



"Mental Health Information and Determinants for the European Level (MINDFUL)"

Interim technical implementation report
13 May 2005

Agreement Number 2003119 between the Commission of the European Communities and the
National Research and Development Centre for Welfare and Health (STAKES), Finland

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1. AIMS AND OBJECTIVES

MINDFUL - "Mental health information and determinants for the European level" is a large-scale project co-funded by the European Commission (between 15 March 2004 and 15 March 2006) from the health information and knowledge strand of the Community action programme in the field of public health.

The goals of MINDFUL are:

- *to improve the level of mental health information within the EU* and
- *to produce a proposal for a comprehensive mental health information system for the EU.*

MINDFUL aims at widening remarkably the scope of contemporary mental health monitoring. The project consists of seven **partnership projects** each with an independent leader and collaborators in different EU Member States.

The work is firmly based on previous projects (funded from the Health Monitoring Programme of the EC), and it also links with many of the ongoing projects (co-financed from the Public Health Programme 2003-2008). The project's modular structure allows effective parallel development in a multitude of different areas.

The partnership projects focus on:

- (1) analysing determinants of mental health and mental ill-health from existing sources;
- (2) exploring and develop the relevant information systems in the new Member States;
- (3) establishing a system for monitoring the impact of policies and programmes promoting mental health;
- (4) offering a training programme for the implementation of mental health promotion and prevention interventions;
- (5) establishing a system to monitor service utilisation data;
- (6) developing the contemporary survey and reporting methods; and
- (7) refining the set of mental health indicators and setting up the MINDFUL database.

All partnership projects will produce their individual reports at the end of the project. However, a proposal for a comprehensive mental health monitoring system can be regarded as the main outcome of MINDFUL. This proposal, tentatively entitled "MINDFUL report" (draft contents outlined in Annex 2), will summarise and bring together all of the work conducted in MINDFUL and pave the way for further development in this area.

2. CO-ORDINATION OF THE PROJECT

2.1. General issues

The official starting date of the project was 15th of March 2004 with a duration of 24 months.

STAKES, as a main beneficiary of MINDFUL, has been responsible for the co-ordination (including the general administration and financial issues) of the project.

This work has included, first of all, the budget negotiations¹, contract preparation (with the six associated beneficiaries) and communicating the relevant information to the partnership project leaders. Secondly, preparation of the project leader meetings (including practical arrangements) and the background material has been the task of the co-ordinating institution.

All associated beneficiaries have been responsible for the work that has been carried out within the partnership projects. They have worked rather independently with their partners and reported on the progress in the meetings.

As an integral part of the dissemination of information of the project, a website has been opened for the project in STAKES (<http://www.stakes.fi/mentalhealth/mindful.html>).

2.2. Meetings

Two meetings of the project leaders have been organised during the first year: the first one took place in Helsinki on 26-27 March 2004, and the second in Barcelona on 19-20 November 2004.

The Helsinki inaugural meeting concentrated on outlining and refining the contents of the project in general, and on discussing in detail the contents and work plans of all partnership projects. Considerable time was also spent on discussing and defining the obvious synergistic nature between the partnership projects. At the end, this meeting resulted in major reallocation of the budget between the partners.

Hence, the first meeting provided a timely chance to still sharpen the focus of the project with regard to the past achievements as well as in view of ongoing and future developments.

The second meeting was used as a checkpoint for monitoring the progress of MINDFUL. The meeting also offered an opportunity to introduce corrective measures with a view of some of the projects involved.

2.3. Working party on mental health

Besides the co-ordination task and carrying out one of the partnership projects, the personnel in STAKES has also been active in operating the Working Party on Mental Health, established under the auspices of the Health information and knowledge strand of the Public Health Programme. The project leader, Prof. Kristian Wahlbeck was elected the chair of the Working party and the project manager, Dr. Juha Lavikainen has acted as the secretary of this body.

One WP meeting has been held within the period of the MINDFUL project.

¹ Due to a derogation, the project was able to start before there was a signed agreement between the Commission and STAKES.

3. OUTCOMES AND FUTURE PLANS

3.1. Results

Taken as a whole, the project has proceeded as planned, although in the beginning, some major adjustments with regard to the duration and budgets had to be made. Despite of this, no significant deviations have or are expected to occur with regard to the initial work programme. At this point it is foreseen that the work can be performed in the anticipated timeframe of two years.

Outcomes of the first year of the MINDFUL project are specified in the individual reports of the seven partnership projects (Annex 1).

In view of the expenditure during the first year, approximately one third of the total budget has been used (see the separate Consolidated financial statement for a detailed description). Up until now, there is a certain imbalance between the percentage of the Commission share compared to that of the partners, but this is expected to be corrected during the second year of the project.

3.2. The way forward

The next meeting of the project leaders will be held in Helsinki, on 10-11 June 2005. In this meeting, detailed plans will be presented and discussed for carrying out the work during the remaining period. The fourth meeting has already been agreed to be held in Vienna, on 18-19 November 2005.

Selected parts of the MINDFUL report will be prepared for the next meeting where they will be presented. The purpose is to motivate all writers (basically the partnership project leaders) to produce their chapters such that the report, a result of a joint effort, would be finished already before the end of the project.

A joint meeting between MINDFUL (the people in STAKES) and ECHIM (a successor of the ECHI and ECHI2; co-ordinated by the National Public Health Institute of Finland) has been agreed to take place in Helsinki in early summer.

In general terms, it is of utmost importance that the generic developments within the EC health monitoring arena will be followed. The Working Party on Mental Health provides a feasible arena for such purposes (next meeting will be in Luxembourg on 30-31 May 2005)

Individual reports of the partnership projects will be prepared and publicised in the MINDFUL website around the end of the project.

