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I. PROJECT SUMMARY

This first section of the report summarises the results found during the three years undertaking the EPREMED Project. A complete list of publications, policy reports and personal communications produced is then presented.

This summary is complemented by other sections that further detail the manpower of the execution, the partners involved, the way in which the action has been coordinated, and present an evaluation of the achievement of the objectives. Furthermore, a detailed description of all the project activities conducted is presented in the form of Work Packages and their corresponding Annexes.
1) Introduction

Although the importance of mental health as a major source of diseases is increasingly recognised in the world, the information on the distribution of mental disorders, their determinants and their social and economic consequences, and the possibilities to prevent them are still limited in Europe. Consequently, mental health policy information research is insufficiently based on the most accurate and up-to-date scientific evidence. The aim of EPREMED has therefore been to qualitatively and quantitatively improve the mental health policy information in Europe through a better understanding of mental health burden, determinants, and services needs. This was achieved first by maximising the production of policy relevant information of the recently completed ESEMeD/MHEDEA project, the most comprehensive mental health study ever conducted in the general population in Europe, funded by the EU Commission. This survey contains detailed data on prevalence, risk factors, burden, and service use of individuals with mental disorders in six European countries (Belgium, France, Germany, Italy, the Netherlands, and Spain) representing about 213 million adult and elderly Europeans.

The EPREMED project involved a large group of experts already collaborating together in the World Mental Health Survey Initiative and it was translated into a substantial increase in scientific publications, an improvement of dissemination practices, and more well-trained personnel.

Effective dissemination strategies were implemented for different key audiences: the scientific community through participation in international conferences and publication of scientific articles in reference journals in the field of mental health (76 manuscripts published, 27 of which in local languages: 9 in Spanish, 7 in French, 6 in Dutch, 4 in German, and 1 in Italian), the policy-makers through organization of meetings and focus groups, and the civil society through media coverage of citizen-friendly information. An active plan of training and mobility has also been developed together with the performance of a formal evaluation of dissemination activities.

We finally believe that the EPREMED project has contributed to the consolidation of a larger, multidisciplinary European mental health policy information research network.
that has been and will be beneficial for the needed dialogue between all stakeholders in mental health policy in Europe.

This Network is composed, mainly, by the following EPREMED partners:

<table>
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<th>INSTITUTION</th>
<th>CONTACT</th>
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2) **Aims and Objectives**

The aim of EPREMED has been to qualitatively and quantitatively improve mental health policy practices and potential in Europe. This aimed to be achieved by assuring the maximum impact of the recently completed ESEMeD/MHEDEA and other related European studies through analyses, data synthesis and translation, and effective dissemination to the relevant stakeholders. By formal evaluation of the dissemination and through provision of training and mobility, the project helped at consolidating a multidisciplinary community better able to address mental health policy information research in Europe.

EPREMED builds on a previous successful research collaboration, focuses on the crucial area of mental health (disorders prevalence and burden; risk factors including poverty, immigration and religion; and services utilisation, with emphasis on unmet need for care). This fills a gap in evidence-based European policy making and feeds another PHP project: Euro Health Expectancy Monitoring Unit -EHEMU. Co-ordination with other relevant activities, in particular those under the Public Health Programme, and with the Working Party on Mental Health has also been assured.

The specific objectives of the EPREMED project have been:

1) To maximise the **production of policy relevant information** from the recently completed **ESEMeD/MHEDEA project**, the most comprehensive mental health study ever conducted in the general population in Europe, funded by the EU Commission. This survey contains detailed data on prevalence, risk factors, burden, and service use of individuals with mental disorders in six European countries (Belgium, France, Germany, Italy, Spain, The Netherlands) representing about 213 million adult and elderly Europeans.

2) To synthesize other relevant activities, in particular those having been carried out under the Public Health Programme.

3) To implement effective **dissemination** strategies to different key audiences: the scientific community, the policy-makers, the civil and society, and the mass media.
4) To develop an active plan of training and mobility together with the performance of a formal evaluation of dissemination activities.
3) Epidemiology of Mental Disorders in Europe

The following EPREMED Results by Topic and Country represent a summary of the more than 76 journal articles and book chapters published during the consecution of this project: 35 International journal articles, and 33 National ones (See the section "Bibliography produced" for a complete list of these publications).

We then present a list of the Policy Reports, Personal Communications and Training and Dissemination Activities which have been carried out (See the detailed explanations in the corresponding Work Packages and Annexes).

EPREMED Results by Topic

Prevalence of Mental Disorders

Mental disorders are frequent in European countries. In the 6 ESEMeD countries, 14.7 % of respondents were found to suffer from any mood disorder, 14.5 % suffered any lifetime anxiety disorder and 4.9 % a lifetime history of any alcohol disorder. In the previous 12 month, the reported prevalence of any mood disorder was 4.5%, that of any anxiety disorder was 8.4 % and that of any alcohol disorder was 0.7 %. Major depression and specific phobia were the most common single mental disorders. Mental disorders were more common in female, unemployed, disabled persons, or persons who were never married or previously married. Younger persons were also more likely to have mental disorders, indicating an early age of onset for mood, anxiety and alcohol disorders.

Some differences in rates exist between participating countries. Out of the 6 countries, France had the highest prevalences (e.g. 6.5% 12-month prevalences of any mood disorder and 13.1% 12-month prevalence of any anxiety) and Italy the lowest figures (e.g., 3.4% 12-month prevalences of any mood disorder 3.4 % and 6.0% 12-month prevalence of any anxiety).
Impact and Severity

Mental disorders can have a big impact on mental well-being, social relationship and work productivity, leading to a worsening of Health Related Quality of Life (HRQL) measures and an increase of Work Loss Days (WLD). Individuals with major depression report, on average, about 25% of work loss days, while people that suffer from heart diseases or diabetes report 18% and 12%, respectively. About two thirds of the individuals with depression report severe interference with normal functioning, representing a much higher proportion than individuals with physical chronic conditions (including chronic pain). Mood disorders (major depression episode and dysthymia) markedly reduce the mental quality of life (QoL) component (about 1 standard deviation in the SF-12). In addition, mood disorders also have a moderate impact on the physical QoL component (almost half a standard deviation), just a little less than the physical impact of heart disease or diabetes (which, on average, do not affect mental QoL levels). Impact of anxiety disorders and alcohol disorders report a significant functional impairment and lowered health related quality of life, but less than those with mood disorders.
Comorbidity

Comorbidity of mental disorders is substantial in clinical populations as well as in the general population. In the ESEMeD countries, the proportion of respondents with a 12-month mood disorder who also met criteria for anxiety or substance use disorder was 43.8%. Among those with an anxiety disorder, 24.0% also had a comorbid disorder. For alcohol this figure was 31.3%.

Of the specific mood disorders, dysthymia had higher rates of comorbidity than major depression (74.3% vs. 54.2%). In general, anxiety disorders were highly comorbid. Agoraphobia (87.4%), GAD (76.0%) and panic disorder (69.0%) were the most commonly comorbid anxiety disorders; specific phobia (26.4%) and social phobia (50.0%) were the least comorbid. Alcohol dependence was much more frequently comorbid with other disorders (43.1%) than alcohol abuse (25.4%). Alcohol abuse was the least comorbid of all the separate disorders. Comorbidity patterns were consistent cross-nationally.

Pure and comorbid risk profiles were different. Risk factors for comorbidity of mood and anxiety disorders were female gender, younger age, lower educational level, higher degree of urbanicity, not living with a partner, and unemployment. Only younger people were at greater risk for comorbidity of alcohol disorder with mood, anxiety disorders, or both.

Use of services and treatment

Although mental disorders are frequent in the ESEMeD countries, the rate of people who consult a medical professional for their mental health problems is considerably low. Among those with a 12-month mood disorder, only between 35.8% (in Italy) and 56.0% (in the Netherlands) reported having consulted a general medical professional due to problems with emotions or mental health.

Among users of services, general medical professionals were the most frequently consulted in all countries (66.4% on average), while the use of a mental health specialist ranged from 39.4% in France to 52.2% in Spain.
A conservative estimate suggests that 3.1% of the general European adult population has unmet need for mental health care (due to the presence of a mental disorder that interferes a lot with their life and had not used any formal services).

In all countries, a consistent pattern of consultation was found with the highest lifetime rates being observed for respondents with mood disorders and the lowest for those without any mental disorder. The presence of comorbid disorders was associated with increased consultations rates. In contrast, consultation rates for those with alcohol related disorders were relatively low compared to those found for the other disorders.

Nevertheless, the overall use of health care varies considerably in the different ESEMeD countries. Up to now, no simple relationship between health care system characteristics and the use of services can explain these differences. It seems that a complex model of health care system variables (e.g. financing, referral system) moderate the use of services within and between countries.

**Suicidality**

Self-inflicted deaths account for 1.5% of total deaths for both genders and are one of the leading causes of deaths in Europe. Among the 6 European countries considered in the ESEMeD study, lifetime-prevalence of suicidal thoughts was 7.8% and of suicidal attempts 1.8%. Lifetime suicidality (i.e. suicide thoughts and attempts) was more frequent among women, younger ages, those previously married (divorced, separated, widowed), and persons living in large urban areas.

There were important country differences in suicidality rates. Suicide thoughts were more frequent among participants from France (12.4%), followed by Germany (9.8%), Belgium (8.4%), The Netherlands (8.2%), Spain (4.4%), and Italy (3.0%). Suicide attempts were again more frequent among those from France (3.4%), followed by Belgium (2.5%), The Netherlands (2.3%), Germany (1.7%), Spain (1.5%), and Italy (0.5%).
Lifetime suicidality was high among respondents with mental disorders (major depression, dysthmic disorder, generalised anxiety disorder, and alcohol dependence), with rates around 30% for suicidal ideas and 10% of suicidal attempts. In fact, mental disorders, especially the major depressive episode, are the most important determinants of suicidality.

**Relevant bibliography**

EPREMED Country Reports

Mental health in Belgium

*Frequency of mental disorders in Belgium*

Overall, almost a third of the Belgian population suffered from at least one of the studied mental disorders once in their lifetime. The most common mental disorder in Belgium is major depression (14.1 % in the general population, lifetime), followed by alcohol abuse (7.8 %, lifetime) and specific phobia (6.8 %, lifetime). Far less frequent are agoraphobia without panic (0.9 %, lifetime), panic disorder (1.6 %, lifetime), alcohol dependence (1.7 %, lifetime) and generalized anxiety disorder (1.9 %). As a group, mood disorders are the most frequent group of mental disorders (14.1 %, lifetime).

Overall, about a tenth of the Belgian population suffered from at least one of the studied mental disorders in the 12 months previous to the interview. In this 12 months period, major depression is the more frequent disorder (5.0% in the general population, previous year), followed by specific phobia (4.4 %, previous year) and alcohol abuse (1.7 %, previous year). The less frequent mental disorders are adult separation anxiety (0.1 %, previous year), alcohol dependence (0.3 %, previous year), agoraphobia without panic (0.4 %, previous year) and oppositional – defiant disorder (0.4 %, previous year). As a group, anxiety disorders are the most frequent group of mental disorders (7.6 %, previous year).
Predictors of mental disorders in Belgium

Overall, mental disorders (previous year) are more frequent among the younger. In particular, those with 18 – 24 years of age show the highest rates of mental disorders (previous year).

Overall, gender, income and marital status are not related with mental disorders, with the exception of substance abuse disorders, which are more likely among those never married.

Treatment of mental disorders in Belgium

The probability of visiting a health care professional during the first year after the onset of a mental disorder varies according to specific disorder: e.g., 56.4 % for panic disorder, 47.8 % for major depression and 46.8 % for generalized anxiety disorder.

Also, the amount of years, since the onset of a mental disorder, passed until visiting a health care professional (i.e., treatment delay) varies according to the specific disorder: e.g., one year for panic disorder, generalized anxiety disorder and major
depression, 18 years for alcohol abuse, 21 years for specific phobia and 23 years for social phobia.

Overall, the general practitioner was the health care professional most commonly visited (previous year). This is specially true for mood disorders (42.9 % of individuals) and anxiety disorders (29.6 %). Nevertheless, it is noteworthy that only a minority of individuals suffering from a mental disorder reported to have visited a health care professional because of their symptoms. Also, only a small proportion of those who reported having visited a health care professional because of their mental health chose a mental health specialist.

**Mental health in France**

*Frequency of mental disorders in France*

Overall, more than a third of the French population suffered from at least one of the studied mental disorders once in their lifetime. The most common mental disorder in France is major depression (21.0 % in the general population, lifetime), followed by specific phobia (10.7 % lifetime) and alcohol abuse (6.7 % lifetime). Far less frequent were panic disorder (2.1 % lifetime), oppositional defiant disorder (2.0 % lifetime) and agoraphobia without panic (1.0 % lifetime). As a group, anxiety disorders were the most frequent group of mental disorders (22.3 % lifetime).

Overall, approximately one fifth of the French population suffered from at least one of the studied mental disorders in the 12 months previous to the interview. In this 12 months period, specific phobia was the most common mental disorder (7.3 %, previous year), followed by major depression (5.9 %, previous year). As a group, anxiety disorders (13.1 %, 12 month) and mood disorders (6.5 %) were the most frequent group of mental disorders.
Predictors of mental disorders in France

Overall, mental disorders (previous year) were more frequent among women. However, men showed higher rates of substance use disorder (previous year).

Age, Income and Marital status were not associated with the likelihood of having a mental disorder.

Treatment of mental disorders in France

The probability of visiting a health care professional during the first year after the onset of a mental disorder varies according to the specific disorder: e.g., 62.9 % of individuals for panic disorder, 42.4 % for major depression, 39.4 % for generalized anxiety disorder.

Also, the amount of years, since the onset of a mental disorder, passed until visiting a health care professional (i.e., treatment delay) varies according to the specific disorder: e.g., One year for panic disorder, 2 years for generalized anxiety disorder, 22 years for social phobia, and 27 years for specific phobia.

Overall, the general practitioner was the health care professional most commonly visited (previous year). Nevertheless, it is noteworthy that only a minority of
individuals suffering from a mental disorder reported to have visited a health care professional because of their symptoms. Also, only a small proportion of those who reported having visited a health care professional because of their mental health chose a mental health specialist.

**Mental health in Germany**

*Frequency of mental disorders in Germany*

Overall, approximately a fourth of the German population suffered from at least one of the studied mental disorders once in their lifetime. The most common mental disorder in Germany is major depression (9.9 % in the general population, lifetime), followed by specific phobia (9.9 % lifetime) and alcohol abuse (6.3 % lifetime). Far less frequent were social phobia (2.5 % lifetime) and panic disorder (1.1 % lifetime). As a group, anxiety disorders were the most frequent group of mental disorders (14.6 % lifetime).

Overall, approximately one tenth of the German population suffered from at least one of the studied mental disorders in the 12 months previous to the interview. In this 12 months period, specific phobia was the more frequent disorder (6.5 % in the general population, previous year), followed by episodes of major depression (3.9 % previous year), social phobia (1.4 % previous year) and alcohol abuse (1.0 % previous year). As a group, anxiety disorders were the most frequent group of mental disorders (8.1 % previous year).
Predictors of mental disorders in Germany

Overall, mental disorders (previous year) were more frequent among women. In particular, women were observed to have higher rates of mood and anxiety disorders (previous year), while men showed higher rates of alcohol use disorder (previous year).

Overall, mental disorders (previous year) were more frequent among younger individual. In particular, those with 18 – 24 years of age showed the highest rates of mental disorders (previous year). This was true for all mental disorders but alcohol use disorder, which was more frequent among those with 25 – 34 years of age. In general, the frequency of mental disorders tends to decline as age increases.

Unemployment is highly related with the risk of suffering from any mental disorder (previous year).

Living alone is highly related with the risk of suffering from any mental disorder (previous year). This is especially true for mood disorders.
Treatment of mental disorders in Germany

The probability of visiting a health care professional during the first year after the onset of a mental disorder varies according to the specific disorder: e.g., 58.6 % of individuals for generalized anxiety disorder, 57.1 % for panic disorder, 40.4 % for major depression, 3.4 % for specific phobia.

Also, the amount of years, since the onset of a mental disorder, passed until visiting a health care professional (i.e., treatment delay) varies according to the specific disorder: e.g., One year for panic disorders and generalized anxiety disorder, 32 years for specific phobia and 20 years for social phobia.

Overall, the general practitioner was the health care professional most commonly visited (previous year). This is especially true for social phobia (27.9 % of individuals) and major depressive episodes (26.8 %), and less so for specific phobia (15.6 %). The proportion of individuals visiting a psychiatrist was highest for major depressive episodes (21.0 %). Nevertheless, it is noteworthy that only a minority of individuals suffering from a mental disorder reported to have visited a health care professional because of their symptoms. Also, only a small proportion of those who reported having visited a health care professional because of their mental health chose a mental health specialist.

Mental health in Italy

Frequency of mental disorders in Italy

Overall, approximately a fifth of the Italian population suffered from at least one of the studied mental disorders once in their lifetime. The most common mental disorder in Italy is major depression (9.9 % in the general population, lifetime), followed by specific phobia (5.4 % lifetime) and panic disorder (1.5 % lifetime). Far less frequent were conduct disorder (0.3 % lifetime) and alcohol dependence (0.3 % lifetime). As a group, anxiety disorders were the most frequent group of mental disorders (11.0 % lifetime).

Overall, almost a tenth of the Italian population suffered from at least one of the studied mental disorders in the 12 months previous to the interview. In this 12
months period, specific phobia was the more frequent disorder (3.5 % in the general population, previous year), followed by major depression (3.0 % previous year), panic disorder (0.7 % previous year) and posttraumatic stress disorder (0.7 % previous year). As a group, anxiety disorders were the most frequent group of mental disorders (6.0 % previous year).

**Predictors of mental disorders in Italy**

Overall, mental disorders (previous year) are more frequent among women. Specifically, women were observed to have higher rates of mood and anxiety disorders (previous year).

Mood disorders (previous year) are more frequent among younger individual. In particular, those with 35 – 49 years of age and with 50 – 64 years of age showed the highest rates of mood disorders (previous year).

Never being married is highly related with the risk of suffering from an anxiety mental disorder (previous year).
**Treatment of mental disorders in Italy**

The probability of visiting a health care professional during the first year after the onset of a mental disorder varies according to the specific disorder: e.g., 65.2 % of individuals for panic disorder, 31.0 % for generalized anxiety disorder, 28.8 % for major depression, 8.2 % for social phobia.

Also, the amount of years, since the onset of a mental disorder, passed until visiting a health care professional (i.e., treatment delay) varies according to the specific disorder: e.g., one year for panic disorders, 31 years for specific phobia, and 20 years for social phobia.

Overall, the general practitioner was the health care professional most commonly visited (previous year). This is especially true for panic disorders (62.1 % of individuals) and major depression (38.9 %), and less so for specific phobia (18.7 %). The proportion of individuals visiting a psychiatrist was highest for panic disorders (19.4 %). Nevertheless, it is noteworthy that only a minority of individuals suffering from a mental disorder reported to have visited a health care professional because of their symptoms. Also, only a small proportion of those who reported having visited a health care professional because of their mental health chose a mental health specialist.

**Mental health in the Netherlands**

*Frequency of mental disorders in The Netherlands*

Overall, approximately a third of the Dutch population suffered from at least one of the studied mental disorders once in their lifetime. The most common mental disorder in The Netherlands is major depression (17.9 % in the general population, lifetime), followed by specific phobia (7.6 % lifetime) and alcohol abuse (8.4 % lifetime). Far less frequent were agoraphobia without panic (0.5 % lifetime), alcohol dependence (1.5 % lifetime) and conduct disorder (1.3 % lifetime). As a group, mood disorders were the most frequent group of mental disorders (17.9 % lifetime).

