels.

To support this initiative, WHO, together with the European Commission Directorate-General for Health and Food Safety and the Organisation for Economic Co-operation and Development, created a survey to explore the capacity of EU Member States, Iceland and Norway (29 countries) to promote mental health and prevent and manage mental health conditions. The survey also sought to identify the key challenges to and enablers of policies and health systems for improved prevention and management of mental health conditions.

All countries responded. Nearly all (27 countries, 93%) had a national mental health policy in place. Two thirds (20 countries, 68%) were in the process of developing, updating or revising these policies. Although most countries were engaging in monitoring activities, about half (14 countries, 48%) requested support

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and capacity-building for these activities – particularly in evaluating the impact of policies. Among the most frequently reported enablers of implementation of these policies were having mechanisms for intersectoral cooperation in place, a high level of cooperation in the community, strong buy-in by mental health stakeholders and good budget allocation.

Policy implementation tends to be most fully realized in the area of mental health service delivery – especially acute psychiatric care and specialized community care. More than half the countries (16 countries, 67%) expressed a need for support in implementing policies to do with building capacity in the mental health workforce. Enabling mental health interventions in primary health-care settings was at least partially implemented by most countries, but work to build capacity of the general health-care workforce was lagging behind, with 12 of the 29 countries not having begun implementation. Similarly, a third of countries did not yet have policies addressing the integration of digital tools and technologies into mental health service delivery.

Since the start of the COVID-19 pandemic, 24 countries (82%) had undertaken a reorganization of mental health services or implemented significant changes within the service system; of these, 15 countries (54%) had undertaken this reorganization as part of larger social and health service reforms. Despite this, one in three countries (10 countries, 34%) reported not implementing policies related to emergency preparedness, response and recovery, and this was the third most common area where further support was requested. This suggests either that policies implemented during COVID-19 had lapsed or that countries had not yet been able to integrate them into larger emergency response policies.

Although most countries had fully or partially implemented policies aimed at promoting well-being and preventing mental ill health across the life-course – particularly in the area of suicide prevention, half (14 countries, 48%) still expressed a need for further support and capacity-building in this area. Further, 11 countries (38%) had not yet implemented policies addressing stigma and discrimination in mental health, which may harm preventive efforts. When it comes to particular population groups, about one third (10 countries, 34%) did not have policies supporting young people not in employment, education or training – a particularly vulnerable group.

Common barriers to implementation of policies were a lack of accessibility and coverage of the health and care workforce (15 countries, 52%), infrastructure insufficient for system needs (13 countries, 45%) and limited buy-in of people with lived experience of mental ill health and/or carers (11 countries, 38%). This last category may reflect tokenism in involvement in policy development and implementation, since 25 countries (86%) reported developing their policies with the involvement of people with lived experience of mental ill health and/or carers. It may also be linked to insufficient infrastructure and lack of coverage, both of which have implications for care continuity, and in turn may limit service user engagement.

It is encouraging that most countries had mental health policies or strategies in place. Recommendations for areas of focus for additional support include:

- expansion and capacity-building of the mental health workforce – particularly in supporting general health-care workers in mental health competencies;
- monitoring and evaluation of the impact of mental health policies and programmes – integrating policies to protect mental health in emergency preparedness, response and recovery;
- scaling up mental health prevention and promotion – particularly through engagement of people with lived experience of mental ill health; and
- designing policies with implementation in mind.
Survey background

WHO defines mental health as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (1). Broad geopolitical trends such as technological change and a rise in living costs have a direct impact on mental health, as do emergent humanitarian crises such as the coronavirus disease (COVID-19) pandemic and the war in Ukraine.

These emergent challenges are dovetailing with existing ones within mental health systems. Such challenges include difficulties in accessing timely mental health care, even for those with the most severe conditions: about one in four people with psychosis are not covered by mental health services. There were also worrying declines in mental health workforce numbers in the WHO European Region, from a median of 50 workers per 100 000 population in 2017 to 44.8 per 100 000 in 2020 (2). In a recent report, the WHO Regional Office for Europe identified the health workforce shortage as a “ticking time bomb” (3).

At a conference on the future of Europe in May 2022, European citizens highlighted mental health as a major concern. The European Parliament and Council have echoed these concerns, calling for action in this area (4). Moreover, the WHO Regional Office for Europe made mental health a priority area through its European Programme of Work 2021–2025 (EPW), developed in consultation with Member States in the Region, the European Commission and other non-State actors (5). Specific objectives of pressing concern for the Region were laid out in the European framework for action on mental health 2021–2025 (6), which aligns with both the EPW and the global comprehensive mental health action plan 2013–2030 (1). All three publications indicate the need for mental health systems that bridge sectors, taking into account the full range of needs and backed by strong, evidence-informed policy-making.