The preparations for the final implementation report will start in due time after the official ending date (15 March 2006) of the MINDFUL project.

ANNEX 1

Reports of the partnership projects

Determinants of Mental Illness; University of Leicester

First year Report; March 2005; Tom Fryers & Terry Brugha.

Summary of Aims.

A review of evidence currently available linking early factors to the incidence, duration or recurrence of mental illness in European populations.

- To search existing literature for evidence of factors affecting the frequency and degree of important mental disorders.
- To focus especially on childhood factors.
- To examine longitudinal data sources, especially from EU populations.
- To identify factors that might be amenable to individual or population intervention to prevent mental disorder and promote mental health.

Summary of Activities.

The following summarises action undertaken mostly by Prof, Tom Fryers, Chief Investigator, and Prof. Traolach Brugha, Project Director, with the assistance of secretarial, financial and librarian colleagues.

- agreeing the revised budget and project protocols
- agreeing the contract and receiving the first funds
- attending MINDFUL meetings in Helsinki and Barcelona
- gaining agreement of four partners in other countries
- informal agreements and meetings with UK colleagues
- attendance at Bristol conference on longitudinal studies
- planning first meeting of partners
- follow-up of international and national contacts
- co-ordinating local contacts and co-workers
- interrogation of the literature
- exploring potential of identified longitudinal data-sets.

Partners.

Four European colleagues agreed to be partners in this project, because of their experience in the field and /or they had close links to longitudinal data-bases which might be useful in the research. Attempts to involve a colleague from Poland as a new EU member state, have, as yet, failed, but we shall try to restore contact and involve them in one way or another.

It was our intention to meet with partners in Leicester early in 2005 to discuss the underlying issues, the potential of longitudinal data, and the possibilities of getting information on programmes of mental health promotion and mental illness prevention in their countries. The delay in the contract and funding arrangements meant delaying the meeting, but dates were offered in March or April 2005.

However, arrangements for such a meeting are proving difficult to complete, so we are having to re-think our work with partners at this stage, which will be pursued by e-mail and telephone, with

individual meetings if appropriate. A later meeting, as planned, may be offered in a more convenient location.

Meetings.

The two meetings organised in Helsinki and Barcelona by STAKES for the six projects within the programme were very successful and helpful in appreciating the EU conditions of research, in clarifying difficult issues, in learning of each others project design and progress, and in making useful professional contacts and links.

The Bristol conference of the International Federation for Psychiatric Epidemiology in September 2004 had a major focus upon longitudinal studies and life-course research in Psychiatry, so was peculiarly relevant to our project. Many papers were extremely useful in this context, but more useful still was the wide range of personal contacts and discussions related closely to the current project.

A formal meeting was also held in Leicester with Prof. Sarah Stewart-Browne and colleagues of Warwick University whose principle research interest is evaluation of programmes of mental health promotion and mental illness prevention. Contacts and collaboration are continuing.

Informal meetings have also been held with several colleagues in Leicester, other UK, other EU, and USA centres.

Through these meetings, telephone conversations and e-mail discussions, we have explored many of the intellectual issues relevant to the project.

Interrogating the literature.

To select key factors, major literature searches have been undertaken:

1. A reference data-base of almost 1000 references relating to the distribution of adult mental illness according to various indicators of social disadvantage created for a UK Government project was searched for those pertaining to the more specific associations with childhood factors.
2. A list of known researchers and authors, especially concerned with known longitudinal data-sets, was created from earlier literature searches and personal enquiries at the Bristol meeting and elsewhere.
3. A new library search was made of the available international reference data-bases for published literature relating to early determinants of mental illness in adults, based upon the author list.
4. 1286 references were identified and, for all these, abstracts were read, selecting over 150 papers for full perusal. This is now on-going.

Longitudinal data-sets.

From personal contacts, meetings and literature, we have established a list of longitudinal data-sets which may hold potential for informing us on the early determinants of adult mental illness.

The process of making personal contact with the chief researchers holding longitudinal data-sets has now begun. We are exploring initially the parameters of the original cohorts, such as sample size and follow-up programmes; the content of the original cohort data-sets and their subsequent follow-ups in respect of measures of mental health or mental illness in adults, and possible ameliorable factors in childhood; the accessibility of data and the potential and administrative constraints on external users.

Equipment: A computer and associated equipment has been purchased.

**EU PROJECT MINDFUL
SLOVENIAN PARTNERSHIP PROJECT**

**»EXAMINING THE MENTAL HEALTH MONITORING SYSTEMS IN THE
NEW EU MEMBER STATES«**

**INTERIM REPORT
FOR THE PERIOD FROM 15/03/2004 TO 15/3/2005**

Ljubljana, 1 April 2005

dr. Andrej Marušič, dr. Tanja Kamin

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I. Intermediate results; accordance of the project with the proposed project schedule

1. PROPOSED STAGES OF THE PROJECT (The tasks in the project plan)

Implementation of the project has involved the following tasks as stated in the Project Plan:

- Invitation for experts from different countries to join the project (10/2004)
- Meeting with project participants (11-12/2004)
- Getting familiar with the mental health data systems in participating countries, preliminary remarks
- Invitation to survey (2/2005)
- Organization of second three day meeting (3-4/2005)
- Preparation of interim reports (3/2005)

2. MANAGEMENT OF PARTNERSHIP PROJECT (Activities to organize the project and establish our network)

1. The project action plan including time schedule and budget plan has been defined according to the contract between STAKES and The Institute of Public Health of the Republic of Slovenia.
2. For the **project coordinator** dr. Tanja Kamin has been appointed in October 2004. The core project team has been given the organizational structure with clear responsibilities and tasks. The core team consists of dr. Andrej Marušič., dr. Mojca Dernovšek, dr. Tanja Kamin, dr. Helena Jeriček, Maja Zorko, Saša Roškar, Nina Pirnat.
3. The **network of representatives** from key countries has been established. Invitation for experts from 9 ex-applicant countries was launched according to the proposed schedule in October 2004.