Overall, more than one tenth of the Dutch population suffered from at least one of the studied mental disorders in the 12 months previous to the interview. In this 12
months period, specific phobia was the more frequent disorder (5.2 % in the general population, previous year), followed by major depression (4.9 % previous year), posttraumatic stress disorder (2.5 % previous year) and alcohol abuse (1.8 % previous year). As a group, anxiety disorders were the most frequent group of mental disorders (8.6 % previous year).

Predictors of mental disorders in the Netherlands

Overall, mental disorders (previous year) were more frequent among women. In particular, women were observed to have higher rates of mood and anxiety disorders (previous year), while men showed higher rates of alcohol use disorder (previous year).

Overall, mental disorders (previous year) were more frequent among those with 35 – 49 years of age and 50 – 64 years of age, and less frequent among those with 18 – 34 years of age and those older than 65. This was true for all mental disorders but alcohol use disorder.
Treatment of mental disorders in the Netherlands

The probability of visiting a health care professional during the first year after the onset of a mental disorder varies according to the specific disorder: e.g., 68.2 % of individuals for generalized anxiety disorder, 56.4 % for panic disorder, 52.1 % for major depression, 18.4 % for alcohol abuse, 16.7 % for specific phobia.

Also, the amount of years, since the onset of a mental disorder, passed until visiting a health care professional (i.e., treatment delay) varies according to the specific disorder: e.g., One year for panic disorders, generalized anxiety disorder and major depression, 9 years for alcohol abuse, and 12 years for social phobia.

Overall, the general practitioner was the health care professional most commonly visited (previous year). The proportion of individuals visiting a psychiatrist was highest for mood disorders (50.2 %). Nevertheless, it is noteworthy that only a minority of individuals suffering from a mental disorder reported to have visited a health care professional because of their symptoms. Also, only a small proportion of those who reported having visited a health care professional because of their mental health chose a mental health specialist.

Mental health in Spain

Frequency of mental disorders in Spain

Overall, approximately one in five subjects in the Spanish general population had at least one of the studied mental disorders sometime in their lifetime. The most common mental disorder in Spain is major depression (10.6 % in the general population, lifetime), followed by specific phobia (4.8 %, lifetime), and alcohol abuse (3.6 %) and dysthymia (3.6 %). Other disorders observed less frequently are generalized post-traumatic stress disorder (2.0 %) and attention – deficit / hyperactivity disorder (1.8 %). The most frequent group of mental disorders in a lifetime period were mood disorders (10.6 %, lifetime).

Overall, 9.3 % of the Spanish population suffered from at least one of the studied mental disorder in the 12 months previous to the interview. In this 12 months
period, major depression was the more frequent disorder (4.0 % in the general population, previous year), followed by specific phobia (3.6 %, previous year) and dysthymia (1.5 %, previous year). The most frequent group of mental disorders in the 12 months period previous to the interview were anxiety disorders (6.2 %, previous year).

### Predictors of mental disorders in Spain

Overall, mental disorders (previous year) are twice as likely among women than among men. Other characteristics such as age, level of household income, marital status or education are not related with the likelihood of having a mental disorder.

### Treatment of mental disorders in Spain

The likelihood of an individual visiting a health care professional during the first year after the onset of a mental disorder varies according to the specific disorder: e.g., 59.3 % for panic disorder, 51.2 % for generalized anxiety disorder, 48.5 % for major depression, 3.6 % for specific phobia.

Also, the amount of years, since the onset of a mental disorder, passed until visiting a health care professional (i.e., treatment delay) varies according to the specific
disorder, ranging from 1 year for panic disorder, generalized anxiety disorder and major depression to 37 years for specific phobia.

Overall, the general practitioner was the health care professional most commonly visited (previous year). This is especially true for post traumatic stress disorder (55.0 % of individuals), panic disorder (53.9 %) and generalized anxiety disorder (48.4 %), and less so for specific phobia (14.3 %). The proportion of individuals visiting a psychiatrist was highest for post traumatic stress disorder (37.7 %), major depressive disorder (34.1 %) and panic disorder (34.1 %). Nevertheless, it is noteworthy that only a minority of individuals suffering from a mental disorder reported to have visited a health care professional because of their symptoms. Also, only a small proportion of those who reported having visited a health care professional because of their mental health chose a mental health specialist.
4) **Strengthening the Epidemiology Policy Research Network in Europe**

Besides the participation in international conferences and the publication of the scientific articles through which the previous results were disseminated, these years conducting the EPREMED Project have also helped at strengthening the Epidemiology Policy Research Network in Europe.

This has been possible thanks to the specific dissemination strategies conducted in each country, the policy reports produced by the EPREMED project or in which data from the project is included, and through personal communications focusing on mental health policy produced by the project, as well as through the yearly workshops conducted and the setting of a mobility of researchers programme.

**Training and Mobility of Researchers**

EPREMED workshops were designed to support the development of scientific knowledge within the project group. This helped to expand statistical, methodological and other knowledge in the field of survey research and epidemiology of mental disorders. These workshops helped to analyse the complex survey data and to develop new ideas for further scientific research.

Each year a workshop was organised and conducted by the EPREMED members and external members. All workshops were attended by members of the consortium and external participants. All participants rated the workshops as a useful and valuable source of information. Workshops helped the project increase the knowledge of young scientist in the fields of mental health epidemiology, health economics and statistical analysis. This helped also to increase the scientific quality of publications in the project.

Workshop about health economy: Introductory Course to the Economic Evaluation of Health Care. October 2006, University of Leipzig, Leipzig, Germany

Workshop about health related quality of life measures: Health Related Quality of Life Measures in the Esemed Dataset. November 2007. PRBB (Barcelona Biomedical Research Park), IMIM-IMAS, Barcelona, Spain

Besides the important work carried out through these workshops, a Mobility Program for EPREMED Researchers was set up, which allowed for 2 exchange activities per year.

2006

- Ana Fernandez visited the ULPZ from August 1st to August 31st 2006. She worked together with Hans-Helmut König and Sebastian Bernert on a paper project titled “Burden of disease in three European countries. Comparing VAS and TTO valuations.”
- Susana Ochoa stayed at the Leicester University during July and August 2006. During her stay, coordinated by Prof. Brugha, analyses and reviews were conducted for the production of a manuscript (see section I.5 of the report “Scientific Publications”).

2007

- Martine Buist-Bouwman (Trimbos Institute) visited IMIM (Barcelona, Spain) to get statistical support for her thesis (Functional limitations associated with mental disorders), including the paper “Psychometric properties of the World Health Organization Disability Assessment Schedule Version” that was used in the European Study of the Epidemiology of Mental Disorders (ESEMeD).
- Ana Fernandez visited Jean Pierre Lépine and colleagues at the Hôpital Ferdinand Widal during the Erasmus Mundus European Master on Dynamics in Health and Welfare study (October 15th- February 29th 2007). Together with the French team she produced a draft version of a paper.

2008

- Florence Vorspan from Paris visited IMIM (Barcelona, Spain) to work on the paper “Age of onset of alcohol use in six European countries. Description and associations with frequencies and ages of onset of anxiety and mood disorders.” (February 2008)

In order to improve the website quality Sebastian Bernert from the University of Leipzig, Germany, visited IMIM, Barcelona, Spain. (March 2008)
EPREMED Website

A website of EPREMED (http://www.epremed.org) was set from the very beginning of the project, as an important part of its dissemination strategy.

(see Annex 13 for a more complete description of the website)

All partners collaborated actively in the setting of this very useful tool, and provided the materials which form its content.

The main objective was to create a public part of the homepage in order to include all the available information for a broader public audience. In order to make the public information more easily understandable, language was transferred from scientific standards to a more casual and yet accurate expression. In addition, web-based information management was reviewed and updated on a regular basis. Thus it provided to all visitors and, importantly, all project partners the necessary and most recent information of the project.
One secondary advantage of the web site as an internal communication too was that it avoided the coordinating centre of being asked by too many simultaneous requests. Regularly updating the web site materials was also couple with an effort to improve its substantive quality. Therefore, the homepage provided the most recent updates of the database, publication issues, and analysis questions among others. It provided an invaluable platform for exchange and communication among the project members.

As part of the mobility program, Sebastian Bernert from the University of Leipzig visited IMIM by the end of 2007, for a more in-depth review of the website (both the open section as well as the restricted area for the EPREMED members). Both sections were more clearly differentiated, the latter becoming a major resource for the coordination and management of the project.

On the public side of the web, country specific data on prevalence rates of the most common mental disorders, suicide rates, access and provision of services, cost of mental disorders and medication use in different European countries was available in early 2007.

Finally, a strategy was put in place to make this source of information better-known to a wider audience, especially lay persons. This was made through easier finding the EPREMED website using websearch engines, such as Google.

The website is still being used by all EPREMED members who will assure its continuity and improvement.
5) Bibliography produced

Scientific Publications

Target audience Nº 1: Scientific community

Note: The journal impact factor is a measure of the frequency with which the "average article" in a journal has been cited in a particular year or period. The annual Journal Citation Reports impact factor, published yearly by the Institute of Scientific Information, a division of Thomson Scientific, is a ratio between citations and recent citable items published. Throughout this list, we use the Impact Factor for 2006, when available, as a proxy for the importance of a journal to its field.

Journal articles with International scope:


Psychol Med. 2008;26:1-12. [IF = 3.82]


Journal articles with National scope:


- Gunther OH, Friemel S, Bernert S, Matschinger H, Angermeyer MC, König HH. [The burden of depressive disorders in Germany - results from the European Study of the Epidemiology of Mental Disorders (ESEMeD)]. Psychiatr Prax. 2007;34:292-301 [IF = N.A.]


  \[IF = \textbf{1.33}\]

  \[IF = \textbf{13.89}\]

  \[IF = \textbf{N.A.}\]

  \[IF = \textbf{N.A.}\]

  \[IF = \textbf{N.A.}\]

  \[IF = \textbf{N.A.}\]

  \[IF = \textbf{N.A.}\]

  \[IF = \textbf{N.A.}\]


Konig HH, Bernert S, Angermeyer MC. [Health Status of the German population: results of a representative survey using the EuroQol questionnaire]. Gesundheitswesen. 2005;67:173-82. [IF = 0.72]


Books / Book Chapters:


de Girolamo G, Morosini P, Gigantesco A, Delmonte S, Kessler R. The prevalence of mental disorders and service use in Italy: Results from the National Health Survey


Scientific communications:

Scientific communications:


[Conference] Kovess V. [Depression in Europe and its management]. Tenth anniversary of the national suicide prevention day organized by the Centre Hospitalier de Pontoise and the European Alliance Against Depression (EAAD). Cergy-Pontoise, France. 31 January 2006. [National]


Kovess V, Carmona E. How to transpose epidemiological data into political action? EPREMED-Fondation MGEN. World Psychiatric Association (WPA) international congress. Istanbul, Turkey. 12-16 July 2006. [International]


Matschinger H. Classification in the framework of Mixture IRT models. Applied Classification”. University of Münster. 15-18 November, 2006. [National]

Kovess Masfety V. Health information and the Well being of the population. WHO interministerial conference. Helsinki, Finland. 12-15 January 2005. [International]


Kovess V. The status of mental health in the European Union. Third meeting of the working party on mental health, European Commission. Luxembourg. 30-31 May 2005. [International]


**Target audience № 2: Policy makers**

[**Italian Focus Group**]*

De Girolamo Giovanni. Italian ESEMeD Focus group. Rome. March 7, 2008. [Data included in National/local health plans; number of participants = 12]

[**Report for the Spanish Health and Consume Ministry**]

Autonell J, Bulbena A, Haro JM; Montero I, Moreno B, Muñárriz M, Torres F, Salvador-Carulla LS, Spanish Society of Psychiatric Epidemiology. Documento técnico para la elaboración de una propuesta de estrategia en salud mental del sistema nacional de salud [Technical document for the elaboration of a strategic proposal in mental health for the national health system]. 2006. [Data included in National/local health plans]

[**REPORT for the Generalitat of Catalonia, Mental Health Directing Plan**]

Haro JM, Salamero M. Epidemiología de los trastornos mentales en Cataluña. Necesidades y necesidades cubiertas [Epidemiology of mental disorders in Catalonia. Needs and met needs]. 2006. [Data included in National/local health plans]

[**REPORT for the Ministry of Health of the Netherlands**]


[**Report for SANCO, European Commission**]


*Note: dissemination activity covering several target audiences (policy makers, patients, Non-governmental organizations, general practitioners, psychiatrists, public mental health services professionals, mass media representatives). Summary available in List 1.
Target audience № 3: Social/civil society


[Mean number of daily edited copies year 2005 = 125,000]


[Mean number of daily edited copies year 2006 = 143,804]


[Mean number of daily edited copies year 2006 = 588,530 (the highest among Spanish newspapers)]

[Meeting]* Kovess Masfety V. La dépression en Europe [Depression in Europe]. Journées européennes de la dépression organisée par l’association France Dépression. Sénat, Paris. 6 October, 2006. [Number of participants = 200; Kind of participants = Patients, families, journalists, psychiatrists, nurses, local authorities, minister of health civil servants]


*Note: dissemination activity covering several target audiences. It is listed here since more than half of participants were civil society members.
Policy information research capacity (training activities organised by the consortium, newly engaged junior researchers, projects generated by the consortium).


[Student training] Brugha T. Susana Ochoa (PhD) from Sant Joan de Déu, Spain stayed during 1 and a half month at the University of Leicester. July-August 2006.

[Student training] Bernert S, König H, et al. Anna Fernández (student) from Sant Joan de Déu, Spain, spent 1 month at the Psychiatry Department of the University of Leipzig. She was trained data analyses for the economic evaluation of health care. August 2006. [First version of a Scientific article produced]


[Exchange activity] Domingo-Salvany A. Florance Vorspan from France stayed during 1 week at IMIM. February, 2008 [First version of a scientific article produced]


[Workshop] König H. Introductory Course to the economic evaluation of health care. Leipzig, October 9th-10th, 2006. [Number of participants =14]

Policy reports

- Report of the methodology review and policy information user dialogues.
- Report of the policy outputs and completion of scientific manuscripts.
- Systematic review of systematic reviews and meta-analyses of psychiatric epidemiological observational studies.
- Report: Syntheses Of Data Using Esemed And Other European Sources.

Policy reports, Laws or Health plans containing EPREMED data

- Sanco Green paper: Improving the mental health of the population. Towards a strategy on mental health for the European Union.
- Spanish national health plan.
- 2 Spanish local health plans.

Personal communications

- Kovess Masfety V. Launching the green paper on mental health Mental health and mental ill health in EU: An overview of situations and challenges. Luxembourg. 24 October, 2005.
- Kovess Masfety V. Initial review of data availability and comparability on selected mental health indicators. Meeting of OECD Health Data national correspondents. Paris, France, 4 October. 2006.
- Kovess V. Risk factors in adult population: an European comparison. WHO Europe interministerial conference. Helsinki, Finland, 12-15 January 2005
II. HUMAN RESOURCES and ACHIEVEMENT OF THE OBJECTIVES

The EPREMED Project has counted with invaluable professionals in the achievement of these objectives and results, simultaneously promoting the consolidation and the development of a multidisciplinary, European mental health policy information research community. The idea has been to serve as an open forum of dialogue between all stakeholders, and to contribute to the advancement of standards in: policy support, research and technology, and dissemination.

As a result, several dissemination activities have been carried out both at an international and at a European level (and in the 6 European countries at stake in particular) and the achievement of the EPREMED objectives has been a real success.
# 1) Partners Involved in EPREMED

Partners of the EPREMED Consortium are referred herein according to the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMAS-IMIM</td>
<td>Institut Municipal d’Assistència Sanitaria – Institut Municipal d’Investigació Màdica (Spain), Coordinator</td>
</tr>
<tr>
<td>K.U.Leuven</td>
<td>Katholieke Universiteit Leuven (Brussels), Contractor</td>
</tr>
<tr>
<td>ULPZ</td>
<td>Universitat Leopzig (Germany), Contractor</td>
</tr>
<tr>
<td></td>
<td>University of Leicester (UK), Contractor</td>
</tr>
</tbody>
</table>

- **IMAS-IMIM**
  - The Municipal Institute of Medical Research (IMIM) is a public centre focused on the scientific research into Biomedicine and Health Sciences, as well as the training of highly qualified researchers in these fields.
  - IMIM belongs to the Municipal Institute of Health Care (IMAS) and is responsible for the support, promotion, and management of the IMAS research.
  - IMIM scientific activity is organized into multidisciplinary Research Groups, which interaction allows the integration of different disciplines into basic, clinical, epidemiological, and health services research. The scientific production generated by this activity includes almost 200 annual publications in international journals listed in the SCI and SSCI index, and it ranks IMIM in the third position among the health centres of biomedical research, both in Catalonia and Spain.

- **K.U.Leuven**
  - The university hospital Gasthuisberg (UHG) is a public hospital with a wide range of public health services and scientific research facilities, organized in the biomedical department of the Katholieke Universiteit Leuven (KUL).
  - Its scientific activity is organized into multidisciplinary research groups, which interaction allows the integration of different disciplines into basic, clinical, and epidemiological research.
  - The scientific production generated by this activity includes more than 1100 annual publications in international journals listed in ICI (Science Citation Expanded), ranking this department in the highest position among health centres of biomedical research in Belgium.

- **ULPZ**
  - The Department of Psychiatry at the University of Leipzig is part of the University Hospital. Besides its clinical facilities (three wards, a day clinic and an outpatient clinic) the Psychiatry Department has a well-established research unit with researchers in the fields of epidemiology, public mental health, ageing and dementia, health economics and statistics in mental health sciences.
  - This research unit serves to facilitate research of psychopathology of mental disorders and its consequences: impact on patients’ and their relatives’ quality of life, the use of mental health services and the costs of specific mental illnesses or mental disorders in general. Associated to the Department are two independent research units: a research unit of public mental health and a unit of health economics. These research units provide access to a set of databases and are supporting students and Phd candidates.

- **University of Leicester**
  - The Section for Social and Epidemiological Psychiatry (SSEP) in an internationally acclaimed research group within the Department of Health Sciences (DHS), School of Medicine, University of Leicester,
ULEIC-DHS

England (United Kingdom). Its scientific activities bring together clinicians in primary care, mental health and public health medicine, epidemiology, biostatistics, social policy and economics and genetic epidemiology.

- The Department of Health Sciences includes over 160 staff primarily dedicated to research on public health, epidemiology, primary care, mental health and policy information. It includes internationally recognised expertise in the epidemiology of ageing, health and social policies in later life and the economics of individual and population ageing, meta-analysis and other quantitative and qualitative synthetic methods.

ISS

Istituto Superiore de Sanita (Italy), Contractor

- The Italian National Institute of Health (Istituto Superiore di Sanità-ISS) is a technical scientific organ of the Italian National Health Service. It undertakes research, control and training functions in the area of public health. The ISS closely cooperates with the Minister of Health in preparing and implementing scientific and health planning; it is the main public health agency in the country. It keeps a variety of national epidemiological registers.
- The ISS currently comprises 20 Laboratories and has some 1000 professionals and researchers involved in active research projects, and a large number of technical and administrative staff. The Unit of Service Evaluation, coordinated by Perluigi Morosini, is part of the Laboratory of epidemiology and biostatistics, which includes a large number of fulltime researchers and collaborators who are involved in a number of international and local collaborative research projects.