In her State of the Union address in September 2022, President of the European Commission Ursula von der Leyen called for a “comprehensive approach to mental health” (7). In response, the Commission announced a new initiative on mental health in June 2023, pledging €1.23 billion in funding across 20 flagship initiatives to “bring mental health on par with physical health”.

The WHO Regional Office for Europe was brought on as a contributing partner for the first of these flagships – the European mental health capacity-building initiative. Its aims are to integrate mental health into all relevant European Union (EU) policies and maximize the value of these policies at the national and local levels to promote mental health; to prevent poor mental health; to treat mental health conditions; and to deal effectively with the consequences. To this end, the Regional Office is planning national tailored policy dialogues aimed at identifying concrete solutions for implementation and measurement of policy, tailored to each country’s specific context.

To inform these policy dialogues, the Regional Office, together with the Organisation for Economic Co-operation and Development, developed a survey evaluating the current state of mental health policy in the 27 EU Member States, Norway and Iceland. Its objectives are:

- to identify the presence of a national strategic policy framework that provides a clear vision for the organization and delivery of mental health services and promotion of population mental health, and implementable, measurable strategies to achieve the vision;
- to determine the status of implementation and evaluation of national policy and identified barriers, enablers and priority areas for reform;
- to assess the alignment of national policy frameworks with relevant Member State-endorsed WHO regional and global policy guidance – specifically:
  - the EPW (5) and more specifically the European framework for action on mental health 2021–2025 (6);
  - the global comprehensive mental health action plan 2013–2030 (1);
  - the mental health policy reform toolkit (currently under consultation); and
- to identify the nature and strength of enabling structures, roles and functions in place to support mental health policy development, implementation, monitoring and sustainment, to improve the outcomes and impact of mental health policy at the service and population levels and to support the development and sustainment of a high-quality, effective and equitable mental health system.
Methods

The initial survey draft was developed by the WHO Regional Office for Europe using relevant sections from existing WHO tools, including the assessment instrument for mental health systems (8), the mental health Gap Action Programme situational analysis tool (9), proMIND profiles for mental health (in development), the mental health atlas (2), the PRIME Situational Analysis tool (10) and a situational analysis tool used by the WHO Special Initiative for Mental Health (11). All relevant health system terminology was defined in the survey text to improve response validity. Enablers explored by the survey are drawn from these WHO regional and global policy guidance and the health system performance assessment framework (12).

All 27 EU Member States, Iceland and Norway were invited to complete the questionnaire. The survey link was distributed to focal points at health ministries of the responding countries for completion in spring 2023. All 29 countries responded to the survey.

The purpose of the survey was to provide a description of the current status, content and governance of mental health policy within the responding countries; accordingly, quantitative analysis was limited to descriptive statistics (numbers and percentages). A basic content analysis was conducted to code and categorize qualitative data concerning national mental health priorities. Categories were inductively derived from repeated readings of the text. Where necessary, text was translated into English from the national language.

Discussion of limitations

The survey instrument design allowed for multiple responses for some items and/or for the input of qualitative data, which led to some inconsistencies between quantitative and qualitative responses. Other survey questions allowed selection of multiple responses in ways that made it difficult to deduce a potential underlying causal effect. For instance, where countries indicated that partial implementation of policies and programmes was taking place in a key area, it is impossible to deduce whether the key area was included in relevant policies, strategies and action plans or not.

With respect to the quality of the responses, the individuals who reported the results on behalf of countries, how this individual/unit was selected to respond, and what kind of review and approval (if any) the responses went through before submission could all have substantial effects on the quality of the responses received. The data quality might be also improved by allowing other stakeholders (such as academics, civil society and service providers) to respond to the survey. This would greatly increase the amount of data and analysis required, but could be considered in future administration of surveys, if/when appropriate, and if resources allow.
Results

Block 1: policy status

1. A Presence of a national strategy

All but two countries (27, 93%) had a national mental health policy in place. Further, 25 countries (86%) had a strategy or action plan in place to guide implementation, 12 of which delegated authority to regions or local areas for developing and implementing the mental health policies/plans. Over two thirds of countries (20, 68%) reported that their policy, plan or strategy was in the process of being developed, updated or revised. Similarly, 20 countries (68%) reported that the policy clearly mentioned objectives and indicators that allow for regular monitoring and evaluation.