The countries to be included in the project “Examining the MH monitoring systems in the new EU states” were: Czech Republic, Cyprus, Hungary, Estonia, Lithuania, Latvia, Malta, Poland, Slovakia and Slovenia, as a leader of the project.

All invited countries agreed to participate in the project, although we haven’t got a reliable contact from Malta.

4. **1st meeting** was organized in Ljubljana from 3 to 4 of December 2004. First meeting was organized as an opening event to inform all project participants on the aims and activities of MINDFUL project. The project “Examining the MH monitoring systems in the new EU member states” has been discussed with the experts from Slovenia, Poland, Hungary, Slovakia, Czech Republic, Cyprus, Estonia and Lithuania. The representative from Latvia was not able to participate at the meeting and Malta has not shown enough interest to participate in the project at all.

All project participants have been informed with content of the project as well as with formal, organizational structure of the project, including details on contract: obligations and budget.

5. Getting familiar with the mental health data systems in participating countries

In advance to the meeting, participants of the project received material with the basic information on the MINDFUL project and subproject “Examining the MH monitoring systems in the new EU member states.” Experts were introduced to the ECHI list. Furthermore, each expert has received a preliminary questionnaire, which we have developed to detect available indicators for monitoring mental health in the new EU states. As a tool for comparison ECHI list was included in the questionnaire. It aimed to provide initial data on comparability of mental health indicators between the new EU member states and other EU member states.

The questions were aiming to get information about:

- the existence of particular mental health indicator in the mental health monitoring system of each partner country
- who collects the data (with particular indicators) on mental health
- how is data on mental health collected in the country in general
- who is the population of the mental health research
- comments on indicators from ECHI list

6. Signing the subcontracts with project partners

So far The Institute of Public Health of the Republic of Slovenia has signed the subcontracts with the following institutions:

HUNGARY	LABO '99 KFT 2092, Budakcszi Jokai-u 24/a
LITHUANIA	MTVC - Training, research and development centre Antakalnio 22b, LT-10305 Vilnius
LATVIA	Psychiatry centre University Department of Psychiatry Tvaika Str 2 LV 1005, Riga
POLAND	Institute of Psychiatry and Neurology Sobieskiego 9 02-957 Warsaw, Poland
THE CZECH REPUBLIC	Prague Psychiatric Center, Ustavni 91, 181 03 Praha 8
CYPRUS	Ministry of Health, Platonou 7, Pantea Mesa Gitonia 4007 Limassol - Cyprus.

3. PRELIMINARY REMARKS

The participants at the 1st meeting agreed that there has been done a lot of research on mental health, however in some countries more widely and more systematically than in others. All in all, the indicators from the ECHI list have in majority being collected in all participated countries. However, the databases for specific mental health indicators are carried out by different actors. This raises question of the comparability of the data, the availability and accessibility of the data for further research and political decision making.

Majority of the participants noted the existence of relevant research on mental health in the framework of public opinion research, research on quality of life, different smaller research at the social sciences faculties, pedagogical departments, high schools and criminal departments. Potential for synergistic benefits need to be further explored and incorporated to the overall MINDFUL subproject research.

The question of usefulness of systematic personal mental health determinants measurement across the countries was raised; especially due to the fact of different cultural contexts. The need to further discuss the validity of the survey instrument was highlighted.

These issues will be discussed in more detail in the final report, which will consist of two parts: descriptive (description of existing mental health information system in each participating country) and analytical (analysis of mental health information systems regarding comparability and reliability of the gathered data).

Each part will be further on divided into chapters. In analytical part of the study, only regular sources on mental health will be included.

II. Plans for further work

1. On April the 21st 2005 the second meeting with all participants will be held. On the meeting the existing mental health indicators in new EU member states will be further discussed. Relevant indicators will be exposed and proposed for a small survey in interested countries.
2. Sign the contracts with representatives from Slovakia and Estonia.
3. Allocation of the budget to the subcontractors by the end of May 2005.
4. Conduction of a survey in interested countries with selected mental health indicators. Analysing the data and conduct selected countries profiles by the end of October 2005.
5. The third (last) meeting of all participants will be organized in December 2005, on which the results from the first part (MH monitoring system) and second part (survey) of the project will be presented and discussed. Comments and suggestions will be collected for the final report.
6. Writing the final report by the end of March 2006.
7. Dissemination of results in the year 2006.

UNIVERSITY OF DEUSTO: MONITORING POSITIVE MENTAL HEALTH
Interim Report April 2005

1. EXECUTIVE SUMMARY

Monitoring Positive Mental Health is part of the project 'Mental Health Information and Determinants for the European Level (MINDFUL)'.

The subject areas of the project are:

- To establish a system for monitoring the impact of policies and programmes promoting mental health.
- To devise and promote a system of indicators of positive mental health for different levels of social systems.

The concrete objectives are:

- To compile the structural indicators used in different European countries for gauging Positive Mental Health status (PMH) and Mental Health programmes and policies.
- To decide, in consensus with health system experts and social managers, on a set of best structural indicators for monitoring PMH status and MHPP programmes and policies.
- To assess the applicability of the set of structural indicators for monitoring PMH status and MHP programmes and policies.
- To establish a process for monitoring the selected indicators.
-

CONCEPTUAL FRAMEWORK OF THE PROJECT

Most definitions acknowledge that mental health and mental illness result from a combination of events and conditions.