TRIMBOS

Stichting Trimbos Institute (The Netherlands), Contractor

- The Trimbos Institute (Institute of Mental Health and Addiction, Utrecht, The Netherlands) is an independent national centre of expertise in the field of mental health care, substance use and the care of addicts.
- The Institute's main activities are research, health education, the promotion of expertise and the dissemination of information. A major focus of the Epidemiology Programme is the assessment and the monitoring of mental health and substance related problems and the related (deterioration of) quality of life and utilisation of care among which we performed the well-known longitudinal study NEMESIS. The Institute is also internationally oriented; it is the Focal Point for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA); it is an active partner in the International Consortium for Psychiatric Epidemiology (ICPE), and the Institute collaborates in health campaigns conducted by the European Union, the World Health Organisation and the United Nations.

AP-HP

Université Paris 7 Denis Diderot Assistance Publique – Hôpitaux de Paris (France), Contractor

- Assistance Publique –Hôpitaux de Paris (AP-HP) is a group of 40 teaching hospitals in the Paris region.
- The department headed by Jean-Pierre Lépine at Hôpital Ferdinand Widal has several senior researchers involved in the different research projects as well as residents and students and are involved in a number of international and local collaborative research projects.
- The Department of Psychiatry at the Hôpital Fernand Widal is devoted to scientific research both in the clinical as well as in the epidemiologic field. It has the task to train in psychiatry, neuropsychology and epidemiology research students in medicine and psychology. Several persons of the Department are acting as scientific experts for government agencies in the field of psychiatry,
psychopharmacology and addictions.

- The Paris Sud Innovation Group in Mental health methodology (PSIGIM) is a unit of research located in another hospital of AP-HP (Hôpital Paul Brousse). The Scientific objective of this unit is to develop new measurement methods in psychiatry. The research topics are psychometrics, statistical multidimensional exploratory methods, psychiatric tools in the field of depressive disorder, substance abuse, schizophrenia, organ transplantation and satisfaction.

SJD-SSM
- Sant Joan de Déu, Serveis de Salut Mental (Spain), Contractor

- San Joan de Déu-Serveis de Salut Mental (SJD-SSM) is a private non-for profit institution that provides comprehensive mental health services to a population of approximately one million people. Besides health care provisions, SJD-SSM carries out post-graduate education and research.

- The Research and Development Unit, directed by Josep Maria Haro, includes more than 10 full time investigators and more than 30 investigators that also work in providing or managing mental health services or in post-graduate training. Professionals come from diverse disciplines (medicine, psychology, nursing, sociology, economy, mathematics, engineering...)

- The Scientific activity of the Research and Development Unit (RDU) of SJD-SSM is organized in two main lines of research: 1) health services research and outcome measurement and 2) schizophrenia. Multidisciplinarity, the cautious observation of ethical principles and the harmonization of research and health care delivery are three of the characteristics traits of the investigation at SJD-SSM. Together with the research, the RDU develops and implements new services, as with the Catalonia case management program, home care for persons with severe mental disorders or tele-psychiatry services.

FSP-MGEN
- Mutuelle Generale de l'Éducation Nationale Public Health Foundation (France), Contractor

- The MGEN Public Health foundation is dedicated to Public health with a special interest to mental health. The foundation is closely linked to Paris 5 University and train PhD and MD students. It is supported by a non-profit health insurance covering around three million people.

- The foundation is monitoring the health and more specifically mental health of his population through a 10 000 people panel along the years and the exploitation of and use of care data bank. It is involved in major surveys on children and adolescents population along with the ministries of health and education. In addition the foundation has been contracted by the French Ministry of Health for developing indicators to plan mental care through an epidemiological approach in four French regions. There are around 10 people working full time plus PhD students.
The Project has been formed by 9 participants belonging to 7 European countries. These partners had been the responsible of the ESEMeD/MHEDEA project, a EU Commission funded RTD within the 5th Framework Programme (QLG5-1999-01042), during the four years previous to the EPREMED Project.

The management structure for the project aimed at the fulfilment of the project work plan and it included three major elements: the Management Team, the Steering Committee and the Workpackages Leaders.

**Project Management Team**

The PMT has been formed by skilled professionals who have developed complementary roles, lead by a Project Manager with the support of experienced technical and administrative personnel at IMIM. They have carried out the daily management of the project. Included has been the management of dependencies between various tasks, co-ordination of technical progress, assurance of project milestones fulfilment, review of technical reports and deliverables and resolution of problems arising within the consortium, as well as, all the administrative and
financial tasks related to the project’s development, including monitoring of resources consumption, support to partners, delivery to the Commission of the corresponding reports and assuring that corresponding Audits were done by the requested partners when necessary. Its specific objectives have been:

1) **Follow-up of tasks** and monitoring of compliance with the project work plan, planned resources and time schedule, promoting as far as possible the synergy between different activities and efficiency throughout.
2) **Risk management.** Identification and assessment of risk. When necessary, contingency plans proposals have been produced to the Project Steering Committee.
3) **Control of effort and resources** spent by the Consortium, their justification and adequacy to the work carried out. Implementation of corrective actions.
4) **Communication** within the Consortium. Consensus building activities. Resolution of conflicts among partners. Reporting of unresolved issues and conflicts (as informed by the WP leaders) to the Project Steering Committee.
5) **Meetings** organisation and meetings minutes’ production.
6) **Liaison with the EC** Project Officers. Timely delivery of project’s deliverables and milestones achievement.
7) Production of administrative and financial **periodic reports**, according to that specified in the EC contract.

**Project Steering Committee**

A Project Steering Committee was soon established, consisting of a representative from each of the contractors and chaired by the Project Coordinator. SC members were required to have the authority to commit his/her organisation in all project-related respects to take corrective actions as necessary. The SC has been the highest decision-making of the project, responsible of decisions regarding the overall policy and technical strategy of the project, changes in the work plan and resource allocation. It has monitored and approved technical progress and ensured that objectives were met, deliverables were produced according to schedule, dealt with any contractual issues and/or knowledge management disputes which could not be resolved at lower levels. The SC has also overviewed the administrative and financial aspects of the project, as reported by the PMT.
The SC has been responsible of ensuring that all the project’s intermediate and final results were produced with the maximum quality level, and that this level was appropriate according to the scheduled objectives and the EC requirements. For these purposes, the SC has been allowed to require specific actions or reports from the PMT and/or Work Package Leaders.

For decision purposes, each member of the SC was allocated one vote. Two thirds of the contractors attending a meeting of the SC constituted a quorum. In the event of a tied vote, the project Coordinator (as chair) had an additional vote.

- Jordi Alonso
- Mattias C. Angermeyer
- Sebastian Bernert
- Ronny Bruffaerts
- Terry Brugha
- Koen Demyttenaere
- Isabelle Gasquet
- Giovanni de Girolamo
- Ron de Graaf
- Josep M. Haro Abad
- Viviene Kovess
- Jean Pierre Lépine
- Gemma Vilagut

Work Package Leaders (WPL)

For each work package there has been an active leader that has been the responsible for securing the completion, the timeliness and the quality of all the deliverables. The WPL has had responsibility for day-to-day management of specific work related to individual work packages. This includes implementation of the work package tasks as defined in the project work plan, solution of technical problems, follow-up and coordination of the activities of the partners involved, production of the corresponding deliverables, preliminary identification of risks and reporting of progress against the plan. The WPL has been in direct contact with involved partners and has reported to the PMT project’s deliverables and financial periodic reports as required.

The following table summarises which activities the various partners have conducted and how they have contributed to the set objectives. Section II of the Report further details the activities conducted.
<table>
<thead>
<tr>
<th>Work package (WP) Nº</th>
<th>Work Package Title</th>
<th>Lead partner for the Work Package (name)</th>
<th>Contribution to set objectives</th>
<th>Person-days</th>
<th>Global Cost (€)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WP1</td>
<td>Coordination and Management</td>
<td>IMIM (Jordi Alonso)</td>
<td>IMIM has provided its previous experience on the coordination of EU projects, in particular MHEDEA 2000 QLGS-1999-01042. It has lead WP1 being in charge of the scientific, financial, and administrative management, and has been the interface between the Commission and the project participants.</td>
<td>766</td>
<td>217,293.50</td>
</tr>
<tr>
<td>WP2</td>
<td>In-depth analyses of the ESEMeD/MHEDEA</td>
<td>IMIM (Jordi Alonso)</td>
<td>IMIM has provided the Public Health perspective, and has lead WP2 securing central analysis and communication. It has as well contributed to WP3, WP4 and WP6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WP3</td>
<td>Data integration and synthesis</td>
<td>ULEIC-DHS (Terry Brugha)</td>
<td>ULEIC-DHS has provided the Consortium the expertise in combining qualitative and quantitative data in complex data analysis, as well as specific expertise in ageing populations, and in testing measures of mental status and of determinants of mental disorders and in calibrating models of outcome taking account of measurement error. It has lead WP3 and has also participated in WP 4.</td>
<td>270</td>
<td>107,699€</td>
</tr>
<tr>
<td>WP4</td>
<td>Dissemination of results</td>
<td>FSP-MGEN (Viviane Kovess)</td>
<td>FSP-MGEN, due to its very close relationship with national and international government agencies this partner has contributed to the effective dissemination to Mental Health policy makers. Its main task has been to transform results into policy makers language, leading WP4. It has also contributed to WP2 and WP3.</td>
<td>376</td>
<td>136,405€</td>
</tr>
<tr>
<td>WP5</td>
<td>Evaluation of dissemination activities</td>
<td>SJD-SSM (Josep M. Haro)</td>
<td>SJD-SSM has provided the perspective of the provider of mental health services as well as its expertise in ethics. It has lead WP5 and has also participated in WP2.</td>
<td>571</td>
<td>142,564€</td>
</tr>
<tr>
<td>WP6</td>
<td>Training and mobility of researchers</td>
<td>ULPZ Mattias Angermeyer</td>
<td>The Psychiatry Department Research Unit has provided the experience of a very old University (Leipzig University was founded in 1409) involved in numerous international research projects and promoting the internationalisation of young researchers and scholars. It has lead WP6 in order to increase communication and expertise of the group, with focus on the complex statistical survey analysis. It has also contributed to WP2 and WP4.</td>
<td>815</td>
<td>134,074€</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>2747</td>
<td>722,320€</td>
</tr>
</tbody>
</table>
The following Institutions have also contributed to the Project, even if not leading a particular WP:

**ISS (Istituto Superiore di Sanita, Roma, Italy)** has provided its expertise in promoting public health programmes at the national level and its experience in supplying information to governments. For its participation on WP4, it has concentrated on the development of effective dissemination strategies targeted to different types of audiences, besides ensuring the ESEmeD/MHEDEA project received adequate space at a European Ministries Health meeting (Finland 2005).

**TRIMBOS (Netherlands Institute of Mental Health Addiction, Trimbos Institute, Utrecht, The Netherlands)** has provided its experience in large research projects. Ron de Graaf being the principal investigator for the project at the Institute, he has participated in both WP2 and WP3.

**K.U.Leuven (University Hospital Gasthuisberg, Leuven, Belgium)** has provided the expertise of the biomedical Department as key opinion leaders in several specific mental disorders. As a participant of the project, it has been involved in WP4, being in charge of the accurate communication of scientific sound data into a broad scientific field. This partner has also participated in WP3.

**AP-HP (Assistance Publique, Hôpitaux de Paris, France)** has provided its experience in provision of mental health care as well as its expertise in psychiatric pharmaco-epidemiology. As Partner of the Project, it has been involved in and contributed to several Work Packages, mostly WP2, WP4 and WP6.
Scientific/Advisory Committee (SAC)

Even though not foreseen by the Project Proposal, a Scientific/Advisory Committee was established, formed by:

a) senior researchers not belonging to EPREMED but with an active role in the ESEMeD project,
b) junior researchers belonging either the EPREMED project or the ESEMeD project,
c) and other scientific researchers whose advice was regarded as necessary by the SC.

The SAC delivered advice upon request of the SC, which used this advice to improve its decision-making abilities.

- Ron C. Kessler
- Hans Ormel
- Gabriella Polidori
- Steven J. Katz
- Jordi Alonso
- Mattias C. Angermeyer
- Sebastian Bernert
- Ronny Bruffaerts
- Terry Brugha
- Koen Demyttenaere
- Giovanni de Girolamo
- Ron de Graaf
- Isabelle Gasquet
- Josep M. Haro Abad
- Viviene Kovess
- Jean P. Lépine
- Gemma Vilagut
- Josué Almansa
- Saena Arbazadeh-Bouchez
- Jaume Autonell
- Mariola Bernal
- Martine Buist-Bouwman
- Miquel Codony
- Antònia Domingo-Salvany
- Montserrat Ferrer
- Montserrat Martinez-Alonso
- Herbert Matschinger
- Fausto Mazzi
- Zoe Morgan
- Pierluigi Morosini
- Carol Jagger
- Wilma A. M. Volleberg
# 2) Manpower for the Execution of the Activities

The following table presents a complete list of all the persons who have participated in the execution of the project and, for each of them, the man/days of work, the professional level or category and the corresponding unit and total cost.

<table>
<thead>
<tr>
<th>Person</th>
<th>Partner</th>
<th>Function</th>
<th>Reference to WP N°</th>
<th>Person – days</th>
<th>Daily cost (€ per day)</th>
<th>Global Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jordi Alonso</td>
<td>IMIM</td>
<td>Coordinator</td>
<td>1,2,4,6</td>
<td>401</td>
<td>359</td>
<td>143,758.50</td>
</tr>
<tr>
<td>Antonia Domingo</td>
<td>IMIM</td>
<td>Scientist</td>
<td>1,2,4,6</td>
<td>106</td>
<td>324</td>
<td>34,291.00</td>
</tr>
<tr>
<td>Montserrat Ferrer</td>
<td>IMIM</td>
<td>Scientist</td>
<td>1,2,4,6</td>
<td>66</td>
<td>284</td>
<td>18,744.00</td>
</tr>
<tr>
<td>Sonia Rojas</td>
<td>IMIM</td>
<td>Statistician</td>
<td>1,2,4,6</td>
<td>125</td>
<td>64</td>
<td>8,000.00</td>
</tr>
<tr>
<td>Joan Marc Carbó</td>
<td>IMIM</td>
<td>Computer specialist</td>
<td>1,2,4,6</td>
<td>20</td>
<td>253</td>
<td>5,060.00</td>
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| Total           |         |                   |                    | 766           | 217,293.50€            |
| Total           |         |                   |                    | 815           | 134,074.75€            |

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<td>Josep Maria</td>
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As agreed in the different Amendments to the Grant Agreement, the following persons have collaborated as well in the project through subcontracting:

**Name:** T. Fryers  
**Organisation:** Visiting Professor of Public Mental Health in ULEIC (tasks of WP3), psychiatric epidemiologist.
**Activities conducted:** He was, for a limited period, consultant to the project with the Leicester team. He contributed generally to the Leicester project team's discussions of epidemiological methods, data collection issues, analytical approach and interpretation of results. He also contributed to early planning of possible publications deriving from the project. With Prof Brugha, he attended the European research group meeting in Leuven, Belgium, February 2007, to contribute epidemiological expertise and experience of previous survey work to discussions of the current and future phases of the project.

**Name:** Janet Harkness,  
**Organisation:** ZUMA, European Centre for Comparative Surveys, Germany  
**Activities conducted:** Professor Harkness, who is also in dialogue with other international centres undertaking research on mental health in the population, was aware of our study and familiar with our data. She expressed an interest in assisting us. Prof Harkness reviewed our methods and her team examined the translation methods used in our main measure of burden. We had reported differences in estimated rates of mental disorders comparing different EU countries in ESEMED. Prof Harkness's team took one or more key examples of questions used to generate these findings in at least two different languages and they considered in some detail possible explanations for such findings in terms of differences in culture, meaning, interpretation and language translation method. Professor Harkness, whose academic background is in the study of languages, has extensive experience of comparative survey work across Europe.

**Name:** Dr. Giulia Rinaldi  
**Organisation:** professional M.D., specialist in psychiatry  
**Activities conducted:** collaboration to specific statistical analyses on the Italian ESeMED data. Collaboration to a review of general population international surveys carried out using Medline, Psychinfo and Sociological Abstracts.  
**Relation to the activities and objectives of the project:** To identify and to compare relevant European studies with other studies and produce data and information synthesis.

**Name:** Dr. Giovanni Santone  
**Organisation:** M.D., specialist in psychiatry, Psychiatric Clinic, United Hospitals of Ancona and Polytechnic University of Marche, Ancona, Italy.  
**Activities conducted:** ESEMeD Italian data management and analysis. Statistical computerized data input preparation for data collection, preservation and analyses. Production of analyses especially focused on the associations between disability and common mental disorders. Collaboration in the preparation of scientific articles. Collaboration to the design of the dissemination activities tailored for the appropriate representatives of the various stakeholders. Oral presentations in congress, conferences and other community events. Collaboration to the coordination of the EPREMED European participants in order to allow a systematic consultation on the results of all European countries involved in the project.  
**Relation to the activities and objectives of the project:** Collaboration to the realisation of the policy information research of the ESEMeD project. Collaboration to the dissemination activities.

**Name:** Dr. Giovanni de Girolamo  
**Organisation:** M.D., specialist in psychiatry, Health Care Research Agency, Bologna, Italy.  
**Activities conducted:** Collaboration to the preparation of various scientific articles especially focused on mental disorders comorbidity and on use of health services by individuals affected. Collaboration to the design and evaluation of dissemination
activities for planning more effective strategies to manage common mental disorders in public health services including a synergy between general practitioners and specialized mental health services, with the aim to offer an integrated care to the patients.

**Relation to the activities and objectives of the project:** Maximisation of the realisation of the policy information research and dissemination activities.

**Name:** Dr. Melinda Tucker  
**Organisation:** professional Psy. D.  
**Activities conducted:** Collaboration to the preparation of various scientific articles. Collaboration with the coordination of the EPREMED European participants in order to produce an international monograph on the ESEMeD results. Collaboration to reviews on general population international surveys carried out using Medline, Psychinfo and Sociological Abstracts.

**Relation to the activities and objectives of the project:** Maximisation of the realisation of the policy information research.

**Name:** Dr. Toni Alessandro  
**Organisation:** professional Psy. D.  
**Activities conducted:** collaboration to specific statistical analyses on the Italian ESeMED data. Collaboration to a review of the ESEMeD study results, Italian arm, in order to draw up a synthetic report on policy relevant information on prevalence of mental disorders in the general population, risk factors, burden and service use of individuals affected.

**Relation to activities and objectives of the project:** Preparation of a report especially focused on the Italian specificities and their main possible explanations which were discussed in The ESEMeD focus group at the National Centre of Epidemiology, Surveillance and Health Promotion (CNESPS), National Institute of Health (ISS), Rome, on the 7th March 2008.
3) Countries involved in EPREMED

For the dissemination strategy targeting national policy-makers, meetings and focus groups were organised, and civil society was informed through media coverage of citizen-friendly information.

Here, a summary of the activities conducted in each of the countries involved and the way in which the results have been made available in each of them is presented.

In general, each country’s activities were conducted on the base of the collection of data and the creation of a database of selected national/regional stakeholders for Belgium, the Netherlands, France and Spain allowing to present key EPREMED data to very diverse audiences, and in particular, to audiences which are not reached by usual scientific publications or communications. This lead to a national audience database, and the same work was achieved for a European audience.

**Belgium:** As part of the dissemination strategy, an *in-person meeting* was organised in Belgium, with Ronny Bruffaerts and Koen Demmytaere, who identified the mutual insurance companies as a key audience for EPREMED dissemination in Belgium. As a result, Viviane Kovess met in Brussels with Jean Hermesse, a representative of Belgian mutual insurance companies, who confirmed their strong interest for EPREMED results.

One focus group was organised in Belgium (see Annex 9).

Around 60 people attended the focus group, among which were represented journalists, psychiatrists, psychologists, Health Ministry representatives as well as patient organisations and scientists from the Scientific Institute of Public Health.