The top three mental health priority areas identified by countries were diversifying where mental health care is offered – for example, in communities (17 countries, 59%); mental health promotion (14 countries, 48%); and improving capacity (11 countries, 38%). Fig. 1 shows the top priority areas (identified by 6–17 countries) in detail.

Fig. 1. Most frequently cited priority areas in mental health (n = 29)

Priority areas cited by only one or two countries included “Improving the social determinants of mental health” (2 countries, 6.8%), “Emergency preparedness” (1 country, 3.4%) and “Continuity of care” (2 countries, 6.8%).

In addition, 18 countries (64%) had a programme or mechanism in place for facilitating cross-departmental mental health policy development and/or implementation.
1.B Implementation evaluation and revision

Of the 27 countries that had a national mental health policy, strategy or action plan in place, two thirds (19 countries, 70%) had undertaken an evaluation of current or previous strategies or action plans, and 20 (74%) were conducting monitoring activities – either within or outside the framework of the policies. Of the 19 countries that had undertaken an evaluation of current or previous national mental health policies, strategies or action plans, 14 (74%) had evaluated the extent of implementation, and 12 (63%) had evaluated the effectiveness, outcomes or impact.

Roughly two thirds of countries (20, 69%) that had a national mental health policy, strategy or action plan in place reported enablers or barriers/challenges to policy implementation. Of those, the most frequently cited enablers were “Mechanisms in place” (11 countries, 55%), “High level of community cooperation and interaction” (11 countries, 55%), “Strong buy-in of mental health sector stakeholders” (11 countries, 55%), “Budget allocated” (10 countries, 50%) and “Strong leadership and prioritization for mental health policy implementation” (10 countries, 50%).

The most frequently cited barrier was “Limited availability and coverage” (15 countries, 75%), followed by “Infrastructure insufficient for system needs” (13 countries, 65%) and “Limited buy-in and involvement of people with lived experience/families/carers” (11 countries, 55%). Fig. 2 shows the full breakdown of barriers and enablers.

Fig. 2. Enablers of and barriers to policy implementation (n = 20)

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2 This subsection does not include a summary of the results from qualitative survey questions 1.G (“Which agencies or institutions are responsible for implementation of national mental health policies and/or plans?”) and 1.H (“Which agencies or institutions are responsible for evaluation of implementation and revision (as necessary) of national mental health policies and/or plans?”) since the survey did not require respondents to answer these questions. Further analysis of the responses received could be undertaken as needed.
Since the start of the COVID-19 pandemic, 24 countries (82%) had undertaken a reorganization of mental health services or implemented significant changes within the service system. Of these, 15 countries (54%) had undertaken this reorganization as part of larger social and health services reforms, while 8 countries (29%) had done so with a focus only on mental health services.

**Block 2: policy content**

**2.A Mental health services**

The category for which most countries reported full implementation was mental health service delivery – particularly specialized care. Half of the participating countries (15, 52%) had fully implemented policies related to "Enabling acute psychiatric care to be delivered in general hospital settings", and one in three (11 countries, 38%) had fully implemented policies related to "Enabling specialized mental health services to be delivered in community settings“ (Fig. 3). The majority of countries had achieved at least partial implementation, at either the national or regional/subnational levels.

Only two countries (Belgium and Norway, 7%) reported full implementation for "Enabling integration of digital technologies and tools into mental health service delivery”. Moreover, seven countries (24%) had not yet addressed this area in policy. Of the 15 countries (52%) that reported at least partial implementation, digital technologies were mostly used in specialist (13 countries, 87%) and primary health care (12 countries, 80%), followed by community settings (9 countries, 60%) and finally awareness-raising and mental health literacy (8 countries, 53%) and self-care and self-management (8 countries, 53%).