The positive model of mental health includes qualities such as life skills, the ability to manage changes and to actively influence the social environment, positive self-esteem, assertiveness, and enjoyment or a state of experienced well-being. These qualities are considered as values in themselves, not only as signs of absence of illness or disorder.

Structural indicators are directly observed phenomena. In this project we consider structural indicators to be those which are related with the context, settings, environments, macro and ecological indicators, objective indicators, as well as statistics about observable human behaviour.

ACTIVITIES IN THE FIRST YEAR

A partner network was formed to manage these objectives. The work of the sectors has been divided between the different partners as follows:

- ❖ Deusto University. Co-ordination of the project. Focus on the sector Elderly People.
- ❖ Bruecke Rensburg and University of Applied Sciences Kiel. Focus on the sector: Leisure Time and Adolescence.

- ❖ Mental Health Matters, and University of Durham. Focus on the sector: Working Settings.
- ❖ Escola Nacional de Saude Publica of Lisbon. Focus on the sector: Urban Environments.
- ❖ Black Water Valley and Hart Primary Care Trust. Focus on the sector: Children Under Ten.

During the first year activities related to the configuration of the network of the partners have been developed as well as the discussion of the basic concepts and the program activities. A revision of the most recent bibliography for the project has also been made. The main activity has been the search and selection of structural indicators of positive mental health. During the first year we have created a provisional set of indicators for its following contrast and evaluation by the Delphi methodology. This evaluation is going to be made by different stakeholders of the European Union countries selected by each partner.

Between March 2004 and March 2005 two meetings and two multiconferences have been held:

Date and Place	Main Points
Meeting in Bilbao 23 rd - 24 th April 2004	<ul style="list-style-type: none"> • General outline of the project and its partnership with the projects: "Mental Health Information and determinants for the European Level" • Work plans, processes and outcomes of the different partners. • Discussion of Key concepts: mental Health Promotion, Positive Mental health, Indicators and Social Capital
Telephone Conference coordinated from Deusto 6 th July 2004	<ul style="list-style-type: none"> • Situation of the bibliographical search • Distribution of countries to contact stakeholders
Telephone Conference coordinated from Deusto 28 th September 2004	<ul style="list-style-type: none"> • Information of the bibliography collected • Situation of the proposal of indicators
Meeting in Bilbao 5 th - 6 th November 2004	<ul style="list-style-type: none"> • Reports about the bibliographical review and first draft survey of indicators. • Letter for the stakeholders and List of people to contact. • Structure of the interim report.

PRODUCTS

The bibliographical research has been completed and the draft questionnaire of indicators that will be sent to fifteen different stakeholders in the second part of the project has been created.

MINDFUL Project

Interim report: Radboud University Nijmegen

“Quality indicators in mental health promotion and mental disorder prevention programmes”

Aims

The aim of this project is to build on the available evidence to develop an overview of quality indicators for mental health promotion and mental disorder prevention programmes and to translate the evidence into a systematic training course to build capacity across European Member States.

Development of the training modules (phase I)

During the first year of the project two major developments have been undertaken: a review of the literature to identify key quality indicators of mental health promotion and mental disorder prevention and the development of a training module on programme development, training and evaluation. Key indicators have also been identified for the second module on implementation, which will be developed during the second year of the project. Identified indicators have been clustered into different headings according to the purposes of the course.

1) Overview on quality indicators

An analysis of the literature, including reviews, meta-analyses and individual intervention studies on mental health promotion and mental disorder prevention, was undertaken to identify quality indicators for programmes’ development and implementation.

Deliverables:

The evidence collected was reviewed and summarized into a list of indicators to be included as basis, and check list in the training modules.

In addition a paper outlining some of the key principles of intervention success across different settings has been prepared and accepted for publication in a peer-reviewed journal. This paper aims to serve as background information to be read by all participants prior the attendance to the course.

2) Training Module: Programme Development, Planning and Evaluation

On the basis of the evidence collected, a first draft of the training module on programme development, planning and evaluation was developed. The training is targeted to health professionals in health promotion, mental health professionals, researchers, programme implementers, experts in national institutes or in non-governmental organizations that are involved in developing and evaluating prevention and promotion programmes in mental health.

The overall goal of the module is to acquire the knowledge and skills needed to develop mental disorder prevention and/or mental health promotion interventions that are attuned to the needs of a target community or target population, and that can show success in reaching its goals.

The training is a two day course with a total of 8 sessions of 1,5 hours. The sessions are divided in 4 clusters of half a day each, and target:

1. Problem analysis and needs assessment
2. Designing a programme
3. Adoption and reinvention of evidence-based model programmes
4. Evaluation, monitoring and quality management

All sessions are based on active principles of learning, including role plays and group work.

Deliverables:

A training material manual is prepared both for the trainers and for the participants of the course. The manual package includes: an overview of all sessions and overall goals and learning objectives for the course; complementary literature; power point presentations; case studies; evaluation form for the training; lists of quality indicators. In addition every session is specified and includes session plans, literature and necessary material for each session.

Training delivery (phase II)

A pilot course with up to 20 participants is set up to take place in June 2005 in Spain. The training delivery will serve as a pilot to test the course materials and identify applicability and language barriers. Changes to the module after the pilot will be made accordingly.

After the revisions of the training module, a full training will take place in the Netherlands in December 2005. The course has capacity for up to 31 participants; 25 places are already reserved to allow one participant from each European Member State.