Contact with Belgian officials suggested that, as in France, they were interested in Use of Care. Their preference was for data that is provided in the same format as they receive data on physical health. They seemed to prefer to keep separate information on anxiety and depression –combining them (into a category of Mixed Anxiety and Depression favoured by UK Policy Advisers) seemed less appealing. They also showed a preference for alcohol and drug misuse to be kept separately. Belgian policy makers seemed to be interested in further collaboration between policy advisers and researchers, but when another opportunity to meet was set up, they did not confirm their assistance but wanted to send instead their data and information technical advisers.

An important effort was made in order to include the EPREMED website as a link in several relevant web sites concerned with mental health, such as scientific societies, patients groups, public health, and epidemiological societies.
France: Two focus groups were organised in France in November 21, 2006 and in March 8, 2007 (see Annex 9)

Representatives of the various stakeholders (scientific community, practitioner’s representatives, policy-makers, civil society, and mass media) were invited to participate, and the participants were emailed three scientific papers in French and a power point presentation in which ESEMED results were discussed.

In general, the dissemination of the ESEMED results in France occurred in the scientific community through national papers and by a presentation delivered at a large conference organised by France Depression (User Group) in which participants included policy makers and other relevant stakeholders; in addition the ESEMED study was quoted in the “National plan for Mental health and Psychiatry” implemented during the last few years in France.

The participants viewed the focus group as a form of continuing education. They felt that this type of format for the presentation of research results was worth to be repeated, as it was the most effective way of transmitting research results to government officials. They would also like to build a knowledge base of expertise that they could use as an information source as they felt that as civil servants they lack the expertise to interpret these results on their own, and need the scientific community to assist them.

In France, this was the first time that government and public health officials were able to have a discussion with a research scientist to discuss research results. The information stakeholders are looking for is what has been done, what are the results, and where can they find the information. The dissemination of results via a focus group was thought to be more effective than simply sending them printed material of which they do not have time to read.

In the group, a journalist provided insight into the type of information journalists wanted and needed. Mental health issues are not clearly understood by journalists and by the public at large and to remedy the situation journalists need to be provided with information (i.e. press release) that they then can disseminate to a larger audience.

Policy advisers did not seem to know what it was they wanted or needed and they appreciated the opportunity to meet and consider the available evidence on rates of mental disorders in the population and on possible determinants.

Following focus group recommendations, a press release for a large audience was produced. The press release was done by a professional journalist who selected the most appealing aspects according to her experience and conducted a life interview to the French Prime Minister. The interview was posted on the EPREMED website, available to a large audience.

The EPREMED website was included as a link in several relevant web sites concerned with mental health, such as scientific societies, patients groups, public health, and epidemiological societies.
**Italy:** A focus group was organised in Rome on March 7th, 2008 (see Annex 9)

The focus group was attended by mental health policy makers, regional health policy makers, patient groups, NGOs, psychiatrists, professionals of mental health services, media, etc.

It provided a chance to note the relative low access to care for mental problems. For example, representatives of general practitioners and psychiatrists considered that one of the unresolved problems of Italian public mental health services is that these services are almost exclusively addressed to the care of severe mental disorders.

The representatives of the diverse groups attending the focus group actively participated in it by suggesting further dissemination strategies in which they could become active and expressed their interest and availability to participate in further programs on this subject.

The EPREMED website was included as a link in several relevant web sites concerned with mental health, such as scientific societies, patients groups, public health, and epidemiological societies.

**Spain:** The Spanish focus group (see Annex 9)

It mainly focused on the evaluation of the dissemination strategy instead. Its primary purpose was to develop indicators to evaluate the impact of disseminated materials. It omitted any discussion of the information needs of policy makers.

In general, it was established that the dissemination of the results of epidemiological studies about mental health in Spain is poor and it mostly occurs to the scientific community through national and international scientific journals.

Due to the fact that the ESEMeD study was presented to the health administration of Catalonia, additional funding was obtained to augment the sample of Catalonia. All the assistants agreed in highlighting the importance of disseminating results in country language, local publications (many times with few or null impact factor), and monographic sessions of courses for specific groups such as psychiatry residents and health professionals working on mental health.

It was as well acknowledged that the evaluation of the impact of the dissemination activities is crucial for epidemiological studies and the fact that future projects should include, a specific part on dissemination to different key audiences was suggested.

An important effort was made in order to include the EPREMED website as a link in several relevant web sites concerned with mental health, such as scientific societies, patients groups, public health, and epidemiological societies.
Germany and The Netherlands:

As opposed to the other countries, focus groups were not organised in Germany and The Netherlands since other important national representative surveys had been conducted in the past (GHS-MHS and NEMESIS, respectively) showing different methods and results than ESEMED). The results from those surveys had already been disseminated among stakeholders, and the EPREMED focus groups could have cast doubts on both surveys.

An important effort was made in order to include the EPREMED website as a link in several relevant web sites concerned with mental health, such as scientific societies, patients groups, public health, and epidemiological societies.
# 4) Achievement of the EPREMED objectives

In this section a quantitative and qualitative evaluation of the achievement of the objectives set is presented.

## Output Indicators

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<th>Output indicator title</th>
<th>Target Value to Achieve</th>
<th>Achievements end reporting period</th>
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</thead>
<tbody>
<tr>
<td>(e.g. Distribution of leaflets)</td>
<td>(e.g. 200 copies)</td>
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<tr>
<td><strong>Scientific production</strong> – Nº of papers and other scientific publications in the field of European mental health policy information research</td>
<td>7-9 yearly</td>
<td>68</td>
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<tr>
<td><strong>Scientific communication</strong> – Participation in scientific events, workshops and conferences in the field with a strong European mental health policy information research component</td>
<td>2-3 yearly</td>
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<tr>
<td><strong>Policy communication</strong> – Nº of publications and dissemination activities to specific policy-making audiences</td>
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<td><strong>Social communication</strong> – Nº of publications and dissemination activities to specific social / civil society audiences</td>
<td>4-6 yearly</td>
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<td><strong>Policy information research capacity</strong> – Nº of training activities organised in mental health policy information research by the Consortium</td>
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<td>3</td>
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</table>
Policy information research capacity – Nº of newly engaged European junior researchers in the mental health policy information research field in the Consortium

Critical mass and interdisciplinarity – Degree of the different parties involved (academia and research institutions; administrations, pharmaceutical and other industries; patients and citizens representatives; etc.)

Overall, the project quantitative objectives have been met and surpassed.

Sixty eight scientific papers have been published (target value = 7 – 9 yearly), with some more either in press, accepted for publication or submitted. The participation of participants of the project in scientific events, workshops and conferences in order to present results related to the project has been frequent (67 overall; target value = 2 – 3 yearly). The number of dissemination activities specifically addressed to policy – making audiences has not met the project expectative (target value = 2 yearly), in despite of what, 5 such activities have been conducted. This shortcoming did not occur in relation to dissemination activities specifically addressed to social / civil society audiences, achieving a total of 14 such activities (i.e., publications, focus groups, personal communication, press releases) (target value = 4 – 6 yearly). The number of training activities organised by the consortium met the project expectative (target value = 3), with 3 workshops carried out. Overall, 6 junior researchers were engaged in the research conducted by the consortium and benefited from the exchange programmes set up from the project (target value = 1 yearly).

Clearly, the project outcomes were excellent in terms both of scientific productivity and dissemination to the civil society. Dissemination to policy-making audiences was not so successful quantitatively speaking, although the Consortium managed to
participate in relevant workgroups engaged in policy-making, and to place key EPREMED results in relevant documents which will play a key role in shaping mental health policies both at an European Union level and in specific countries (i.e., Italy, Spain). This is a success in that it implies the translation of the scientific data obtained by the Consortium to useful information for policy makers. Last but not least important, this will ensure that the hard to collect epidemiological information produced by this project will continue to have an influence far after the project has ended.
III: DETAILED DESCRIPTION OF ALL THE ACTIVITIES CONDUCTED
Workpackage 1: Coordination and Management

Workpackage description

a) Overview

<table>
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<th>Lead Partner</th>
<th>Institut Municipal d’Assistencia Sanitària (IMAS-IMIM)</th>
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<tr>
<td>Partners involved</td>
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</table>

b) Description of work

**Coordination:**
Scientific co-ordination of the WPs and technical activities of the project, ensuring project’s results are produced timely with the maximum quality level. Taking decisions regarding the overall policy and technical strategy of the project.

**Operational management:**
Day-to-day management. Follow-up of tasks and monitoring of the project work plan and time schedule. Administration of resources. Risk management. Resolution of conflicts among partners and consortium. Agreement implementation. Meetings organization and minutes production. Permanent contact point for the project and liaison with the EC Project Officers. Timely delivery of project’s deliverables and milestones achievement. Production of administrative and financial periodic reports and audits.

The management will be implemented through the Project Management Team giving support and assistance to the Project Coordinator, the Steering Committee, the Work Package Leaders and the Consortium as a whole.

c) Deliverables

**DL1.1:** Report on the set up of an internal communication flow.

**DL1.2:** Report on quality and assessment.
1 – Work package progress of the period (2005-2008)

1.1. Work package objectives

The work package 1 has focused on providing the EPREMED Consortium the adequate degree of coordination to facilitate the partner’s work in the framework of the project and assuring the most adequate implementation of the project. This main objective has been divided in two areas: 1) coordination and 2) operational management.

1) Overall Project Coordination

Coordination activities have been dedicated to guarantee the progress of the technical activities plan, ensuring the achievement of project’s results timely and with the maximum quality level in order to maintain the scientific scope of the project. These activities have involved much more than the mere coordination of the partners work. They involved scientific, technical and professional leadership. Project coordination activities included scientific expertise for several SANCO initiatives and a strong coordination with the World Mental Health Survey initiative.

2) Operational management

Operational management has been concerned with the day-to-day management of the project. Therefore, it has followed up the adequate completion of planned tasks; monitored the work according to the agreed time schedule; and administrated the resources among the consortium. It has promoted the Consortium agreement implementation and has also been involved in the responsibility of arbitrating in the resolution of conflicts among partners when any did arise. Furthermore, it comprised too the organization of meetings and teleconferences, and the production of the corresponding minutes, and finally the coordination of the reporting to the Commission.

The management has been implemented through the Project Management Team, whose objectives were the following:

- To set-up a project management structure which ensures an efficient operational management including administrative and financial tasks.
- To ensure that the project is appropriately coordinated, managed, and implemented according to the work plan with an adequate quality level.
- To comprise resources, procedures and tools for assurance of the Contract proper fulfillment, Consortium Agreement implementation and timely delivery of project results.
To produce the financial report of the whole Consortium.

1.2. Progress towards objectives – tasks worked on and achievements made with reference to planned objectives

The Steering Committee and work package leaders meetings, as well as the teleconferences organised and continuous communication via newsletters, email and the EPREMED webpage helped at adequately coordinating and managing the project. Although some changes aroused needing the amendment of the contract agreement and an extension of the contract without further cost for the Commission, the team worked well towards the objectives set. Special mention must be done to the participation of the Project Coordinator in several SANCO initiatives and activities.

Steering Committee and Work Package Leaders Meetings

The kick-off meeting of the project took place at the very beginning of the activity period in Barcelona, 21-22 February, 2005. This meeting was the starting point for building up the management structure of the project; agree who would be in each specific group and which responsibilities were involved in each of them. Following the management structure foreseen in the contract, the following teams were established by the whole Consortium: the Project Management Team, the Work Package Leaders group, the Project Steering Committee and the Scientific Advisory Committee. The project management team was agreed to be integrated by personnel of the main beneficiary: IMAS-IMIM.

The Work Package Leaders group was decided to be integrated by:

<table>
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<th>Lead partner</th>
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</thead>
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<td>WP1 Coordination and management</td>
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<tr>
<td>WP2 In-depth analyses of the ESEMeD/MHEDEA</td>
<td>Institut Municipal d'Assistència Sanitària</td>
</tr>
<tr>
<td>WP3 Data integration and synthesis</td>
<td>University of Leicester</td>
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<tr>
<td>WP4 Dissemination of results</td>
<td>MGEN Fondation de Santé Publique. Université Paris 5</td>
</tr>
<tr>
<td>WP5 Evaluation of dissemination activities</td>
<td>Sant Joan de Déu- Serveis de Salut Mental</td>
</tr>
<tr>
<td>WP6 Training and mobility of researchers</td>
<td>University of Leipzig</td>
</tr>
</tbody>
</table>
The Steering Committee has been the highest decision-making organ of the project and was agreed to be integrated by each participating partner and chaired by the project coordinator:

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Acronym</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jordi Alonso</td>
<td>Institut Municipal d’Investigació Mèdica</td>
<td>IMIM - IMAS</td>
</tr>
<tr>
<td>Chair person</td>
<td></td>
<td></td>
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<tr>
<td>Mattias C. Angermeyer</td>
<td>Universität Leipzig</td>
<td>ULPZ</td>
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<tr>
<td>Traolach Brugha</td>
<td>University of Leicester</td>
<td>ULEICS-DHS</td>
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<tr>
<td>Giovanni de Girolamo</td>
<td>Istituto Superiore di Sanita</td>
<td>ISS</td>
</tr>
<tr>
<td>Ron de Graaf</td>
<td>Netherlands Institute of Mental Health and Addiction</td>
<td>TRIMBOS</td>
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<tr>
<td>Koen Demyttenaere</td>
<td>Katholieke Universiteit Leuven</td>
<td>GHB</td>
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<tr>
<td>Jean Pierre Lépine</td>
<td>Universite Paris 7 Denis Diderot-Hôpital Fernand Widal</td>
<td>AP-HP</td>
</tr>
<tr>
<td>Josep M. Haro Abad</td>
<td>Sant Joan de Deu – Serveis Salut Mental</td>
<td>SJD-SSM</td>
</tr>
<tr>
<td>Viviene Kovess-Masféty</td>
<td>Mutuelle Generale de l’éducation nationale-MGEN public health foundation</td>
<td>FESP</td>
</tr>
</tbody>
</table>

Finally, several experts external to the project were proposed as candidates to become members of the Scientific Advisory Committee. It was planned that the first action would be to contact them through a formal letter for offering them to become member of this Committee. Afterwards, taking advantage of meeting all of them face to face at the WHO Annual Meeting (Amsterdam), the Scientific Advisory Committee was created in the framework of the meeting by July 2005.

Besides the formal constitution of the management structure, three additional key issues, in terms of management, were dealt with at the kick-off meeting:

a) Firstly, a draft version of the **Consortium agreement** (Annex 2) was prepared by the coordinator and discussed during the meeting. Once a major agreement was reached by all participants in the meeting, each partner was asked to make it revised by the competing authority of each institution before the final approval of the document could be signed.

b) Secondly, the previous ESEMeD/MEDHEA 2000 **Publication guidelines** (Annex 5), yet in force among partners, were considered as a starting point in developing the new publication rules for the EPREMED project. Though the
major points of these rules were discussed and agreed in the meeting, all participants committed themselves to think about them after its conclusion and approve them getting the final agreement by e-mail.

c) Thirdly, part of the meeting was devoted to discuss the design and implementation of the project website. It was agreed to develop a restricted area addressed to the coordination of the project. One of its main objectives would be to serve as a platform for exchanging data and to become a reliable information point of the project for each participant institution. It was also agreed to develop a public area mainly addressed to disseminate the project at different policy levels and having in mind different target audiences.

The second in-person meeting of the Steering Committee took place in Paris, on February 3-4, 2006 and was hosted by FSP/MEGEN. This meeting was the occasion for reviewing the project evolution, discussing the reporting and agreeing the need of an amendment of the contract. A third in-person meeting was held in the context of the 4th meeting of the World Mental Health Survey Initiative which took place in Providence, RI, the United States. In that occasion discussions focused on the scientific production and the collaboration of the EPREMED partners in the World Mental Health Surveys Initiative. In that meeting it was agreed that there is plenty of room for flourishing this collaboration. In fact, a number of EPREMED collaborators are actively involved in the organisation of WMH organization. Jordi Alonso (IMAS-IMIM) is member of the Editorial Committee, Josep M. Haro (SJD-SSM) is the leader of the Clinical Reappraisal working group, and Giovanni de Girolamo (ISS) is the leader of the Personality Disorders working group. All EPREMED collaborators are active members of any of the WMH workgroups. (See list in Annex 3).

A teleconference of the Steering Committee (SC) was also organised in December 15, 2006 to review the project progress, with a detail review of the Work Packages status. Also, the situation of a contract amendment need was analyzed. And the preparation for the next in person meeting was also discussed.

In addition two Work Package Leaders teleconferences were also held in between the above SC meetings.
The third in-person meeting of the Steering Committee took place in Leuven, on February 8-9th, 2007. This meeting was crucial to start reviewing the financial situation of each partner, specifically focusing on further planning of expenditures; since some partners already showed signs that they would have problems spending the whole of the budget. Given the fact that other partners have been carrying out activities needing for further funding instead (such as coordination), the possibility of transferring budget from one partner institution to another that carries out the tasks not currently done was also mentioned. The meeting also allowed for further revision and improvement of each Work Package, and the progression and development of the project’s website was thoroughly discussed. Finally, the collaboration with the World Mental Health (WMH) Survey Initiative and the future of the EPREMED Consortium were part of the agenda, discussing possible initiatives to enhance these actions.

At Leuven, it had been agreed that the next Steering Committee meeting would take place in Portsmouth, USA, in June 2007 in the occasion of the WMH Congress. Discussions were held about the specific publications and activities necessary for the conclusion of the project. Coordination with other researchers and stakeholder participate in the WMHSI achieved through personal contacts.

Finally, a last meeting took place in Barcelona, in November 2007. Lacking a final response for the 3 months extension asked for, we agreed that a new amendment was desirable to facilitate expending the budget in those chapters more easily justifiable. On this area, all partners were also informed of the procedure for submitting their final reports and a deadline schedule was set. After the revision of all the work packages progress, the need to improve on three key areas was observed: project website use and visibility, benchmarking and policy reporting. Progress made on the activities carried out in other WMH European country reports (Bulgary, Northern Ireland, Romania) as well as proposals regarding further collaboration with SANCO (EPREMED Contribution to SANCO Report on Major Chronic Diseases and submitting a new proposal to the DG SANCO 2008 call) completed the agenda of the meeting.

**Contract Amendments**

The EPREMED Project has needed the Amendment of the Grant Agreement in three different occasions. Those have been well justified and the circumstances
leading to those needs could not have been foreseen. The operational management of the project coordinated all partners in these endeavours, making sure that a correct planning of the resources needed was established by all partners before finalising the amendment procedure. In particular, graphics reminding each partner the economic resources having been used and those still to use and justify, per cost category, were created and sent, asking each of them to provide feedback on planned activities and costs.

The main changes requested for EPREMED action was deemed necessary during 2006 due to the request of an internal budget reallocation from partners: IMAS-IMIM (Coordinator), ISS and FSP-MGEN. The reason for these changes responded - in the case of the Spanish (IMAS-IMIM) and the French (FSP-MGEN) partners- to the increasing necessity of dissemination reached at that stage of the project. Concerning the Italian partner (ISS), this reallocation came up because of a change in the norms and rules of its institution.

A request to SANCO was submitted in October 2007, asking for a 3-month extension, at no cost for the project, and thus further reallocations were deemed necessary due to further changes in the schedule planned and the work progress of the action.

Both the Amendments and extension were approved and have considerably helped the achievement of the objectives, though some partners not leading any work package have under spent in some of the categories planned.