In the area of mental health workforce and human resources, the results showed a similar picture, with most countries reporting (at least) partial implementation at various levels (Fig. 4). In the case of national guidelines to support mental health workforce skills and competency, 13 countries reported full or partial implementation (45%) and 13 reported having not started implementation. Workforce recruitment appeared the most fully addressed, with 17 countries (59%) reporting implementation at the regional or national level.
Fig. 4. Implementation status of policies in key areas of mental health workforce and human resources (n = 29)

- **Presence of national guidelines to support mental health workforce skills and competency**
  - Unsure/other: 3
  - Addressed in policy, but not implemented: 3
  - Partially implemented (either regional or national): 10
  - Fully implemented: 7

- **Building capacity in mental health for the general health workforce**
  - Unsure/other: 3
  - Addressed in policy, but not implemented: 5
  - Partially implemented (either regional or national): 7
  - Fully implemented: 9

- **Supporting systematic analysis and planning for the mental health workforce**
  - Unsure/other: 3
  - Addressed in policy, but not implemented: 3
  - Partially implemented (either regional or national): 8
  - Fully implemented: 11

- **Supporting workforce recruitment and retention**
  - Unsure/other: 1
  - Addressed in policy, but not implemented: 4
  - Partially implemented (either regional or national): 7
  - Fully implemented: 14

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Fewer than half of the countries (13 countries, 45%) reported having a national quality framework or quality indicators for mental health services to guide credentialing processes, including monitoring and evaluation and quality improvement activities. In contrast, 16 countries (55%) had included/implemented mental health quality indicators in other health-care or population health monitoring systems, and 10 countries (34%) reported having both national quality indicators and indicators embedded in other health monitoring systems.

### 2.B Integration of mental health into emergency preparedness, response and recovery

Compared to policy related to mental health services, fewer countries reported full or partial implementation of policies related to mental health in emergencies (Fig. 5). Only two countries (Cyprus and Norway, 7%) reported full implementation of policies in this area, both for embedding mental health and psychosocial support in public health emergency response plans, and for strengthening mental health resilience in communities as a part of emergency response and recovery. Fewer than half of countries reported at least partial implementation: 13 countries (45%) reported it for embedding mental health and psychosocial support in emergency response plans, and 12 countries (41.3%) for strengthening mental health resilience. These results may indicate that policies implemented during COVID-19 had lapsed or that countries had not yet been able to integrate them into larger emergency response plans. The qualitative responses do not shed much light on why implementation is lacking: countries reported either that policy was to be included in a future strategy or that small-scale training sessions had been conducted.

Fig. 5. Implementation status of policies in key areas of integration of mental health into emergency preparedness, response and recovery (n = 29)

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- **Embedding mental health and psychosocial support as an integral, cross-cutting component of public health emergency response plans**
  - Unsure/other: 6
  - Addressed in policy, but not implemented: 4
  - Partially implemented (either regional or national): 6
  - Fully implemented: 11

- **Strengthening mental health resilience within communities as part of emergency response and recovery actions**
  - Unsure/other: 5
  - Addressed in policy, but not implemented: 5
  - Partially implemented (either regional or national): 7
  - Fully implemented: 10

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2.C Mental health promotion/prevention and resilience over the life-course

Most of the countries surveyed had begun implementation of mental health policies and programmes in key areas related to mental health promotion and resilience over the life-course (Fig. 6). This area also had the lowest numbers of countries reporting no implementation. Suicide prevention policies were among the most advanced, being present and implemented in 23 countries (79%). Among these, the majority (18 countries, 78%) had also implemented programmes to address after-care for individuals who have attempted suicide.

Policies targeting children, adolescents and young people had begun implementation in the majority of countries. For children and adolescents up to 19 years of age, 23 countries (80%) had either partially or implemented policies, while 21 countries (72%) had done so for young people aged 15–24 years. Programmes improving mental health awareness and literacy were also well implemented: 22 countries (75%) reported partial or full implementation of policies.

Areas where countries had the lowest levels of implementation were policies or programmes tackling mental health stigma and discrimination and mental health of older adults. About one in three (11 countries, 38%) had not begun implementation of the former. That said, the majority of countries reported (at least) partial implementation in these areas.

Fig. 6. Implementation status of policies in key areas of mental health promotion/prevention and resilience over the life-course (n = 29)

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Total Countries</th>
<th>Unsure/Other</th>
<th>Addressed in policy, but not implemented</th>
<th>Partially implemented (either regional or national)</th>
<th>Fully implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting suicide prevention</td>
<td>29</td>
<td>5</td>
<td>12</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Supporting and promoting mental health of children</td>
<td>29</td>
<td>4</td>
<td>7</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>and adolescents (aged up to 19 years)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Supporting and promoting mental health of young people</td>
<td>29</td>
<td>4</td>
<td>12</td>
<td>12</td>
<td>0</td>
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<tr>
<td>(aged 15–24 years)</td>
<td></td>
<td></td>
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<tr>
<td>Supporting mental health in educational settings</td>
<td>29</td>
<td>4</td>
<td>12</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Supporting mental health of older adults</td>
<td>29</td>
<td>4</td>
<td>12</td>
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<td>0</td>
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<tr>
<td>Improving mental health awareness and literacy</td>
<td>29</td>
<td>4</td>
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<tr>
<td>Addressing mental health stigma and discrimination</td>
<td>29</td>
<td>4</td>
<td>12</td>
<td>12</td>
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2.D Policies and programmes relating to specific population groups