MINDFUL-Vienna Project

“Establishing a System to Monitor Service Utilisation Data”

Interim report 15 March 2004 to 14 March 2005

The aim of this project is to identify, describe, analyse and compare existing monitoring systems for mental health service utilisation at the national and international level in Europe, to identify sources of error, to suggest improvements in these monitoring systems and to elaborate recommendations how the field should develop, thereby taking into account findings and suggestions of other EU activities, such as the European Community Health Indicators (ECHI) Project and the Hospital Data Project.

Six EU countries, three “old” ones (Austria, Greece and Spain) and three “new” ones (the Czech Republic, Latvia and Slovakia), representing a wide range of mental health service systems, are participating in this project. For each of these countries the data flow of mental health service use data from the service level over several intermediate steps to the national and to the international level is described and analysed.

During the first project year inpatient data were the focus of interest. Two groups of indicators were studied, hospital discharges with a psychiatric diagnosis (and related indicators, as e.g., average length of stay) on the one hand, and psychiatric beds on the other. The working method consisted in jointly elaborating structured questionnaires, schemas and procedures and in applying these questionnaires and procedures locally in each of the participating countries, with reports back to the whole group. Four two day meetings were held in Vienna, in which all country experts participated (3/4 April 2004, 9/10 July 2004, 27/28 November 2004, and 11/12 February 2005) and where – following an iterative work method – interim results were reported and discussed, which led to new questions and activities in each of the participating countries, the results of which were reported back, etc.

Both a bottom-up and a top-down approach were applied. In the bottom-up approach the data flow was analysed in each country from the service level to the national agencies (such as the ministries of health and the national statistical offices) responsible for reporting data to international agencies, such as EUROSTAT and the World Health Organization. It was found that even between only six countries these pathways are very different and difficult to compare, since data are often collected for specific purposes (e.g. for financing purposes and the financing systems are very different from country to country). In the top-down approach internationally available databases and publications (such as the WHO-HFA database, the EUROSTAT publication ‘Health Statistics – Key Data on Health’ and the EUROSTAT Newcronos data base) were analysed in respect to their content of mental health service use data; the reports were checked for validity on the one hand and inconsistencies on the other, by combining the bottom-up with the top-down approach.

An interim report has been prepared on in-patient data (discharges with a psychiatric diagnosis, average length of stay, psychiatric beds and others) according to the following structure:

Chapter 1: Available data at the international level

- a) Descriptive part
- b) Analytical part
- c) Recommendations part

Chapter 2: Data flow from the national to the international level

- a) Descriptive part
- b) Analytical part
- c) Recommendations part

Chapter 3: Data flow from the services level to the national level

- a) Descriptive part
- b) Analytical part
- c) Recommendations part

Professor Heinz Katschnig, Director
Vienna, 31 March 2005
Ludwig Boltzmann Institute for Social Psychiatry
Vienna, Austria

INTERIM REPORT - MGEN PUBLIC HEALTH FOUNDATION

The main objectives of the project

The global objective of the project 'Mental Health Information and Determinants for European Level MINDFUL' is to set up a system across EU and CC which allows to monitor mental health on regular basis using suitable methodology and instruments for the all population; this will be integrated to the indicators from other sources. This project has to be in line with previous work on mental health indicators: EU monitoring group, WHO Europe coordination work and the two corresponding pilot surveys and ESEMED funded by European Union.

The project aimed to conduct pilot surveys as previously done in five other countries in order to finalise a set of validated instruments for EU needs and to include CC countries and Romania which is candidate country participant. Countries participants are: Italy, United Kingdom, Belgium, Romania and Spain.

The work on the project is divided into two parts:

- a part on clinical validation (120 persons by countries – General Practitioner consultations)
- a part on general population survey to pilot the validated instruments in each participating country (about 400 phone interviews).

The tasks of the Partners:

- The partners have participated in a designation of a final list of instruments (core and non core instruments) using results of the diverse pilot surveys: *July 2004 to January 2005*

Instruments to be tested for the surveys are:

CIS-R (Clinical Interview Schedule – Revised),

CIDI-SF (Composite International Diagnostic Interview Short Form),

GHQ (General Health Questionnaire)

three subscales of the SF-36:

MH-5 (psychological distress measure),

EVI (energy and vitality which are positive mental health measures) and

“Role Emotional” – Impairment (Role limitation items of the SF-36),

mastery versus SCID-I (Structured Clinical Interview for DSM-IV-TR Axis I Disorders).

PARTNER	CIS-R	SCID-I	CIDI-SF	GHQ	SF-36 :MH-5, RE ;Mastery ; Self-reported use of mental health services
ITALY	Translated	On Request	Available modifications	Available	Under translation
BELGIUM French	To be translated	On Request	Available	Available	Available
SPAIN	Available (some modifications)	Available (some modifications)	Available	Available	Under translation
UNITED KINGDOM	Available	Available	Available	Available	Available
ROMANIA	Translated	Under translation	Available modifications	Available	Under translation

- Calibration of the above instruments: validation in a small patient population (120 persons – GP consultations) by comparison with clinician diagnoses using a designated clinical diagnostic instrument: *March to July 2005* (all partners except UK)

A clinical validation is based on face to face interviews with general practitioner's patients. Each interview lasts from 20 to 30 min. The SCID-I like semi-structured psychiatric interview, will be administrated by mental health professional (experienced psychiatrist or psychologist). The others quality of life scales would be administrate by a lay interviewer. The GHQ will be use to over represent cases (≥ 4 100%; ≤ 3 50% only). There will be one session only. The different instruments will be used at the same interview in a random order (SCID-I versus others scales).