**Collaboration with SANCO**

As expected from the coordinators of SANCO funded projects, the coordinator of EPREMED has participated in a number of SANCO initiatives and activities. An important activity is the collaboration in the SANCO Working Parties. In the past, the coordinator of EPREMED had been part of the Mental Health Working Party. This party had its last meeting on 30-31, 2005 in Luxembourg and from that point in time the coordinator is part of the **Mortality and Morbidity Working Party**. As a member of that party the EPREMED coordinator attended the MMWP meeting on the 13th of December 2006.
A specially intensive and fruitful collaboration of the EPREMED coordinator, Dr. Alonso, was the Consultation of the Green Paper, where he was the rapporteur of the subgroup on Policy Research Interaction. The whole process totalled 4 meetings, three of which took place in 2006 (January 16-17, Luxembourg; March 16-17, Vienna; and May 18-19, Luxembourg). At the end, a report of the process was released (see Annex 4).


Two other activities included the active participation of EPREMED partners in the Barcelona Conference in September 2007, the Brussels High Level Conference on Mental Health, and the elaboration of the pact for Mental Health (Brussels 12, 13 June 2008). A “Summary Report on the EPREMED Project Findings“ was presented, in which the project summary presented in this report is based (pages 3-50).

**Setting and Updating of the EPREMED Web Site**

Soon, at the beginning of the project, the decision to create a website focused on dissemination was established.

Efforts for continuing improving the project website (http://www.epremed.org) continued during 2006 till 2008. A major decision made in that period was to open most of the content of the web site to everybody, while keeping a restricted area for the EPREMED collaborators. This effort was lead by the coordinating institution (IMAS-IMIM) with support from the ULPZ.

A redesign of the open section of the website was proposed by IMIM, with a new sectioning of the results. In short, the new layout of the open section of the web is the following:
Project Presentation:
- Introduction
- Aims and Objectives
- Methods and Instruments
- Partners
- Structure
- Contact
- Official Documentation

Epidemiology of Mental Health in Europe:
- By Topic
  - Prevalence of Mental Disorders
  - Impact and Severity
  - Comorbidity
  - Use of Services and Treatment
  - Suicide
- Country Reports

Scientific Publications

EPREMED in Action:
- Newsletters
- Workshops
- Training and Mobility
- Upcoming Events

Links of Interest

The web includes as well a private zone, accessible only with a private login and password. The restricted section of the website served to better coordinate the actions among partners, as well as for the day to day management of the project to be more transparent and efficient to all the partners.

This private part contains information on the EPREMED Consortium, a Forum for discussion, access to the ESEMeD database together with a codebook and questionnaire, additional documentation and a FAQ section. World Mental Health Initiative Cross-national Tables, in which the documents for each country regarding lifetime prevalence, lifetime treatment, prevalence, and treatment per 12 months can be found. A section in which each partner can upload its work package and comments on the progress done, has been very helpful, as well as the one with
workshops information and further information for participating on the mobility program. Finally, a table of upcoming events and links of interests has also been included.

Further information regarding the web, including images of it, may be found in Annex 13.

**Interim & Final Reports**

In general, IMIM has made every effort to assure that all Reporting to the Commission is made on time and with the maximum quality. Both for the interim and final reports, however, some documents have been missing from some of the partners, needing to send the Report with missing documents, which were sent during the following 10 days.

As previously explained deadlines were set early in advance at Steering Committee meetings and reminded via email. Still internal administrative requirements made it difficult for some partners to send the requested documents duly signed on time, and in other cases, those responsible of these actions left the partner institution needing for the replacement and training of a new person.

Overall however, having a Project Manager as well as the experience provided by the IMIM in coordination issues has been very helpful in the achievement of these objectives.

**2 – Evaluation of the work undertaken and major achievements**

In terms of coordination and management of the project, all the work done during the reporting period has allowed the fulfilment of most of the planned objectives. Therefore, from the point of view of the coordination and management activity there are no significant deviations from the work programme.

1) By the 1st of March, 2005, the Publications guidelines were completed. This document then became the regulatory basis of the group dynamics for the scientific papers elaboration process.

2) On June 2005 a fully functioning version of the project website restricted area was working. The restricted area of the website is mainly addressed to
facilitate the management of the project and is one of the pillars of the communication workflow between the partners.

3) Having a Consortium agreement signed by all participant institutions was a goal that needed for its achievement more time than was previously foreseen at the beginning of the reporting period. The final agreement was managed by e-mail. This implied that, once each institution’s correspondent authority had revised it, each institution made particular amendments at different times. As the final document needed unanimous approval for coming into force, each institution approval was required each time that an institution suggested an amendment.

After the circulation of several versions, the final Consortium Agreement was approved by all partners involved in the project on July 2005.

Besides these 3 specific achievements, this is a selected list of quantitative indicators for the evaluation of the project milestones:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>2005 achievements</th>
<th>2006 achievements</th>
<th>2007-2008 achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kick-off meeting</td>
<td>1</td>
<td>√</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>In-person coordination and Work package leader meetings</td>
<td>1 yearly</td>
<td>√ (2)</td>
<td>√ (2)</td>
<td>2</td>
</tr>
<tr>
<td>Coordination and WP leader teleconferences</td>
<td>9-11 yearly</td>
<td>Sufficient (3)</td>
<td>Sufficient (3)</td>
<td>Sufficient (2)</td>
</tr>
<tr>
<td>Periodic activity reports</td>
<td>1 yearly</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Periodic financial reports</td>
<td>1 yearly</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Milestone 1: Consortium Agreement signed</td>
<td>1</td>
<td>√</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Milestone 2: completion of Data Bases of target audiences</td>
<td>1</td>
<td>On going</td>
<td>Almost completed</td>
<td>Completed</td>
</tr>
<tr>
<td>Milestone 3: completion of the in-depth analysis of ESEMeD/MHEDEA</td>
<td>1</td>
<td>On going</td>
<td>Substantially improved</td>
<td>Completed</td>
</tr>
<tr>
<td>Milestone 4: completion of aggregation of data synthesis analysis methods</td>
<td>1</td>
<td>Not achieved</td>
<td>In progress</td>
<td>Completed</td>
</tr>
</tbody>
</table>
### 3 – Working dynamics

**Strengths**

All EPREMED principal investigators are linked to the field of psychiatric epidemiology and mental health care, and all of them are reputed scientists with international prestige. Their common interest on psychiatric epidemiology and on informing health policy research, have made it easier to refine the objectives of the project and to plan its work programme.

Taking into account that all investigators worked together in the previous European project ESEMEeD/MEDEA 2000, EPREMED benefited from the liaison existing among them, which was inherited from the working time they spent together prior to this project.

Most of the principal investigators of the project are active members of some key international project in the field of mental health and mental health care. This enhanced the possibility of having the investigators in the cutting edges of developments and also put the Consortium in a good position to have an impact in the policy mental health policy making at different levels. Also, our group has kept a close relationship with SANCO through participation in the Mental Health Working Party, until it disappeared and with the Morbidity and Mortality WP thereafter. A very special participation was the collaboration in the Green Paper Consultation Process ("Promoting the Mental Health of the Population. Towards a Strategy on Mental health for the European Union").

Finally with the European Pact for Mental Health, an active and productive collaboration with the World Mental Health (WMH) Survey Initiative has been another important strength of the Consortium.

**Weaknesses**
Even though knowing one another in advance has facilitated the development of the project, in other aspects it has been an element that has generated difficulties.

At the very beginning of the project it was proposed to carry frequent teleconference calls to track the project progress. But, considering how frequently the partners communicated through the electronic mail, teleconferencing so often was regarded as unnecessary. Nevertheless, there were occasional overlaps among the work done by the partners in the development of the tasks during the first year.

The task of coordinating the different work Packages has been difficult since some activities are made in parallel while others would benefit from a sequential approach. For instance, it has been a challenge to start the dissemination activities without a complete vision of what information was relevant for which audience and what is the best format for such an information. Similarly, starting the design of the evaluation of the dissemination activities, without a clear design of these activities was an important challenge. However, the email has successfully replaced teleconferences and additional meetings.
4 – Summary of Achievements – Lessons Learnt

Main achievements of the EPREMED project include:

Making the Project very visible by:
  - Promoting within the Consortium the use of the website of the project as the central point of information about it
  - Fostering the final design and implementation of an open website of the project.

Tracking effectively the project progress by:
  - Continuously defining and developing robust documentation and communication procedures about the activities carried out.

Avoiding overlaps in the development of the project activities by:
  - Holding teleconferences and replacing them for emails when this was the easiest and most effective procedure
  - Editing and circulating newsletters with relevant information linked to the project.

Guaranteeing the adequate operational management of the project by:
  - Assuring the reporting activity
  - Monitoring the development of the activities planned.
Workpackage 2: In-depth analyses of ESEMeD

Workpackage description

a) Overview

<table>
<thead>
<tr>
<th>Lead Partner</th>
<th>Institut Municipal d’Assistència Sanitària (IMIM – IMAS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners involved</td>
<td>IMIM – IMAS; ULPZ; ISS; TRIMBOS INSTITUTE; GASTHUISBERG; AP – HP; FSP</td>
</tr>
</tbody>
</table>

b) Objectives

Workpackage 2 was devoted to the organisation, implementation and synthesis of the in-depth analysis of the ESEMeD/MHEDEA data from 6 European countries (Belgium, France, Germany, Italy, Spain and The Netherlands). The general objective of this workpackage was to maximise the realisation of policy information research, scientific manuscripts and community potential of the ESEMeD/MHEDEA project.

The activities were grouped in two major areas or phases. The first one (Phase 1: Organisation and implementation of the analysis), lead by the Analysis Team, intended to guarantee the organisation and implementation of the analysis. While the second one (Phase 2: Production of scientific papers and summaries) intended to guarantee the production of scientific papers and reports establishing 5 separate Lines of Analysis, each line lead by one Line Coordinator.

The workpackage had additional objectives, common to the overall project, including: the consolidation of a multidisciplinary European mental health policy information research network to serve as an open forum of dialogue between all stakeholders, and the advancement of the standards in policy support, research, technology, and dissemination.
b) Description of work

Phase 1: Organisation and implementation of the analysis

1. **Analysis Team**: It assured and documented the management, quality and accessibility of the ESEMeD/MHEDEA database.
2. **Analysis Plan**: Covering analyses to be performed, priority criteria, request procedures, follow-up documentation and procedures to obtain the formal Consortium approval.
3. **Lines of Analysis**: A total of 5 analysis lines (detailed below) were lead by a Line Coordinator.
4. **Publications Guidelines**: Agreed upon detail of the priorities about topics and scientific journals, the rules and the requirements for authorship and for submission of scientific products.

Phase 2: Production of scientific papers and summaries: Scientific manuscripts related to the following lines of Analysis under a European scope:

1. Prevalence of mental disorders.
2. Impact and severity.
3. Comorbidity.
4. Use of services and treatment
5. Suicide

c) Deliverables

**DL2.2**: Report of the summary of the in-depth analyses and each scientific manuscript (9 a year planned).

d) Milestones

**ML 3**: Completion of the in-depth analysis of ESEMeD/MHEDEA.
**Progress towards objectives**

**Phase 1**

Since EPREMED was a project closely related to ESEMeD / MHEDEA 2000, a previous EU Commission co-sponsored (CE: QLG5-1999-01042) project, at the beginning of the project (2005) a sizeable deal of work had been already done. Specifically, the analysis team was already formed and an analysis plan agreed. Nevertheless a great effort was devoted to adapt these elements to the new project features and requirements. Specially, new publication guidelines were agreed upon (March 1, 2005) which were more fit to optimize the scientific production attending to all five lines of analysis. The publication guidelines were designed as a dynamic document, periodically reviewed and updated responding to emerging needs throughout the project.

An online database of publications under development was designed by the leading partner and put in place in the project website (only for certified users) in order to make easier to all the participants tracking the current status of all the scientific manuscripts being written at each given time, preventing overlaps. The database enabled authors to comment on each draft’s last version.
### Publications Plan

**European Policy Information Research for Mental Disorders**

**Last update:** 20/11/2007

#### EPRED Scientific publications agreement

The aim of EPRED is to maximize the scientific impact of the project by facilitating the production of high quality scientific papers and reports in a timely manner, disseminating them in the most efficient way, and ensuring the appropriate acknowledgement of authorship, collaboration and financial support.

All Partners shall act in accordance at all times with the following rules:

**EPRED Scientific publications agreement**

- **Assigned manuscripts**

The list of assigned manuscripts is a dynamic list displaying the assigned manuscripts for each principal investigator together with the date in which it was assigned. As a general principle each principal investigator shall have a maximum of two assigned papers in queue, and three additional papers for which interest has been expressed by the investigator. Once a paper has been submitted to a scientific journal, a new one can be assigned irrespective of whether the submitted one is rejected by the journal. When some outline, draft or preliminary analyses are submitted to the rest of investigators from them to review, the corresponding assigned manuscript cases to be in the list and then that received and will be incorporated in the 'work in progress' section on the EPRED website.

#### To be assigned manuscripts List:

<table>
<thead>
<tr>
<th>Title</th>
<th>Assigned on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low burden and projected risk of mental disorders (MH+ data analysis)</td>
<td></td>
</tr>
<tr>
<td>Prevalence, severity and comorbidity of 12-month mental disorders (MH+ data analysis)</td>
<td></td>
</tr>
</tbody>
</table>

#### Assigned manuscripts List:

**IMM, Institut Municipal d’Investigació Médica**

<table>
<thead>
<tr>
<th>Assigned manuscripts</th>
<th>Assigned on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jordi Novo: Differences to mental health services among individuals with depression and anxiety disorders in six European countries.</td>
<td>01/06/2005</td>
</tr>
<tr>
<td>Gemma Viaplè: Analysis issues for data from complex design survey. An application to the ESEN&amp;No project.</td>
<td>01/06/2005</td>
</tr>
<tr>
<td>Gemma Viaplè: Performance of MSQL: measure in individuals with mental disorders from the general population: influence of personal and other factors.</td>
<td>01/06/2005</td>
</tr>
</tbody>
</table>

**Istituto Superiore di Sanità**

<table>
<thead>
<tr>
<th>Assigned manuscripts</th>
<th>Assigned on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giovanni di Girolamo: Risk factors for late onset of depression.</td>
<td>01/06/2005</td>
</tr>
<tr>
<td>Giovanni di Girolamo: Paper on psychosocial assessment.</td>
<td>01/06/2005</td>
</tr>
<tr>
<td>Giovanni di Girolamo: Prevalence of mental disorders among the elderly of six European countries.</td>
<td>01/06/2005</td>
</tr>
</tbody>
</table>

**Schilling Telekios Institute**

<table>
<thead>
<tr>
<th>Assigned manuscripts</th>
<th>Assigned on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ron De Graaf: Mediating pathways between mental illness and work loss days and health utility.</td>
<td>01/06/2005</td>
</tr>
<tr>
<td>Ron De Graaf: Modelling effect of person-linked and contextual characteristics on the association of (prevalence of) mental ill health with quality of life (disability, handicap, health utility).</td>
<td>01/06/2005</td>
</tr>
<tr>
<td>Ron De Graaf: What prevalence do we want? How rates of mental disorder vary depending on level of impairment and perceived need.</td>
<td>01/06/2005</td>
</tr>
<tr>
<td>Ron De Graaf: Prevalence, risk factors and comorbidity with other disorders of reported prevalence in the past 12 months of symptoms of 3 child-adolescent disorders (among 15-44 year old subjects): ADHD, conduct disorders and oppositional-defiant disorder.</td>
<td>01/06/2005</td>
</tr>
</tbody>
</table>
Also the ESEMeD database was made available to all the participant partners through the restricted part of the website.

Phase 2

The main beneficiary of this work package either performed the statistical analysis requested by other participants or, when statistical analysis were carried by other participants, assessed the methodological procedures used. In all cases, the analysis team, lead by the main beneficiary, supervised and approved the final results.

Additionally, the leading partner of this work package issued methodological information and recommendation of analytical interest, to be used by all the participants carrying out analysis, through two main channels: 1) the project website (only for certified users) and 2) periodical newsletters.

Because of its importance, the complete summary of the in-depth analyses and each scientific manuscript can be found in the first part of this report (“Executive Summary”, sections “Epidemiology of Mental Disorders in Europe” (p.8) and “Bibliography Produced” (p.30). Here, the methodology used in the analysis, and a summary of the main findings is presented.

Analytical Issues

Throughout the project the database underwent a thorough and constant review leading to the refinement of the database and of the analysis procedures employed. The leading partner of the work package ensured that all the analysis performed by all the project participants were homogeneous and carried out under following the most strict quality standards. The steps followed in order to achieve this objective were:

- Communication of any change effected upon the database or the analysis algorithms. This communication was carried out through ad hoc newsletters distributed by e-mail. Additionally, all the newsletters were made available to the participant parties through the project website, together with any specific material needed in order to implement the analyses. Overall, 6 newsletters were issued throughout the project. Table 1 presents a
summary of the communication with analytical relevance. Table 2 presents a summary of the material posted in the web.

- Review and approval of all the analysis conducted with the ESEMeD sample. All the manuscripts carried out upon the whole sample (i.e., the six participant countries) were reviewed by the leading partner of the workpackage, who did make sure that all the analysis followed the most up to date analytical procedures.
Table 1. Summary of the changes in the ESEMeD database and the analysis procedures throughout the project

<table>
<thead>
<tr>
<th>Area of change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight and Height</td>
<td>As a result of an analysis of the BMI (body mass index), some incoherent values were detected in height and weight variables. All these inconsistencies have been cleaned on the ESEMED database; therefore, a new version it is available on the project website.</td>
</tr>
<tr>
<td>Sheehan disability scale</td>
<td>Mainly due to mistakes in some filters of the computerized adaptive personal interview (CAPI) used in the ESEMeD project, there is a substantial proportion of the sample with missing Sheehan scale scores. In order to avoid the exclusion of these cases of the analysis of severity, the IMIM analysis team, in collaboration with Harvard analysis team, has been working to find the most suitable imputed values for these missings. The only missing values that have been imputed are those with the specific mental disorder to which every Sheehan scales are referred. Therefore, changes in the diagnostic algorithms can introduce new cases with missing and without a defined imputed alternative, and the imputed Sheehan is provisional and subject to possible updates of the diagnostic algorithms. All the mentioned updatings and news are accessible to all partners through the project website, <a href="http://www.EPREMED.org">www.EPREMED.org</a>.</td>
</tr>
<tr>
<td>Core Tables</td>
<td>We have posted to the webpage the latest version of the tables for each of the WMH survey core papers 12 month prevalence, 12 month treatment, Lifetime prevalence and Lifetime treatment, together with the latest version of the 4 official datasets (demographic, diagnostic, constructed and raw) for ESEMeD, latest set of diagnostic algorithms (SAS code) and the Severity code to create the wmh_sev variable (SAS code).</td>
</tr>
<tr>
<td>Missing date and subgroup analysis in SUDAAN, SAS and STATA</td>
<td>We have realized that, in STATA and SAS (not in SUDAAN), individuals with missing in the analyzed variables are excluded from the estimation and its complex design structure ignored.</td>
</tr>
<tr>
<td>Modified datasets</td>
<td>A new version of the ESEMeD Database was uploaded to the Epremed Web page on February. Only DIAG and USE_SERVICES datasets have changed. And there are three new datasets: IMP_SEV, WGT_HGT_BMI and PBI_SCORES. All the datasets are available in three formats: SAS, SPSS and STATA. The dataset that has changed the most is DIAG. The disorders that have changed compared to the July ’05 version basically are Panic disorder, minor depression, Conduct disorder, bulimia and anorexia. Moreover, there is one new eating disorder diagnostic (binge). But due to the changes on these disorders, some others that depend on them may have also changed (i.e. dsm_agp, or dsm_pd_ago,..). Also the Harvard group imputed the Age of Onset of the disorders and therefore the dsm and icd onset variables for some individuals have also changed. We have also included in the DIAG dataset the severity variable, before imputation (WMH_SEV) and after imputation (WMH_SEV). USE_SERVICES: the use of services variables that take into account the information on use from the Use of services section, toghether with the info available in the other diagnostic sections. The old variables in the USE_SERVICES dataset have not changed at all, but there are new ones (those whose names start with SER_xxx). New datasets IMP_SEV: includes the all imputed sheehan variables for each disorder. WGT_HGT_BMI: Includes cleaned variables of Height, weight and BMI. These variables are new. PBI_SCORES: Includes the factor scores of the Parental Bounding Instrument that were obtained by the German team. For more information on this issue, visit the ESEMED Database FAQ nº8 (Available from March ’06).</td>
</tr>
<tr>
<td>OCD Problem</td>
<td>A number of problematic Skips patterns in the OCD section was found that lead to an important high underestimation of this disorder by 17th of February of 2006. For this reason, the OCD disorder should not be included in the analysis. The document describing these problems can be downloaded from the EPREMED web page (Analysis&gt;Additional</td>
</tr>
</tbody>
</table>
| Algorithms updates | In the WMH Newsletter of September, it was announced that some diagnostic algorithms had been updated since Jan 2006 and that the new versions of the DIAG dataset and the SAS algorithms had been uploaded to the e-room. The changes result in a small increase in LT prevalence of PTSD disorder (from 2.5% to 2.6%), although the overall prevalence of Any lifetime disorder has not changed. The 12 month prevalences of Agoraphobia, PTSD, Social Phobia and Specific phobia have also increased, resulting in a change of any 12 month anxiety disorder from 8.4% to 8.9% and an increase of Any disorder from 11.5% to 11.9%.