The majority of countries reported full or partial implementation of policies and programmes for specific population groups, including young people who are not in education, employment or training (NEET countries) (13 countries, 45%); migrants, refugees and asylum seekers (19 countries, 66%); and incarcerated/detained people (17 countries, 59%) (Fig. 7). Of these groups, young people who are NEET appear to receive the least attention in policy: about one in three countries (10, 34%) reported that this group was not specifically addressed in policies or programmes.

Five countries (17%) – Austria, Belgium, Cyprus, Greece and Norway – reported that they had also fully implemented policies and programmes to address the mental health of other identified population groups, including men; women (particularly those with perinatal mental health problems); adolescents with psychosocial problems; people with autism or other specific mental disorders; and Roma population groups. One country (Portugal) did not answer this question.
2. E Policies and programmes relating to specific conditions

All but one country (Italy) reported on policies and programmes relating to specific conditions. Policies and programmes covering dementia were implemented either fully or partially in the majority of countries (21, 75%). A not insignificant number of countries (as high as one in three in the case of neurological disorders and/or brain health) reported being unsure about the existence of policies or programmes for specific disorders. This may be due to confusion over whether to count the activities of nongovernmental organizations (NGOs) offering such services, or it may suggest that programmes are implemented on a relatively small scale.

Four countries (14%) – Cyprus, Germany, Greece and Norway – reported that they had also fully implemented policies and programmes to address other specific conditions, such as autism, depression and eating disorders. Information on this topic was missing from two countries (Italy and Portugal).

2. F Areas identified requiring further capacity-building and support

Countries were also asked whether there were any specific areas where they required further support to identify and implement actions to promote good mental health and to improve prevention and management of mental health problems. Countries’ answers to this question shed further light on the results above. The top four areas for which countries reported requiring further support included *Mental
Results

health workforce planning and/or capacity-building” (16 countries, 67%), “Monitoring and evaluation of mental health policy” (14 countries, 58%), “Mental health promotion/prevention and resilience over the life-course” (13 countries, 54%) and “Integration of mental health into emergency preparedness, response and recovery” (13 countries, 54%). Fig. 9 shows the full list of answers to this question.

Fig. 9. Policy areas requiring further support and capacity-building (n = 29)

Block 3: governance and other enablers

Enablers explored in these questions were drawn from relevant WHO regional and global policy guidance including the WHO European framework for action on mental health 2021–2025 (6), the global comprehensive mental health action plan 2013–2030 (1), the EPW (5) and the health system performance assessment framework (12).

The majority of countries (26, 90%) reported developing or updating their national health policies, strategies, plans, guidelines or laws with the broad participation of key stakeholders. Such stakeholders ran the full gamut of professional and sectoral representation, ranging from “Cross-sectoral government stakeholders – education sector, community/social welfare sector, finance/treasury, employment/training” (26 countries, 93%) to “People with lived experience/service users” (25 countries, 89%), “Academia” (24 countries, 86%), “Civil society organizations” (23 countries, 82%), “Workforce representatives” (22 countries, 79%) and “Families and carers of people with lived experience” (21 countries, 75%).

Most countries reported having mechanisms and dialogue platforms in place to ensure involvement of key stakeholders in mental health policy development/review processes, such as an advisory institution, agency or other body established to provide strategic mental health policy and/or technical advice to government (21 countries, 75%). Such agencies were either situated within government departments (9 countries, 31%) or independent (11 countries, 38%). Surprisingly, these advisory bodies actively recruited people with lived experience and/or carers/family members to participate in only a few countries (8, 28%). In contrast, well over half of responding countries had a national group or network for mental health service users/people with lived experience (18 countries, 64%) and/or a national mental health carers group or network (16 countries, 57%) in place. To what extent these networks work with government agencies is unclear.