- Conduction pilot survey: around 400 phone interview: *August 2005 to December 2005* and forward to MGEN Foundation for Public Health computerized data: *December 2005 to February 2006* (all partners) then MGEN Foundation for Public Health will prepare the final report.
- The following meetings have been organised (3 meetings in Paris and phone conferences:
 - **1st meeting (face to face) 28-29 June 2004**
 - Phone conference 4th October 2004
 - **2nd meeting (face to face) 8-9 January 2005**
 - Phone conference April 2005
 - **3rd meeting (face to face) September 2005**

STAKES - The set of mental health indicators within MINDFUL

The set consists of 36 indicators that are grouped into 8 domains and 3 groups (see annex 1). There are two main types of indicators: Firstly, annually collected health statistics that are available for most of the countries, and secondly population survey data that are collected irregularly and in most cases not in the whole EU at a time.

The main characteristics of the indicator data are:

- The whole EU is included (25 countries).
- Time series begin from 1990 for the statistics that are annually collected.
- The breakdown of the data varies according to the indicator. The *Cause specific mortality* indicators will be broken down by sex, age groups, and NUTS 2 regions. Some of the *Health care utilisation; psychiatric care and social services* indicators will be broken down by sex and/or NUTS 2 regions. The survey indicator data are broken down in some cases, and there are no continuous time series.

The indicator list is in need of development, some indicators are lacking operational definitions. Thus, some indicators need to be removed or replaced by more relevant ones. This is to be decided at the MINDFUL meeting in Helsinki, 10-11 June 2005.

Availability and definitions of data (see annex 2 for detailed information)

The availability of the data is very irregular. For some indicators there are almost complete time series and breakdowns, for some others there are no data at all. Data for the domains *Cause specific mortality*, *Health resources* and *Health care utilisation; psychiatric care and social services* are best available; there are almost complete time series, age groups, sex, and NUTS 2 divisions. Also some survey indicator data e.g. domains *Morbidity*, *generic* and *Social and cultural environment* are fairly well available.

The main data source for health statistics is Eurostat, supplementary data are provided by e.g. WHO, OECD, and some national statistical organisations. For population survey data there are no major sources.

The main problem concerning the data is the poor international comparability in many cases, that is why some existing data are not included in MINDFUL. The biggest comparability problem is the use of different definitions, such as inclusion of different sets of ICD-10 items. The definitions for the indicators within MINDFUL are sometimes in conflict with the existing data. Thus, e.g. *Alcohol* and *drug related deaths* data provided by Eurostat cannot be directly used in MINDFUL.

The MINDFUL database

The data will be gathered in an on-line database that is currently being developed. The database will be created in Microsoft Access format, the user interface will be Cognos PowerPlay. The data will be possible to be visualised in tables and graphs, and it can be downloaded in different formats. Some indicator data are represented in different ways. E.g. *Cause specific mortality* data will be represented as absolute number, crude death rate and standardised death rate. Besides the numerical indicator data, the database also contains the complete metadata for each indicator after country. The definition systems and survey instruments will be explained as well.

Annex 1. The set of mental health indicators within MINDFUL

GROUP	DOMAIN	INDICATOR
Health status	<i>Cause specific mortality</i>	1. Suicide
		2. Events of undetermined intention
		3. Drug related deaths
		4. Alcohol related deaths
	<i>Morbidity, disease specific</i>	5. Generalised anxiety disorder
		6. Major depression
		7. Alcohol dependence
		8. Lifetime occurrence of suicide attempt
	<i>Morbidity, generic</i>	9. Psychological distress
		10. Psychological well-being: A) Energy, vitality B) Happiness
		11. Role limitations due to emotional problems
Determinants of health	<i>Personal conditions</i>	12. Sense of mastery
		13. Optimism
	<i>Social and cultural environment</i>	14. Social support
		15. Social isolation
		16. Life events
		Health systems
18. Projects to support parenting skills		
<i>Health resources</i>	19. Number of psychiatric beds	
	20. Number of psychiatrists	
	21. Number of child psychiatrists	
	22. Number of clinical psychologists	
	23. Number of other professionals than physicians in mental health care	
	<i>Health care utilisation; psychiatric care and social services</i>	
25. Number of in-patient episodes due to mental health conditions for minors		
26. Long-stay patients		
27. Use of outpatient services		
28. Self-reported use of mental health services		
29. Use of antidepressants		
30. Use of antipsychotics		
31. Use of anxiolytics		
32. Use of hypnotics		
33. Proportion of disability pensions due to mental disorders		
34. Sickness compensation periods due to mental disorders		
<i>Expenditure</i>		
	36. National quality accreditation	