The new version of the DIAG table has been uploaded to the EPREMED web page. |
Table 2. Material with analytical relevance available through the project Website.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
</table>
| World Mental Health Crossnational Tables (Last update: March 2006) | – Belgium: lifetime prevalence; lifetime treatment; prevalence 12 month; treatment 12 month.  
– France: lifetime prevalence; lifetime treatment; prevalence 12 month; treatment 12 month.  
– Germany: lifetime prevalence; lifetime treatment; prevalence 12 month; treatment 12 month.  
– Italy: lifetime prevalence; lifetime treatment; prevalence 12 month; treatment 12 month.  
– Netherlands: lifetime prevalence; lifetime treatment; prevalence 12 month; treatment 12 month.  
– Spain: lifetime prevalence; lifetime treatment; prevalence 12 month; treatment 12 month. |
| Frequently Asked Questions (note that only the questions are presented in this table. The answers are lengthy and thorough and can be found at the restricted section of the project website) | **Question 1:** *Sudaan.sav* contains two stratum variables (stratum, stratum1) and two secu variables (secu, secu_010). Which stratum and secu variable is the best to choose?  
**Question 2:** *Weights.sav* contains three wt4 variables (wt4, wt4_trim, wt4part2). What are the differences, or when to choose which weight? I remember you recommended using wt4part2 when analysing (adult) ADHD.  
**Question 3:** To present data on the prevalence of (adult) ADHD, (adult) conduct disorder (CD) and (adult) oppositional-defiant disorder (OD). AD and CD were administered to those applying to newgroup=1 and age<=44. However, OD was administered to those applying to newgroup=1 and age<=44 and CD40 in [1,2,3], which weight I have to use?  
**Question 4:** I want to present the correlates between the socio-demographic variables sex, age, education, marital status, employment, income, urbanicity, and the disorders adult ADHD, adult CD and adult OD. But when I want to present this table which weight do I have to use?  
**Question 5:** Which weight(s) I have to apply to make this table?  
**Question 6:** Example 1, the PTSD section was asked to those applying to newgroup=1. We also know that certain questions in this section were mistakenly not asked. Therefore, a special weight was calculated. Is that weight wt6?  
**Question 7:** I read that the alcohol section was not asked to everybody: newgroup=1 or SU20=3 complete drugpart. There also went something wrong in asking people about druguse. Which weight is appropriate to calculate comorbidity between adult ADHD/ adult CD/ adult OD and alcohol disorders? Stated differently, which weight is appropriate to calculate the percent of respondents with adult ADHD/ adult CD/ adult OD who have alcohol disorders, as well as the percent of respondents with alcohol disorders who have adult ADHD/ adult CD/ adult OD?  
**Question 8:** The drug section was mistakenly asked to nobody, is that correct? Does this mean that drug abuse is also not asked for?  
**Question 9:** Severity of mental illness can be defined by using the Sheenan scales. These scales range from 0 (minimum) to 10 (maximum). In a table of Kessler and colleagues three severity levels are mentioned: mild, moderate, and serious. Do you know which cutoff points he used when constructing these levels? |
Is there a standard in doing so?

**Question 10: Which weight do I have to use? The one to be used for table 1: wt4part2?**

<table>
<thead>
<tr>
<th>ESEMeD Database</th>
<th>The latest version of the ESEMeD database in SAS, STATA and SPSS format can be downloaded here. It is structured in 75 datasets that are stored in 9 different zip files in alphabetical order. All the 9 zip files should be downloaded in order to have the complete dataset.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>DIAG</strong> dataset includes modified diagnostics of PTSD (LT, 12month and 30 days), and 12 month SO, 12 month SP, 12 month AGO and 12 month AGP. And also includes the new severity variable <em>(WMH_SEVJ)</em>.</td>
</tr>
<tr>
<td></td>
<td><strong>WHODAS_SCALE</strong> includes the scales of WHODAS computed as suggested by Harvard (feb 06). The codesheet for this new dataset has been included in the section ESEMeD Database\Codebook. For more information about the construction of the scales see &quot;WHO-DAS Scoring Memo&quot; in the section ESEMED Database\Additional Documentation.</td>
</tr>
<tr>
<td></td>
<td><strong>IMP_SEV</strong>: includes the imputed sheehan scales for each disorder. The codesheet for this new dataset has been included in the section ESEMeD Database\Codebook.</td>
</tr>
<tr>
<td>Codebook</td>
<td>A copy of the Codebook of the ESEMeD database downloading a zip file.</td>
</tr>
<tr>
<td>Diagnostic Algorithms</td>
<td>The SAS script files with the most updated diagnostic algorithms available for ESEMeD, updated September 2006, are included in a zip file.</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>The paper version in English of the questionnaire (mastercopy) used in ESEMeD is available here for download. The versions in Blaise that have been used in each of the countries can also be downloaded.</td>
</tr>
</tbody>
</table>
| Additional documentation | – Description of the sections of the questionnaire, types of variables in each section, the questionnaire itinerary, the construction of Newgroup variable, instructions about the Blaise Software, etc.  
– Description of the error found in Drug abuse and dependence  
– Sheehan scale. Missing imputation process  
– Cleaning of height and weight and BMI calculation  
– Whodas Scoring Memo, by R. Kessler, M.VonKorff and N. Sampson (Feb '06) |
Summary of the main findings

Mental disorders are frequent in European Countries.

Furthermore, the impact and severity of these disorders has important consequences over individual’s well-being, social relationship and work productivity. In particular, they lead to a worsening of Health Related Quality of Life (HRQL) measures and an increase of Work Loss Days (WLD). Impact and severity of mental disorders proves to be much more important than for physical illnesses.

Comorbidity of mental disorders is also consistent cross-nationally, and is substantial in clinical populations as well as in the general population.

- In the ESEMeD countries, the proportion of respondents with a 12-month mood disorder who also met criteria for anxiety or substance use disorder was 43.8%.
- Among those with an anxiety disorder, 24.0% also had a comorbid disorder.
- For alcohol this figure was 31.3%.
In particular, anxiety disorders were highly comorbid, with agoraphobia (87.4%), GAD (76%), and panic disorder (69%) as the most commonly comorbid anxiety disorders.

*Risk factors for comorbidity* of mood and anxiety disorders were female gender, younger age, lower educational level, higher degree of urbanicity, not living with a partner, and unemployment. Only younger people were at greater risk for comorbidity of alcohol disorder with mood, anxiety disorders, or both.

The study of the *use of services and treatment* shows that although mental disorders are frequent in the ESEMeD countries, the *rate of people who consult a medical professional for their mental health problems is considerably low.*

- A conservative estimate suggests that 3.1% of the general European adult population has *unmet need for mental health care* (due to the presence of a mental disorder that interferes a lot with their life and had not used any formal services).

The overall use of health care varies considerably in the different ESEMeD countries. Up to now, *no simple relationship between health care system characteristics and the use of services can explain these differences.* It seems that a complex model of health care system variables (e.g. financing, referral system) moderate the use of services within and between countries.

**Suicidality:** Self-inflicted deaths account for 1.5% of total deaths for both genders and are *one of the leading causes of deaths in Europe.* Lifetime suicidality was high among respondents with mental disorders (major depression, dysthmic disorder, generalised anxiety disorder, and alcohol dependence), with rates around 30% for suicidal ideas and 10% of suicidal attempts. In fact, *mental disorders, especially the major depressive episode, are the most important determinants of suicidality.*

Complete information on the results by country may be found in the Executive part of this report (“EPREMED Country Reports”, p.13). Here, a table summarising these results is presented:
<table>
<thead>
<tr>
<th>Country</th>
<th>General Comment</th>
<th>Most Common Mental Disorders (general population, lifetime)</th>
<th>Other disorders observed less frequently (general population, lifetime)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Almost a third of the Belgian population suffered from at least one of the studied mental disorders once in their lifetime.</td>
<td>Major depression (14.1%)</td>
<td>Agoraphobia without panic (0.9%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol abuse (7.8%)</td>
<td>Panic disorder (2.1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specific Phobia (6.8%)</td>
<td>Alcohol dependence (1.6%)</td>
</tr>
<tr>
<td>France</td>
<td>Almost a third of the French population suffered from at least one of the studied mental disorders once in their lifetime.</td>
<td>Major depression (21.0%)</td>
<td>Panic disorder (2.1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specific Phobia (10.7%)</td>
<td>Oppositional defiant disorder (2.0%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol abuse (6.7%)</td>
<td>Agoraphobia without panic (0.9%)</td>
</tr>
<tr>
<td>Germany</td>
<td>Almost a fourth of the German population suffered from at least one of the studied mental disorders once in their lifetime.</td>
<td>Major depression (9.9%)</td>
<td>Social phobia (2.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specific Phobia (9.9%)</td>
<td>Panic disorder (2.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol abuse (6.3%)</td>
<td>Agoraphobia without panic (0.9%)</td>
</tr>
<tr>
<td>Italy</td>
<td>Almost a fifth of the Italian population suffered from at least one of the studied mental disorders once in their lifetime.</td>
<td>Major depression (9.9%)</td>
<td>Social phobia (2.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specific Phobia (5.4%)</td>
<td>Panic disorder (2.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Panic disorder (1.5%)</td>
<td>Agoraphobia without panic (0.5%)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Almost a third of the Dutch population suffered from at least one of the studied mental disorders once in their lifetime.</td>
<td>Major depression (17.9%)</td>
<td>Alcohol dependence (1.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specific Phobia (7.6%)</td>
<td>Conduct disorder (1.3%)</td>
</tr>
<tr>
<td>Spain</td>
<td>Aprox. a fifth of the Spanish population suffered from at least one of the studied mental disorders once in their lifetime.</td>
<td>Major depression (10.6%)</td>
<td>Post traumatic stress disorder (2.0%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specific Phobia (4.8%)</td>
<td>Attention-deficit / hyperactivity disorder (1.8%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol Abuse (3.6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dysthymia (3.6%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mood disorders as a group (10.6%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country</th>
<th>Mood disorders as a group (14.1%)</th>
<th>Anxiety disorders as a group (22.3%)</th>
<th>Anxiety disorders as a group (14.6%)</th>
<th>Mood disorders as a group (11.0%)</th>
<th>Mood disorders as a group (17.9%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Major depression (21.0%)</td>
<td>Specific Phobia (9.9%)</td>
<td>Alcohol abuse (6.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>Major depression (9.9%)</td>
<td>Specific Phobia (5.4%)</td>
<td>Alcohol abuse (6.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>Major depression (9.9%)</td>
<td>Specific Phobia (5.4%)</td>
<td>Alcohol abuse (6.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>Major depression (9.9%)</td>
<td>Specific Phobia (5.4%)</td>
<td>Alcohol abuse (6.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>Major depression (17.9%)</td>
<td>Specific Phobia (7.6%)</td>
<td>Alcohol Abuse (8.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>Major depression (10.6%)</td>
<td>Specific Phobia (4.8%)</td>
<td>Alcohol Abuse (3.6%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other disorders observed less frequently**: Agoraphobia without panic (0.9%), Panic disorder (2.1%), Oppositional defiant disorder (2.0%), Alcohol dependence (1.6%), Agoraphobia without panic (0.9%).
<table>
<thead>
<tr>
<th>Mental Disorder</th>
<th>Population Proportion Suffering at Least One of the Studied Mental Disorders (12 Months Previous to the Interview)</th>
<th>Most Common Mental Disorder (12 Months Previous to the Interview)</th>
<th>Less Frequent Mental Disorder (12 Months Previous)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generalized anxiety disorder (1.9%)</td>
<td>1/10</td>
<td>1/5</td>
<td>1/10</td>
</tr>
<tr>
<td>Most common mental disorder</td>
<td>Major depression (5.0%)</td>
<td>Specific Phobia (7.3%)</td>
<td>Specific Phobia (6.5%)</td>
</tr>
<tr>
<td>[Specific Phobia (4.4%)</td>
<td>Major depression (5.9%)</td>
<td>Episodes of major depression (3.9%)</td>
<td>Major depression (3.0%)</td>
</tr>
<tr>
<td>Alcohol abuse (1.7%)</td>
<td>Social phobia (1.4%)</td>
<td>Alcohol abuse (1.0%)</td>
<td>Panic disorder (0.7%)</td>
</tr>
<tr>
<td>Anxiety disorders as a group (7.6%)</td>
<td>As a group: Anxiety disorders (13.1%) and Mood disorders (6.5%)</td>
<td>As a group: Anxiety disorders (8.1%)</td>
<td>As a group: Anxiety disorders (6.0%)</td>
</tr>
<tr>
<td>Adult separation anxiety (0.1%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1.7%)

(1.0%)
to the interview) Alcohol dependence (0.3%)
Agoraphobia without Panic (0.4%)
Oppositional-defiant disorder (0.4%)

| Predictors of mental disorder (previous year) | - Younger (18-24 years of age) show the highest rates of mental disorders (previous year) | - Gender, income and marital status are not related with mental disorders (exception: substance abuse disorders are more likely among those never married). | - Mental disorders were more frequent among women. - Men showed higher rates of substance use disorder - Age, income and marital status are not related with mental disorders - Mental disorders were more frequent among younger individuals (18-24 years of age). In general the tendency of mental disorders tends to decline as age increases.
- Unemployment and living alone are highly related with the risk of suffering from mental disorder. | - Mental disorders were more frequent among women (mood and anxiety disorders) - Men showed higher rates of alcohol use disorder - Mental disorders were more frequent among those with 35-49 years of age and 50-64 years of age, and less frequent among those with 18-34 years of age and those older than 65 (true for all disorders except alcohol use disorder) | - Mental disorders were more frequent among women (mood and anxiety disorders) - Never being married are highly related with the risk of suffering from an anxiety mental disorder. | - Mental disorders are twice as likely among women than among men. - Age, level of household income, marital status or education are not related with the likelihood of having a mental disorder. |

| Treatment of mental disorder | - | - | - | - | - | - |
### Probability of visiting a health care professional during the first year after the onset of mental disorder varies according to specific disorder

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic disorder</td>
<td>56.4%</td>
</tr>
<tr>
<td>Major depression</td>
<td>47.8%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>46.8%</td>
</tr>
<tr>
<td>Major depression</td>
<td>58.6%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>57.1%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>62.9%</td>
</tr>
<tr>
<td>Major depression</td>
<td>42.4%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>39.4%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>58.6%</td>
</tr>
<tr>
<td>Major depression</td>
<td>40.4%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>3.4%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>65.2%</td>
</tr>
<tr>
<td>Major depression</td>
<td>31.0%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>28.8%</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>62.9%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>31.0%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>8.2%</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>28.8%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>56.4%</td>
</tr>
<tr>
<td>Major depression</td>
<td>42.4%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>39.4%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>65.2%</td>
</tr>
<tr>
<td>Major depression</td>
<td>57.1%</td>
</tr>
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<td>Generalized anxiety disorder</td>
<td>40.4%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>65.2%</td>
</tr>
<tr>
<td>Major depression</td>
<td>31.0%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>28.8%</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

### Amount of years, since the onset of a mental disorder, passed until visiting a health care professional varies according to the specific disorder

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Years Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic disorder</td>
<td>1</td>
</tr>
<tr>
<td>Major depression</td>
<td>1</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>1</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>18</td>
</tr>
<tr>
<td>Social phobia</td>
<td>21</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>23</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>2</td>
</tr>
<tr>
<td>Major depression</td>
<td>2</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>27</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>2</td>
</tr>
<tr>
<td>Major depression</td>
<td>2</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>22</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>1</td>
</tr>
<tr>
<td>Major depression</td>
<td>1</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>20</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>31</td>
</tr>
<tr>
<td>Major depression</td>
<td>31</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>32</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>20</td>
</tr>
<tr>
<td>Major depression</td>
<td>20</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>20</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>27</td>
</tr>
<tr>
<td>Major depression</td>
<td>37</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>37</td>
</tr>
</tbody>
</table>

### Final comment

The general practitioner was the health care professional most commonly visited (previous year).

- Only a minority of individuals suffering from a mental disorder reported to have visited a health care professional because of their symptoms.
Only a small proportion of those who reported having visited a health care professional because of their mental health chose a mental health specialist.

<table>
<thead>
<tr>
<th></th>
<th>BELGIUM</th>
<th>BELGIUM</th>
<th>BELGIUM</th>
<th>BELGIUM</th>
<th>BELGIUM</th>
<th>SPAIN</th>
</tr>
</thead>
</table>

Overall evaluation of Workpackage 2 during the overall duration of the project

The main objective of the area II (Production of scientific papers and summaries), was achieved meeting each year's expected results (see “Scientific Publications” in I.5). The total scientific production of the project was regarded as good to very good both in quantity and in the overall relevance of the scientific journals in which the manuscripts were published, with a variety of scientific publications published in peer-reviewed scientific journals in the fields of psychiatry and psychiatric epidemiology and public health.

It is important that as a result of the EPREMED project, the consortium has produced:

i. International original manuscripts.
ii. International review manuscripts.
iii. National original manuscripts.
iv. National review manuscripts.
v. Other documents such as dissemination material and policy reports.

The publication guidelines, combined with the online database of publications under development in the web site, proved themselves a useful tool to track the process of elaboration of scientific manuscripts, facilitating the collaboration among researchers. As importantly, the online database has been an invaluable tool to document the publication process. This was important both to help identifying key messages with health policy implications (see workpackage 4) and to help evaluating the impact of dissemination (see workpackage 5). The publication guidelines
enabled the Consortium to focus on topics that are more relevant both to the project and SANCO.