The vast majority of countries (22, 79%) enacted mental health legislation at the national level; five countries (18%) enacted it at both the national and regional levels. Well over half of countries (61%) had not conducted an evaluation of the impact of the country’s mental health legislation.
Conclusions

It is encouraging that most of the participating countries had national mental health policies or plans in place, and appeared to be actively updating or revising them, especially since the start of the COVID-19 pandemic. In other words, many of the countries appeared to be aware of the strengths and weaknesses of their policy landscape in the area of mental health, and were actively working to change them to align with the needs and preferences of their populations.

Implementation was strongest in the area of mental health services – especially in delivery of acute and specialized community care. Policies related to protecting mental health across the life-course were often future-oriented, focusing on suicide prevention and supporting the mental health of children, adolescents and young people. Participation of key stakeholders in policy development was widespread, including people with lived experience of mental ill health and caregivers. Implementation of these policies was being supported by enablers like strong leadership and the buy-in of various mental health sector stakeholders. Working across government departments to develop and implement these policies appeared to be the norm rather than the exception. All these results suggest that basic infrastructure is in place for enacting a comprehensive approach to mental health.

However, the survey highlighted a number of areas where policy-makers and mental health stakeholders should devote particular attention in order to translate those policies into practice, which in turn can improve population mental health.

- **Policy-makers should adopt a focus on prevention rather than reaction when developing or updating policies.** A medical perspective remains predominant, given that mental health service delivery is where most countries have achieved full policy implementation. Preventive interventions, including those addressing the social determinants of mental health, are widely considered to be among the most effective public mental health interventions (13). However, only 10 countries (34%) considered early detection and prevention a priority. Moreover, only two countries (6.8%) prioritized the social determinants of mental health. There are also gaps in protection of particularly vulnerable groups, such as young people who are NEET: a third of countries reported that they had not addressed or implemented mental health policies specific to this group. It is important that policy-makers build in a preventive perspective in mental health policies, especially for vulnerable groups.

- **Monitoring and evaluation activities should cover the impact of policies and legislation.** While a number of countries had conducted evaluations of their mental health policies, plans or strategies, such evaluations appear to have focused on extent of implementation as opposed to impact. Moreover, few countries have evaluated the impact of mental health legislation. Monitoring and evaluation of policies and plans was also one of the top areas where countries requested further support and capacity-building. These findings also indicate that countries may be in the process of determining what meaningful impact looks like in their specific contexts.

- **Countries may need more time to synthesize lessons from ongoing emergencies.** While most countries had begun to reorganize their mental health services since the COVID-19 pandemic, about half indicated that they required further support and capacity-building in making mental health a part of emergency preparedness, response and recovery plans, and overall the lowest number of countries reported full implementation. Given the succession of crises in the WHO European Region over the past three years, many countries may have focused their attention on the “response” phase of emergencies as opposed to preparedness or recovery. In other words, countries may need support in integrating interim measures into the development of their mental health systems.

- **People with lived experience of mental ill health should be included, not just involved.** Among the major barriers to implementation were limited buy-in of people with lived experience of mental ill health and/or carers, infrastructure insufficient for system needs, and a lack of accessibility and coverage. These illustrate that mental health systems are not aligned with the needs and preferences of the people who require support or with the interests and capacities of stakeholders in sectors who are responsible for implementation of policy. Moreover, while almost all countries reported involving people with lived experience in policy development, this may not extend past one-off consultations with service users or their networks. Tokenism may still be the dominant mode of engaging with these key stakeholders.
- **Enabling mental health interventions in primary health-care settings must be backed by a strong workforce.** While most countries had enabled mental health interventions to be delivered in primary healthcare settings, building capacity of the general health-care workforce was lagging behind: a third of countries reported not having begun implementation, and this was the top area for which countries requested support. In addition, one of the most common barriers to implementation was the lack of availability and coverage of the workforce. This reflects broader concerns for European countries about the need to curb the decline in the mental health workforce. The 2022 WHO report on the health and care workforce (3) listed 10 actions aimed at addressing this shortage. These actions include strengthening continual professional development and investing in education of the workforce, which would include training general health-care providers to provide mental health care and investing in the professional development of people with lived experience of mental ill health to act as peer supporters within health-care contexts.

- **Policies should be designed with implementation in mind.** Policy-makers should identify and address potential barriers from the earliest stage of policy development. They should also incorporate feasible objectives and strategies that account for contextual factors including workforce capacity, funding availability and the needs and preferences of key stakeholders including people with lived experience of mental ill health and health-care staff.
References


3 All references accessed 4–5 March 2024.
The WHO Regional Office for Europe

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