Annex 2. Definition of indicators and data availability within MINDFUL

INDICATOR	DEFINITION	DATA AVAILABILITY AND NOTES
1. Suicide	ICD-10: X60-X84.	EU-25: 1990-2003 (variation after country).
2. Events of undetermined intention	ICD-10: Y10-Y34.	EU-25: 1992-2003 (variation after country).
3. Drug related deaths	ICD-10: F11-F12, F14-F16, F19, X41-X42, X61-X62, Y11-Y12; T40.0-T40.9, T43.6 (The EMCDDA definition).	Data accordant with different set of ICD-10 items available.
4. Alcohol related deaths	ICD-10: F10, G312, G621, G721, I426, K292, K70, K860, O354, P043, X45.	Data accordant with different set of ICD-10 items available.
5. Generalised anxiety disorder	A disorder with pervasive anxiety lasting for at least six months during past 12 months. Instrument: CIDI-SF.	FI 00; BE, DE, ES, FR, IT, NL during 00-02.
6. Major depression	An episode of depression for at least two weeks during past 12 months. Instrument: CIDI-SF.	DE, FR,GR 99; FI: 99, 00.
7. Alcohol dependence	Caseness: for men 3 and for women 2 positive answers in the CAGE instrument.	DE, FI, FR,GR 99.
8. Lifetime occurrence of suicide attempt	Positive answer to the specific question: Have you ever attempted suicide?	DE, FI, FR,GR 99.
9. Psychological distress	MHI-5 index from the SF-36 questionnaire. Suggested cut-off point: score 56 or less predicts disorder.	DE, FI, FR,GR 99; EU-15: 2002.
10. Psychological well-being: A) Energy, vitality B) Happiness	A) Energy and vitality index (EVI) from the SF-36 questionnaire. Suggested population norm: mean score 70. B) 4-step verbal question: Taking all things together, would you say you are?: - very happy - quite happy - not very happy - not at all happy very = 4not at all = 1	A) DE, FI, FR,GR 99; EU-15: 2002. B) AT 90, 99, 02; BE 90, 99; CZ 99; DE 98, 99; DK 90, 99; EE 90, 96, 99; ES 90, 95, 99, 00; FI 90, 96, 00; FR 90, 99; GR 99; HU 90, 91, 96, 99; IE 90, 91, 99, 01, 03; IT 90, 91, 99; LT 90, 96, 99; LU 99; LV 90, 96, 99; MT 99; NL 90, 99; PL 92, 93, 97, 99; PT 90, 99; SE 90, 96, 99, 00; SI 91, 92, 95, 99; SK 96, 99; UK 90, 91, 98.

11. Role limitations due to emotional problems	Role limitations due to emotional problems -index from the SF-36 questionnaire. Suggested population norm: mean score 89. Suggested cut-off score: 80.	DE, FI, FR,GR 99.
12. Sense of mastery	The 7-item version of the SOM questionnaire (Perlin et al. 1981). Score under 20 indicates low sense of mastery.	DE, FI, FR,GR 99.
13. Optimism	The 6-item Revised Life Orientation Test (LOT-R). Cut-point for optimism: 20 or more. Cut-point for pessimism: 12 or less.	DE, FI, FR,GR 99.
14. Social support	The 3-item Oslo Social Support Scale. Poor social support: score 3-8. Moderate social support: score 9-12. Strong social support: score 12-14.	DE, FI, FR,GR 99; EU-15: 2002.
15. Social isolation	The 4-item Social Isolation scale (Beaudet et al. 1996). A negative answer to at least one of the questions indicates social isolation.	DE, FI, FR,GR 99.
16. Life events	The 12-item Threatening Life Events (LTE) questionnaire (Brugha et al. 1985) Cut off point: two or more events during past 6 months.	DE, FI, FR,GR 99.
17. Suicide prevention projects	Any national or regional suicide prevention programmes/projects conducted.	Perhaps should be omitted or replaced by some other indicator.
18. Projects to support parenting skills	Any national or regional programme/project on supporting parental skills or early interaction conducted.	Perhaps should be omitted or replaced by some other indicator.
19. Number of psychiatric beds	Hospital beds: Number of psychiatric beds.	EU-25: 1990-2003 (variation after country).
20. Number of psychiatrists	Registered medical specialists: Psychiatry/Neuropsychiatry.	EU-25 except CY, IT, PL: 1990-2004 (variation after country).
21. Number of child psychiatrists	Physicians with specialist rights in child psychiatry.	BE 95; DE 00; DK 95; FI 90, 95, 00, 03; FR 93; GR 96-98; IE 99-01; IT 98; LU 94; PT 96, 98-01; SE 95; UK 93.
22. Number of clinical psychologists	Clinical psychologists.	Perhaps should be omitted or replaced by some other indicator.

23. Number of other professionals than physicians in mental health care	Other persons than physicians and psychologists, working in the public mental health service system.	Very difficult to define. Perhaps should be omitted or replaced by some other indicator.
24. Number of in-patient episodes due to mental health conditions	ICD-10: F00-F99.	EU-25: 1990-2003 (variation after country).
25. Number of in-patient episodes due to mental health conditions for minors	ICD-10: F00-F99 for those under 18 years of age.	AT 98; BE 97; DE 98; DK 99; FI 97-99; FR 99; GR 96-98; IE 99-00; IT 98-99; NL 97; PT 97; SE 97; UK 97.
26. Long-stay patients	Number of mental patients in mental hospitals and departments at the end of given calendar year with a length of stay of 365 days or more. Data from the routine reporting system.	BE, CZ, DE, FI, HU, IE, IT, LT, LV, NL, SE, SI, SK: 1990-2002 (variation after country).
27. Use of outpatient services	Persons treated in psychiatric outpatient clinics.	DK 96-99; FI 96-98; GR 97; IE 97-00; NL 99; PL 95-03; PT 98; SE 98; SI 90, 95, 00-02; UK 99.
28. Self-reported use of mental health services	Positive answer to the question about help-seeking from some professional (or healer) due to mental health problem during the past 12 months.	DE, FI, FR, GR: 1999; AT, DE, DK, ES, FI, FR, IE, IT, SE, UK: 2000.
29. Use of antidepressants	Consumption of antidepressants (ATC-group N06A), DDD/1 000 inhabitants/day.	AT 99/00; BE 97-02; CZ 90-02; DE 98, 00; DK 96-03; ES 00; FI 90-03; FR 00; GR 95; HU 95-02; IE 00; IT 00; PT 00-02; SE 99-03; UK 00.
30. Use of antipsychotics	Consumption of antipsychotics (ATC-group N05A), DDD/1 000 inhabitants/day.	AT 99/00; BE 99; DE 98; DK 99-03; FI 97-03; GR 95; SE 99-03.
31. Use of anxiolytics	Consumption of anxiolytics (ATC-group N05B), DDD/1 000 inhabitants/day.	AT 99/00; CZ 90-02; DE 98; DK 95-03; FI 97-03; GR 95; HU 95-02; PT 00-02; SE 99-03.
32. Use of hypnotics	Consumption of hypnotics and sedatives (ATC-group N05C), DDD/1 000 inhabitants/day.	AT 99/00; BE 97-02; CZ 90-02; DE 98; DK 97-03; FI 90-03; GR 95; HU 95-02; PT 00-02; SE 99-03.
33. Proportion of disability pensions due to mental disorders	Number of people (16-64 years old) receiving disability pensions due to mental disorder (ICD-10 category F) out of all disability pensions at the end of the year.	AT 99-00; DE 98-99; FI 98-99; GR 94, 96-99; IE 99; NL 99; PT 99; SE 98; UK 98-99.