Secondarily, the ESEMeD/MHEDEA data is currently being analyzed in a number of studies carried out by the World Mental Health Survey initiative, with coordination centers at Harvard and WHO, Geneva, therefore contributing to a greater visibility our results. Several ESEMeD researchers are currently involved in active Workgroups from the WHO World Mental Health Initiative -i.e., 1) ADHD (Ron de Graaf); 2) CIDI validity, reliability, and cultural differences (Terry Brugha, Josep Maria Haro, Vivianne Kovess); 3) Clinical Reappraisal (Josep Maria Haro –chair-, Terry Brugha, Giovanni de Girolamo); 4) Drug Dependence (Terry Brugha, Ron de Graaf, Jean Pierre Lépine, Jordi Alonso); 5) Family, Genetic Factors, and Mental Health (Jean-Pierre Lépine); 6) Gender (Terry Brugha, Koen Demyttenaere, Vivianne Kovess); 7) Impact of Mental and Addictive Disorders (Jordi Alonso, Matthias Angermeyer, Sebastian Bernert, Ronny Bruffaerts, Koen Demyttenaere); 8) Mental-Physical Comorbidity (Jordi Alonso, Ronny Bruffaerts, Koen Demyttenaere); 9) Methodology (Gemma Vilagut); 10) National Reports (Vivianne Kovess); 11) Nosology (Jordi Alonso, Terry Brugha, Josep Maria Haro); 12) Personality Disorders (Giovanni de Girolamo –chair-, Jean Pierre Lépine); 13) Services (Jordi Alonso, Ronny Bruffaerts, Giovanni de Girolamo, Koen Demyttenaere, Josep Maria Haro, Vivianne Kovess); 14) Social Class (Sebastian Bernert); 15) Suicide (Ron de Graaf, Josep Maria Haro). As a result of such collaboration several scientific publications have been authored by ESEMeD researchers in collaboration with the WMH Survey Initiative which are already published, in press or submitted (See “Scientific Publications” in I.5)
We have also been active in the elaboration of the first two volumes of the “World Health Organization World Mental Health Survey Series” ("1. Patterns of mental illness in the WMH Surveys" and "2. Mental-physical comorbidity in the WMH surveys"; Cambridge University Press). Several book chapters are being authored by ESEMeD researchers ("4. The Burden of Mental Disorders in the WHO World Mental Health Surveys"; Cambridge University Press. In preparation)

An effort has been made to improve communication with SANCO officers and to make published manuscripts available to them. Through this communication, topics of special interest for the EU Commission have been identified, being Positive Mental Health a major one. While the scientific production may be adequate, the production of policy reports, a major concern of the project, is insufficient according to the planned target number of reports to be produced each year. However, specific policy reports have been elaborated for the Italian government, and the ESEMeD data have been used by the Spanish government to inform the development of a Mental Health Law.

Finally, throughout the duration of the project there were no significant deviations from the project work programme.
Key achievements

- Elaboration of the Publication Guidelines.
- Agreement of key Lines of Analysis.
- Set up of Online database of Publications.
- Completion of the In-depth Analysis of ESEMeD / MHEDEA
- Publication of Scientific Manuscripts on Relevant National and International Journals.
- Elaboration of Several Policy Reports.
- Participation in Workgroups From the WHO World Mental Health Initiative.
- Participation in the Elaboration of the First Two volumes of the “World Health Organization World Mental Health Survey Series” ("1. Patterns of mental illness in the WMH Surveys” and ”2. Mental-physical comorbidity in the WMH surveys”; Cambridge University Press)
**Workpackage 3: Data Integration and Synthesis**

**Workpackage description**

*a) Overview*

<table>
<thead>
<tr>
<th>Lead Partner</th>
<th>University of Leicester (ULEIC-DHS)</th>
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<tr>
<td>Partners involved</td>
<td>University of Leicester (ULEIC-DHS)</td>
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*b) Description of work*

**Phase 1:** Aggregation and refinement of existing methods of synthetic analysis:
- Systematic review of existing methods.
- Identification of principles whereby qualitative/qualitative synthetic methods can be applied to survey data.
- Preliminary testing of methods to ensure utility and reliability.

**Phase 2:** Agreement on key issues requiring synthetic estimates: Mental Health
Policy information developers to be identified (in concert with relevant activities in other work packages) at national and European level to:
- Generate potential issues for more detailed analysis
- Generate prior estimates of expected findings in relation to information crucial to key policy making decisions.

**Phase 3:** Secondary data analyses:
- Collection of survey datasets on prevalence and treatment of mental disorders
  Pooled analyses to generate synthetic estimates as defined in Phase 2.
- Mental and physical health expectancies using prevalence data
  Preparation of policy report and scientific papers.

**C) Deliverables**

**DL3.1:** Report of the methodology review and policy information user dialogues.
**DL3.2:** Report of the policy outputs and completion of scientific manuscripts.
The aim of this workpackage was to enable policy information development and dissemination in the European Union. This was achieved through a series of studies. We reviewed the development of methods to synthesise analyses of general population surveys of mental health functioning and other mental health epidemiological studies. We then used two data synthesis methods in order to make informative comparisons. Specifically, we compared mental health expectancies across the 6 EU ESEMed countries using ESEMed community survey and life table data. We drew synthetic inferences from ESEMed findings on associations between adult mental disorder and quality of parenting and longitudinal data from a seventh EU country in which comparable measures have been collected using independent birth cohort data prospectively. We carried out three studies of the use of population based information by policy and decision makers.

The review of synthetic methods yielded new information on their use and how to use them in developing mental health policy information. We listed recommendations for the future use of such methods pointing to strengths and weaknesses in published reviews of epidemiological studies in the mental health field. We were able to show that mental health expectancies vary across the 6 countries in which the ESEMed survey was conducted providing the first analysis of mental health expectancies across 6 EU Member States. We were also able to test and verify the robustness of ESEMed findings on associations between poor parenting and adult mental health. We found a wide range of uses and needs for information across Europe providing fresh insights into a wide range of policy information needs across parts of the EU and made recommendations for reducing this variance in policy development.

Our summary recommendations are:

Synthesis of findings between different studies should be carried out using the best methods in current use as set out in detailed recommendations in this report;

The importance of parenting as a predictor of adult mental health argues strongly for the introduction and evaluation of parenting training;

The wide range of mental health policy information use and understanding across EU Governments argues for the need for the successes of the best to be shared by others.
Systematic and periodic public health data should be collected and expertise in its interpretation should be represented within policy divisions of government.

GENERAL INTRODUCTION

Work package no 3 includes a review of synthetic methods that can be used to bring together the results of different studies of possible determinants and prevalence rates of mental disorders. On the basis of the recommendations of the review, examples of how to use the methods are applied to data collected in Europe, including data collected in ESEMed. This report also informs about dialogues with policy and decision makers in which they were asked what kinds of information would be helpful to their work (The report is set out in this order although each of these three steps was carried out in parallel). Policy makers in general sought information on prevalence rates and determinants, which were already available and provided as part of our dissemination package (WP-4). The potential value of synthetic estimates was not raised by policy makers. The present report will perhaps serve as a first opportunity to highlight the potential of such methods to the policy and decision making process.

This report begins with a description of the methods used and is followed by the results in the form of a series of reports, available as annexes numbers 7 and 8) on the different components of the work package. As far as possible no results are described in the first part and very little further information on methods is included in the results sections (annexes 7 and 8).

Description of Work Methods

A review of synthetic reviews was undertaken. Two uses of such methods were then developed. Regular co-ordination meetings in Leicester were chaired by the WP-3 co-ordinator throughout 2006-2007. Taking part were D.R.J., Professor of Medical Statistics and a leading expert on synthetic methods, and C.J., Professor of Epidemiology, who is a world leading authority in health expectancies using prevalence data. Progress of this work was reviewed by EPREMed partners in February 2007 and at further opportunities for discussion during 2007 including the final meeting in Barcelona.
Systematic review of existing methods of data synthesis.

The aim of this study was to produce Guidelines on the use of Systematic Review and Synthetic Methods such as meta-Analysis in the field of observational psychiatric epidemiology.

A detailed search of the literature was carried out assisted by a professional medical librarian (Mary Edmunds Otter, a professional librarian and information scientist). The search was for psychiatric epidemiology and public mental health reviews of evidence from 2 or more studies. We searched for papers that use terms such as ‘meta analysis’ and those that do not, so that comparisons can be made (the search terminology is included in the report). A second research assistant (RM) completed this work from a protocol developed by the chief investigator (TSB) assisted by a professorial medical statistician with international level experience in systematic review methodology (DRJ).

We completed a scoped out analysis of themes and principals. We identified a similar review of reviews (applied to the use of systematic reviews and method analyses in the animal research literature that demonstrated strengths and deficiencies in that literature). We identified, in like manner, widely used quality standards for appraising systematic reviews. These form the basis of our final recommendations with little modification as they appear entirely appropriate to the field of mental health epidemiology.

Four hundred and ninety articles were identified from the search strategies, of which 105 were classed as potentially relevant after reading abstracts. Full text copies of the 105 papers were obtained. After reading the papers, 57 were selected as relevant and reviewed by RM. A further four papers were identified through searching the reference lists of the reviewed papers.

We list strengths and deficiencies where they have arisen in the final subset of eligible reviews. We completed summarised work on the main findings and methods employed in each eligible literature review. We abstracted observations of the main methods used by reviewers. (Details will be published in a separate scientific journal article).
A more detailed evaluation of the correct or flawed use of review methods was carried out. A final set of recommendations is made on the use of synthetic methods to derive scientific and health policy information that highlights issues of applicability to the field of mental health epidemiology and public mental health.

Our research evaluated selected review source papers, examining them in depth and evaluating the assumptions made in combining or synthesising findings from potentially heterogeneous studies. For example, assumptions have been made with regard to data synthesis from different ways of measuring the same construct, different ways of sampling from a finite (e.g. ‘general’ or community) population and so forth. We concluded that the most promising and helpful approach would be to compare estimates of prevalence with estimates of association between an outcome and a determinant (which is explained fully in the results).

On the basis of this work we choose and took forward two examples of the use of synthetic principles and methods.

**Methods used to generate synthetic estimates**

Such methods were used to examine two issues using European data. The first was the effect of poor parenting as a determinant of mental disorder. We synthesised findings from the ESEMed surveys and from longitudinal data collected in a seventh EU country. The second was a synthesis of life tables and tables on the prevalence of common mental disorders from the ESEMed countries.

1. Mental health and parenting: combining cross sectional and longitudinal data from EU national surveys.

EU Public Health is required to focus attention on prevention (UK Presidency, 2005; Mental Health Green paper) particularly of depression and suicide. There are interventions that can alter parenting (leading to better behavioural, occupational and educational outcomes). Published outputs from ESEMed show that the relationship between parental child-rearing styles and mood disorders is mostly homogeneous across the six ESEMed countries (Heider et al, Psychiatry Res. 2006 Jun 30;143(1):89-98). The Parental Bonding Interview (PBI) dimensions 'maternal
care’ and ‘paternal care’ had the strongest (inverse) associations with mood disorders. However this is a cross sectional study and therefore the direction of the association cannot be known: it is possible that survey respondents with depression viewed in a biased negative way the quality of their parenting and that reported poor parenting is not causal but is a result of poor mental health.

New secondary analyses of longitudinal data collected from birth were analysed in order that such cause and effect questions could be tested objectively. Birth cohorts have been maintained over time successfully within Europe, particularly in Finland and Great Britain only. The PBI (a subset of the exact same questions on parenting quality) has been used in prospective data collection in two such birth cohorts (in Great Britain). In the present final report we combined the birth cohort and ESEMed findings with a view to generating guidance on the potential impact of such information for future prevention research and policy.

2. Mental health expectancies using prevalence data and lifetables.

We used the ESEMed data set and nationally available information on survival rates according to population socio-demographic categories to generate mental health expectancies.

Sullivan’s method of calculating health expectancies, which is an established method, was used to link the prevalence of mental disorder (and specifically depression but also anxiety disorders) with mortality rates in the 6 ESEMed survey countries in order to estimate the average number of years expected with and without mental disorder (and depression). In order to establish prevalence estimates of depression among adult and older populations in these six countries, data were drawn from the CIDI data in the six ESEMed general population data sets in France, Spain, Italy, Netherlands, Belgium, Germany.

Estimated life expectancy with depression anxiety disorder and ‘any’ anxiety or depressive disorder, at various age groups from 16 up to 50 years (to exclude possible institutional effects in older adults) and by gender were compared across these countries and rankings were produced.
3. Dialogue with policy information users on the use of information.

The information needs of policy makers may vary substantially from country to country (or region, or context). Some will have developed a sophisticated information base and a substantial policy analysis background; others will be beginning to consider how information can serve their needs.

The core questions addressed were as follows:

What are the key questions and decisions you now face in your responsibilities as a mental health policy decision maker or adviser?

If you had the necessary information for example from a health survey what would you expect it to show?

Where ever possible the above two questions were put to policy information users in the context of meetings and dissemination opportunities.

Three pieces of work were carried out in order to collect such information:

Focus group meetings with policy makers in Europe

Information on use of data conducted in conjunction with the European Health Expectancy Monitoring Unit (EHEMU)

A report of cross governmental use of mental health survey information used in England

a. Focus group meetings with policy makers in Europe

Initial meetings of the WP3 and WP4 partners took place in July and September 2005 and in October 2007. They agreed on the methods to be used and the data to be shared between the two Work Packages. They together agreed on the following questions to be put to the policy and decision makers in the governmental areas to be visited (table 1).
Table 1. Questions to be put to participants in Focus Group Discussions

<table>
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<th>Question</th>
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<tr>
<td>Does this information help you to set, modify or consolidate health information?</td>
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<tr>
<td>Does this information help you in the organization of the health system?</td>
</tr>
<tr>
<td>Is the information presented in a format that enables you to use it at different levels (national/regional/local)?</td>
</tr>
<tr>
<td>Which information would enable you to support changes in policy?</td>
</tr>
<tr>
<td>In which forms should it be presented so that it justifies and motivates change?</td>
</tr>
<tr>
<td>After seeing the data will you change something in your policy or your action in general?</td>
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</table>

Mental Health Policy information developers were identified (in concert with relevant activities in other work packages) at national and European level. The WP n°-4 team conducted meetings with policy and decision makers and other stakeholders in appropriate governmental areas using the focus group method. WP n°-3 also initiated consultations with policy information data experts in relation to the value to policy makers of information on mental health expectancy.

During 2007 the written reports and analyses of the focus group meetings conducted by WP4 were reviewed as they were transmitted to the EPREMED central co-ordinator and to the WP3 co-ordinator. Based on the material provided by WP4, the WP3 co-ordinator summarised information on the expectations that appear to reflect the thinking and understanding of policy makers and stakeholders begun during 2006. These were shared with and refined through discussions with the EPREMED co-ordinator, the WP4 and WP5 coordinators.
A further meeting of the EPREMED partners took place in Autumn 2007 in Barcelona, during which the WP3 and WP4 package leaders completed a final review in detail of all the materials gathered up to that point.

**b. Information on use of data conducted in conjunction with the European Health Expectancy Monitoring Unit (EHEMU)**

A member of the WP n°-3 team also met with, and requested from, members of a public health network information on mental health policy information needs that arose in their work with policy advisers in their respective European governments. This was undertaken in conjunction with the European Health Expectancy Monitoring Unit (EHEMU), a project funded by the Comission of the European Communities with the objective of analyzing health expectancies in Europe and establishing a repository for data on EU health expectancies, to provide added value to their analyses and to monitor possible ‘trade-off’ between improvements in one domain and worsening in another. Health expectancy is included in the list of structural indicators to be developed for the EU.

**c. A report of cross governmental use of mental health survey information used in England**

The WP n°-3 leader also took part in a series of meetings with Key Cross Governmental policy makers in England (in 2007 and in 2008 but also by way of background to this in 2005), which provides invaluable insights into the potential role of both health and other government policy makers in relation to the mental health of the population. (The WP3 co-ordinator has had prior experience of working as a full time Policy Adviser in Central Government for an 18 month period in the mid 1990’s and is familiar with the needs, pressures, constraints, opportunities and reliance on policy information faced by policy makers).
In conclusion, after the three years of work, WP n°-3 has produced:

(a) Valuable new information on synthetic methods and how to use them in developing mental health policy information; and
(b) The first analysis of mental health expectancies across 6 EU Member States; and
(c) Insights into a wide range of policy information needs across parts of the EU.

WP N°-3 Overall Recommendations:

Synthesis of findings between different public health epidemiological studies should be carried out with caution using the best methods in current use as set out in detailed recommendations within this report;
The importance of parenting as a predictor of adult mental health argues strongly for the introduction and evaluation of parenting training across Europe;
The wide range of policy information use and understanding found across EU Governments argues for the need for the successes of the best to be shared by others.
Systematic and periodic public health data should be collected and expertise in its interpretation should be represented within mental health policy divisions across government departments, not only health but also education, employment and others.
Workpackage 4: Dissemination of Results

The main objectives of WP 4 were to show and make clear the implications of the ESEMED data for all the potential audiences in order to improve the understanding of mental health across Europe and provide the whole society, and especially stakeholders, with practical knowledge about the state of mental health in Europe.

The specific tasks to be performed were:

- to develop a database of different audiences, defined on both national and European level, for mental health interest
- to develop specific dissemination activities to each group of stakeholders, thanks to many dissemination supports: scientific or non-scientific meetings, written documents, press conferences, Internet websites with a special interest to guarantee an appropriate transfer of epidemiological knowledge into mental health policy

The steps to achieve the successful completion of these tasks were:

**1) Defining a dissemination strategy**

In order to identify target audiences and develop tailored dissemination strategy to reach them FESP organized or was involved in diverse meetings with EPREMED partners.

- The first dedicated meeting was organized in Paris (27th of September 2005). Viviane Kovess, Terry Brugha, Alejandra Pinto, Toni Martinez and Elodie Carmona attended this meeting. This meeting objective was to discuss strategies aimed to involve partners with experience in working with health ministries and stakeholders, discussing issues about disseminating information to stakeholders, giving them opportunities to share their experiences and identifying key-messages based on EPREMED evidence that could be useful for health policy making. During this meeting, the partners shared their experiences, identified the target audiences and decided a dissemination strategy, and especially the key-topics that were likely to interest policy-makers.
A phone meeting was organized with Trimbos team leader, Ron De Graaf, who could not attend the meeting in Paris. He stressed the fact that, as the results of an important, national representative study (NEMESIS) having been disseminated in the Netherlands, the dissemination of the EPREMED results might be less appealing for the national stakeholders.

An in-person meeting was organized in Belgium, with Ronny Bruffaerts and Koen Demmyttaere. They identified the mutual insurance companies as a key audience for EPREMED dissemination in Belgium.

As a consequence, Viviane Kovess met in Brussels Jean Hermesse, a representative of Belgian mutual insurance companies, who confirmed the strong interest of mutual insurance companies for EPREMED results. They are particularly interested in issues such as prevalence of mental disorders, role of practitioners (GP, psychiatrists etc...), psychotropic drugs usage, days of work loss and suicide.

Viviane Kovess met in Vienna the IMHPA (Implementing Mental Health Promotion Action) network leader, Eva Jane Llopis. She provided us with advice for dissemination, and with a document summarizing the IMHPA coalitions (lists of audiences having an interest in mental health issues).

Thus, during these EPREMED meetings, the main aims of the project and target audiences were identified.

a) **Audiences identified**

Beside the scientific community, reached through scientific papers and personal communications at scientific meetings, two kinds of relevant audiences have been identified: policy-makers and the civil society.

A. Firstly, the policy-makers want to know about the situation of mental health, and whether the resources (financial as well as human) allocated to mental health are allocated in an appropriate way.

In addition, they want to know if their current priorities are appropriate taking into account the EPREMED results, and, if not, how they should adapt such priorities. They must be provided with tailored and recent information about the most crucial problems, so that they could have elements to implement European, national and regional plans.
This first identified audience was composed of various kinds of stakeholders:

- **EU and international policy makers.**

  Esemed data have been largely available at the EU level through presentations at two main meetings: the WHO interministerial conference held at Helsinki in January 2005 with the participation of EU and an EU conference preparing the green paper at Luxembourg in October 2005.