34. Sickness compensation periods due to mental disorders	Number of people (16-64 years old) having received sickness benefit due mental disorder (ICD-10 category F) out of all sickness benefits during a year.	AT 98; FI 99; SE 97.
35. Total national expenditure on psychiatric services	Total expenditure on specialised psychiatric services per total population during a year. Euros spent per capita.	BE 94; DE 94, 98; IE 97-01; IT 99; NL 98-99; PT 98; SE 97; UK 98.
36. National quality accreditation	Existing national quality accreditation system for mental health services.	No solid data available.

ANNEX 2

MINDFUL Report

Proposal for Developing European Mental Health Information Systems (Short outline of the content)

Executive Summary

Preamble (STAKES)

The preamble describes shortly the background, aims, process, participants and outcomes of the MINDFUL Project. After that a short outline of the aims and content of the MINDFUL Report will be given.

1 Introduction (STAKES)

The chapter begins with the questions why health monitoring is imperative in the context of the public health of the EU Member States and why mental health must be an essential part of the general health monitoring. The key concepts are then shortly defined: mental health and mental disorders, mental health work (promotion, prevention, care and rehabilitation), health indicator and health monitoring. After that it will give an overview of what has already been done at the EU level: the Public Health Programmes, the ECHI system, the mental health projects (Establishment of mental health indicators and Mental health report) and by other international organisations (WHO, OECD, Eurostat), and in some individual countries (e.g. the UK and Norway).

2 The Set of Mental Health Indicators (STAKES)

The chapter will present the 'final' set of specific mental health indicators to be included in the EU health monitoring system. There will be both statistical indicators (e.g. suicide mortality) and survey-based indicators (e.g. psychological distress). The presentation will start with the proposal by the Mental Health Indicators project. However, for some of these indicators there clearly is a need for refinement, modification or even exchange. Some of the indicators have also to be skipped because data will not be available or because the indicator cannot be defined unambiguously enough. The unambiguous definition of each selected indicator will be given, as well as information of their availability and utilisation in the Member States (a detailed description of the availability will be presented in chapter 12).

3 Availability of data (STAKES)

The chapter will give an overview on the availability of relevant data combining all existing information. Special focus will be directed to gaps in the needed information and barriers to its achievement. The existing relevant data will be collected and presented in Annex 1.

4 Mental Health Monitoring (STAKES)

The chapter will start with the idea of mental health monitoring as part of the general health monitoring. The following issues will be handled: methods of collecting the data in the Member States (health statistics and population surveys), data collection at the EU level (sources of data), analysis of the data and reporting and feedback. The needed electronic database will be outlined.

5 Macro level indicators of positive mental health (Deusto)

The chapter will be based on the results of the sub-project 'Developing an indicator system for positive mental health'.

6 Determinants of mental ill-health (Leicester)

The chapter will be based on the results of the sub-project 'Analysing the determinants of mental health and mental ill-health from existing sources'.

7 Relevant survey methods (MGEN)

The chapter will be based on the results of the sub-project 'Development of mental health survey and reporting methods'.

8 Service indicators (Vienna)

The chapter will be based on the results of the sub-project 'Establishing a system to monitor service utilisation data'.

9 Quality indicators for mental health promotion and prevention (Nijmegen)

The chapter will be based on the results of the sub-project 'Training and monitoring for effective mental health promotion'.

10 Situation in new EU Member States (Ljubljana)

The chapter will be based on the results of the sub-project 'Examining the mental health monitoring in the accession countries'.

11 Proposal of the mental health information system for the EU (STAKES)

The chapter will be partly based on the sub-project conducted by STAKES, and partly take advantage of the relevant results of all sub-projects. Establishment of a comprehensive mental health information system as part of the comprehensive EU health information system will be outlined, comprising data collection, data control, analysing data, reporting and feedback at the EU level.

12 Implementation (representative of DG SANCO? - to be confirmed)

The chapter will describe how the new health information will be implemented in the member States and at the EU level, and what kind of training and other supportive measures will be needed for this task.

13 Future needs (STAKES)

The chapter will present the prospects for the future concerning the development of the mental health information system. Special attention will be paid to the harmonisation of the national definitions of the different indicators, to ensuring their extensive and timely collection in the member States, and especially, in developing a system of repeated population surveys including relevant mental health measures to be conducted in all member States.

14 Conclusions (STAKES)**Annex 1.**

The existing data from different sources on the indicators will be presented as annex.

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