  Both events have provided us with an opportunity to present key EPREMED results to a very large international and European audience, as well as to a larger audience since press conferences were held in both meetings.

  Then when, the European Commission decided to present a Green paper “Promoting the Mental Health of the Population. Towards a Strategy on Mental health for the European Union”, the EPREMED data contributed key information used for the preparation of the European Green Paper.

  Moreover, the European Commission invited European institutions, Governments, health professionals, stakeholders in other sectors, civil society including patient organisations, and the research community to communicate their views on this document, leading to a wide circulation of key EPREMED results.

- **National stakeholders.**

  - First of all, this implied to disseminate towards mental health policy-makers and other health-related policy-makers as well.
  - There was also a range of government departments for which such information could be of value. Indeed, the politicians in charge with employment, education welfare, benefits and pensions or internal Affairs could be interested in ESEMED outcome, in so far as information concerning areas such as loss of productivity issues, child protection, issue of early return to gainful productivity, maintaining independence in the community in older age, conduct disorder, effects of substances, etc., are closely related to both their own fields of action and mental health topics.
  - The representative of medical practitioners
  - The representative of mutual insurance companies were greatly interested in issues such as use of care, use of medical drugs, and work days loss because of mental health disorders, which represents a very heavy burden for the whole economy and society.
✓ **Regional policy makers**, especially in non-centralized countries (e.g. Spain, Germany)

B. The second identified audience was the **civil society**, which included:

- **NGOs**
- **representatives of patients**
- **media**

These groups of stakeholders were interested in the same topics as policy makers and, additionally, in such issues as stigma and discrimination in relation to mental health. The ESEMED database provided relevant information about these topics.

The FESP team collected data and created a database of selected national/regional stakeholders for Belgium, the Netherlands, France and Spain. In order to implement this task, we were helped by Doctor Eva Jane Llopis, who previously determined country-based “coalitions” for the project IMHPA (Implementing Mental Health Promotion Action1). (see annex 10) We reused these coalitions to establish our lists of potential audiences when possible. Once completed, the lists were sent to national partners (current: Belgium and Spain, at term, all the involved countries) so that they could be completed and validated by the national partners, according to their own networks and experiences. This lead to a national audience database. The same work was achieved for an European audience.

b) **Instruments for the dissemination**

A draft of dissemination plan was prepared and sent to all the partners.

This plan aimed at organizing, in each country and for each audience, meetings such as focus groups that would involve the selected audiences. During these meetings main EPREMED topics, data and results from ESEMED survey and research activities which are likely to interest the audience were presented. Then, the speakers had a discussion with the attendees so that they could present their questions, further expectations and own proposals.

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1 Although some lists are very helpful, some countries do not have any coalition (France), or they have a coalition that is too restricted for EPREMED dissemination. For these countries, we have to collect further information in order to complete the database.
In order to prepare such focus groups, FESP team has prepared short notes (3 pages maximum) about key-figures for the EPREMED countries plus a powerpoint presentation illustrating the main results in order to introduce our results to the focus group participants.

In addition an EPREMED Focus Group Guideline (see below) was prepared and circulated to all partners in order to ensure that the focus groups were dealt with in a similar manner. Written minutes were required:

The purpose of Focus Group was described as:

- To disseminate EPREMED results as widely as possible
- Ideally each country had to run 1 focus group with a duration of at least 2 hours with the selected audience
- During this meeting 2 phases have to occur.
  - A presentation (power point) of the main EPREMED topics. Data were compiled from national and European ESEMeD publications, survey and research activities, The World Mental Health Survey Initiative, and the WHO Health for All Database and other research activities which were likely to interest the audience will be presented.
    - Special attention has to be given to the 3 following issues:
      - European perspective (rank of the country for main mental health problems, main trends,) and national context
      - National specificities
      - Propose leads (or even solutions) in order to explain these peculiarities and improve the national mental health
  - A discussion should happen with the attendees so that they could present their questions, further expectations and own proposals.

Topics, audience and material were also presented.

**EPREMED Focus Group Guideline**

1. Format of the Group
   - Size 8-12 per session
   - Length 1.5 to 2 hours
   - Number of sessions: 1
   - Participants should include the following representatives of the
     - Ministry of Health
     - Patient Groups
     - NGOs
     - Media
     - Health Insurance Company
     - Medical profession body i.e. Psychiatrists Association
     - Educational training institute – i.e. university etc
e. Data collection: Audiotape, Transcribe
f. Moderator: Flexible yet focused, Uses interview guide
g. Formats for reporting: summary of discussion

2. Interview Guide – 5 to 7 questions (please see below)

3. Planning the Session
   a. Scheduling - Plan meetings to be 1.5 to 2 hours long. Over lunch works very well.
   b. Setting and Refreshments - Hold sessions in a conference room, or other setting with adequate airflow and lighting. Configure chairs so that all members can see each other. Provide nametags. Provide refreshments, especially light lunch if the session is held over lunch.
   c. Points - It is critical that all members participate as much as possible, yet the session move along while generating useful information. Consider the following three ground rules: a) keep focused, b) maintain momentum and c) get closure on questions.
   d. Agenda - welcome, review of agenda, review of goal of the meeting, review of ground rules, introductions, questions and answers, wrap up.
   e. Membership: 8-12 members
   f. Record the session with an audio recorder. Also, involve a co-facilitator who is there to take notes.

Facilitating the Session

1. Major goal of facilitation is collecting useful information to meet the goal of the meeting.
2. Introduce yourself and the co-facilitator
3. Explain why we have to record the session
4. Carry out the agenda
5. Carefully word each question before that question is addressed by the group. Allow the group a few minutes for each member to carefully record their answers. Then, facilitate discussion around the answers to each question, one at a time.
6. After each question is answered, carefully reflect back a summary of what you heard
7. Ensure even participation. If one or two people are dominating the meeting, then call on others. Consider using a round-table approach, including going in one direction around the table, giving each person a minute to answer the question. If the domination persists, note it to the group and ask for ideas about how the participation can be increased.
8. Closing the session - Thank them for coming, and adjourn the meeting.

Immediately After Session

9. Verify if the tape recorder, if used, worked throughout the session.
10. Write down any observations made during the session. For example, where did the session occur and when, what was the nature of participation in the group? Were there any surprises during the session?
11. We will not be asking you to transcribe the taped session but rather we will ask you to produce a summary of the talk
12. Also during the last 20 minutes or so of the focus group, we will ask you to have a wrap session up with the group in which they produce a summary of things.
**Topics for focus group have been proposed**

1. Which are the conclusions you can draw from these results?
   a. As a professional?
   b. As a health planner?
   c. As a user?
   d. As a civil society or media?
   e. As a teacher in public health or psychiatry?

2. Does this information help you to set, modify or consolidate health information?

3. Does this information help you in the organization of the health system?

4. Is the information presented in a format that enables you to use it at different levels (national/regional/local)?

5. Which information would enable you to support changes in policy?

6. In which forms should it be presented so that it justifies and motivates change?

7. After seeing the data will you change something in your policy or your action in general?

**2) Implementing the strategy**

**The focus groups**

Focus groups appear the best strategy to communicate results across various stakeholders. It allows making different people working together and by doing that to define national or regional strategies based on the survey results.

✔ However, in two out of the six countries (Germany and the Netherlands), other important national representative surveys have been conducted in the past (GHS-MHS and NEMESIS, respectively), showing different methods and results than ESEMED. These results were disseminated among stakeholders and the teams do not want to present different results to the same stakeholders thinking that it will cast doubts on both surveys even though we thought that, it might be feasible to propose an appropriate communication strategy in order to explain these differences.

In the remaining countries the following focus groups have been organised:
- In France 2 focus groups were organised (minutes in annex 9)
- In Belgium and Italy 1 focus group was organised (minutes in annex 9)
In Spain focus groups were organised too but focused on evaluation of dissemination strategy instead.

In the three countries were focus groups were held, they allowed to present key EPREMED data to very diverse audiences and to audiences which are not reached by usual scientific publications or communications. They also allowed to discuss epidemiological results like prevalence of mental disorders, risk factors and health care utilisation for mental health problems in a European perspective. All participants regarded that as an added value.

Minutes described the characteristics of the participating stakeholders in each of the 3 countries:

- professionals: psychiatrist, GP, psychologist
- patient’s groups and civil society representative: journalist
- government and/or diverse regional or local authorities in charge of mental health delivery planning

The focus groups were given an opportunity to learn about frequency of anxiety and depressive disorders, and for some countries, such as France, it provided a chance to learn about higher prevalences than in those observed in other participating countries. Specially in Italy, the relative low access to care for mental problems was noticed. That stimulated a discussion about possible solutions. Lack of relation between primary and psychiatric care system was also underlined in some countries, such as France.

Additionally, the participation in the focus groups provided policy makers with a unique opportunity to be in touch with epidemiological data presented in such a way that they could easily understand and that they considered accessible enough to them. In France it was very much appreciated and considered as a sort of continuing education which should be repeated.

Conclusion; the focus groups were very useful and allowed the diverse stakeholders involved in mental health to meet together around scientific data; in addition the ESEMED comparative perspective add a unique element with the potential to help clarify priorities.
**Participation in scientific events**

In addition to the focus groups, a scientific dissemination plan was created by searching at the diverse pertinent scientific society websites and listing to each pertinent scientific meetings where a presentation of our results could be proposed. The dissemination WP was very active on stimulating participation in scientific events, issuing a scientific events program each year and trying to stimulate participation to those events by organising specific symposium on EPREMED results allowing to present diverse EPREMED findings.

The list of scientific events on which EPREMED data were presented shows the diversity of reached audiences: EU meetings, International and national scientific meetings. ESEMED data presentation were the focus of one specific symposium at a WPA meeting (Istanbul 2006) and at the IFPE meeting (Goteborg 2007).

A secondary, but significant, dissemination outcome was the publications list which is available on the project web site, providing us with an efficient way to communicate to large national and international audiences, increasing the visibility of the findings.

**Involvement in the “web dissemination”**

The EPREMED website is expected to become a reference site on mental health for both specialized and non-specialized European audiences.

A variety of materials have been developed and posted on the open access section of the EPREMED web site (see at http://www.epremed.org), with information on mental health both at European and at national levels.

Although, ideally, dissemination information on the EPREMED web site should be available both in English and in the participating countries languages, currently only English material is posted, owing to time constraints. However, the English version will allow web visitors to have an European vision and to learn about country results. The web dissemination materials were developed taking as a basis chapters on country results that were written in English for each country; these chapters (from a book soon to be published) described the country, its health care system specialised
or not in mental health, the ESEMeD survey methodology and its national implementation, the main results: prevalence, risk factors and health care utilisation for mental health problems.

In France, following focus group recommendations, we issued a press release for a large audience. The press release was done by a professional journalist involved in the fields to whom all publications on ESEMeD were provided. She selected the most appealing aspects according to her experience and decided to conduct a life interview from one of the French PI because the questions / answers style appears to her the most adapted form to communicate that sort of complex knowledge. The interview (written in French) is available on the section of the EPREMED website showing information about France and may be consulted by journalists who want to make paper or need information and by a large audience.

For each country we managed to include the EPREMED web site in several relevant web sites concerned with mental health, such as scientific societies (in France Fédération Française Psychiatrie which groups all societies involved in psychiatry), patients groups (such as France Depression), public health (société française de santé publique) and epidemiological societies (groupe français d’épidemiologie psychiatrique).

OVERVIEW

The aim of WP 4 was ESEMED results dissemination. Beside scientific dissemination through papers in scientific journals and participation at scientific meetings, WP4 was directed to large audience dissemination mainly policy makers, patients and public at large and mental health practitioners.

In order to obtain this results focus groups were organised : 2 in France and Spain, one in Italy and one in Germany. Easy to use material was prepared to open the focus groups allowing to gather the main results and to lead the discussion.

To continue the dissemination on a more permanent basis, this material and other elements were put in the epremed web site in English and local languages as well so people could easily access to it.

Globally the main objectives were completed however in two countries out of six, it was not possible to disseminate the results beside scientific papers and having the material posted in the web site was hard to obtain and somewhat incomplete.
Workpackage 5: Evaluation of Dissemination Activities

Workpackage description

a) Overview

<table>
<thead>
<tr>
<th>Lead Partner</th>
<th>Joan De Deu-Serveis Salut Mental (SJD.SSM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners involved</td>
<td>SJD.SSM</td>
</tr>
</tbody>
</table>

Objective

The objective is to evaluate the dissemination activities carried out in WP4. The design and initiation of the evaluation was planned to be conducted in parallel to the planning of the dissemination activities.

b) Description of work

The evaluation of the dissemination activities is based on the specific objectives of the dissemination activity. Four types of evaluations have been carried out.

Formative evaluation: It aims to estimate the effectiveness and usefulness of the dissemination materials and approaches. Its results have been used to refine activity strategies and/or materials. Focus groups with 8 to 10 individuals who are part of the target audience have been used.

Impact evaluation: It aims to provide information concerning the long-term impact of the dissemination activities. The following indicators were used: impact factor from the Journal Citation Reports 2006, number of book copies edited, presentation
level (national/international), number of assistants to a meeting, number of participants to a workshop, ESEMeD data inclusion in national/local health plans, number of participants in a focus group, mean number of daily edited copies of paper mass media, estimated number of radio listeners, kind/variety of participants to a meeting.

**Outcome Evaluation:** It aims to measure the effects of project activities upon identified target audiences. Onsite evaluations with the audiences or postal questionnaires have been used.

**Process Evaluation:** When possible, process evaluation has been carried out when implementing a new activity. Its results have been used to make changes in the efficiency and effectiveness of the implementation process in repeated actions.

c) **Deliverables**

**DL5.1.** Report on the strengths and weaknesses of each dissemination material.

**DL5.2.** Report on the strengths and weaknesses of each dissemination activity, frequency of accomplishment of the dissemination activities objectives and accomplishment the objectives of the overall dissemination strategy for each of the target audiences or stakeholders.

**DL5.3.** Report on the extend that each dissemination results varied according to the variables of user group, content, context, medium and information source.

**DL5.4.** Report on the recommendations to improve the procedures for future dissemination processes.
Key achievements:

1. Relevant stakeholders for disseminating results were identified.
2. The format of the most adequate kind of dissemination material for each stakeholder was discussed and agreed. Thus, we tailored the material format (report, oral communication, summary of results, etc.) to stakeholder needs.
3. Impact indicators were proposed, discussed and agreed in a specific Focus group carried out in Spain (formative evaluation activity) and a personal interview to Ms. Teresa Marfull (formative evaluation activity).
4. An internal survey for summarising all EPREMED dissemination activities was performed.
5. An examination of Spanish national/local health plans was carried out as a way of estimating the impact of the ESEMeD data on health/mental health policies.
6. An impact evaluation of each of the dissemination material/activity listed was done.
7. A summary of strengths and weaknesses of each dissemination activity/material, frequency of accomplishment of the dissemination activities objectives and accomplishment the objectives of the overall dissemination strategy was done by target audience.
8. A table summarising of dissemination results variations according to the variables of user group, content, context, medium and information source was done.
9. A list of key recommendations to improve the procedures for future dissemination processes is provided.
10. Dissemination material/activities (scientific papers, book chapter, oral and poster presentations, reports to policy makers, and mass media presentations) were developed.
Deliverable 1: Strengths and weaknesses of each dissemination material.

&

Deliverable 2: Report on the strengths and weaknesses of each dissemination activity, frequency of accomplishment of the dissemination activities, objectives and accomplishment the objectives of the overall dissemination strategy for each of the target audiences or stakeholders.

Note: deliverables 1 and 2 were merged in a single document containing:

1. Scientific production evaluation
2. Scientific communication evaluation
3. Policy communication evaluation
4. Social communication evaluation
5. Policy information research capacity description and evaluation
6. The EPREMED webpage: a tool for disseminating results to all audiences.

1. Scientific production: papers and books/ book chapters

Scientific papers are dissemination materials specifically developed for the scientific audience. This kind of material is the most common way of disseminating the results of epidemiological studies since it allows short communications of specific topics. Most of this kind of dissemination was produced in English language and published in international journals, most of them indexed in easy accessible databases such as PubMed.

Impact evaluation of this kind of material was easily feasible and objective, since the scientific community has developed and validated impact indicators (e.g. journal impact factor, number of citations of a given manuscript, etc.).

According to the project publications plans, the target value to achieve regarding scientific production was 7-9 yearly (21-27 during the whole EPREMED period). During the EPREMED project a total of 68 manuscripts were published in 32 different journals. This is more than double the amount expected. Among them, 27 were produced in local languages (9 in Spanish, 7 in French, 6 in Dutch, 4 in German and 1 in Italian). In total, published papers accumulated 143.33 points of impact factor. Mean impact factor was 3.41. A detailed evaluation of each publication and its
impact evaluation are available in section I.5 of this report ("Scientific Publications").

An important weakness, from a dissemination standpoint, was the imbalance between number of local language publications/ number of English language publications. In each country, the number of local language publications was smaller than publications in English. Probably, the fact that local language journals often have low or null impact factor could explain researchers tendency to publish in international English language journals. Such limitation could hinder efficient dissemination to country/regional scientific/academic community. Also, most of this dissemination was performed via psychiatric/psychological journals (69.5%). Efforts should be made to disseminate it through general medicine, primary care, and general practitioner journals, since in many European countries general practitioners or primary care physicians are situated at a privileged position to reach patients and citizens and may benefit from having this information available for their routine clinical practice.

As could be expected, books/ books chapters produced were few compared to papers (see section I.5 of the report). This kind of material was targeted for the scientific and academic community and allowed a more extended and comprehensive way of disseminating epidemiological data. However, this kind of material is not so readily available for the intended audience (they are usually indexed in library catalogues and copies are restricted to the geographical location of the editorial).

The evaluation of the impact of dissemination through books may be considered less objective. There are no consensus indicators available. However, the number of books edited and editorial coverage (one or more countries) could allow estimating impact.

During the EPREMED project a total of 8 books/ book chapters were produced (7 in English and 1 in Dutch). Six of them were evaluated in terms of their impact since we had data about number of copies edited (1000 copies in the United States). Again, an important limitation was the small number of local language books/chapters production.
2. **Scientific communication: participation in scientific events (oral communications, conferences, symposiums, round tables, posters, workshops).**

Scientific communications are activities specifically developed for the scientific audience. They are a rapid way to communicate results and disseminate epidemiological data live and onsite, allowing other researchers (often from many countries) to be aware of the study and its results. This kind of materials are usually collected and published in congress abstract books (available for congress registered members). Some of these abstracts are published in scientific journal supplements, making them accessible to persons not registered to the congress. This kind of dissemination was more extensively produced in local/regional languages. However, abstracts collected in abstract books or journal supplements are usually published in English.

Impact evaluation of these materials is complex, since no objective indicators are available. A focus group conducted in Spain (see Annex 9 for a summary of it) suggested the following indicators: number of presentations, congress/meeting level: national/international, and number of registered participants (data extremely hard to find).

The planned target number of scientific communications to achieve was 2-3 yearly (6-9 during the whole EPREMED period). During the EPREMED project, a total of 65 scientific communications were produced (much more than the expected value to achieve). Among them, 12 were collected in journal supplements. Total impact factor for abstracts published in journals was 15.20 (mean value 2.53). Communications were disseminated in 32 national congresses and in 32 international congresses (See section I.5 “Personal communications”).

Some strengths of scientific communications are: they are live and more commonly produced in local/regional languages, therefore audience is immediately reached and there is a chance for questions and clarifications which promotes knowledge exchange; they reach scientific audience from different countries (in case of international events) and from different disciplines; and they allow publicity for the study results.

Some important weaknesses are the common lack of easy available abstracts of the material disseminated (this is not true in case of journal supplement published abstracts) and the subjectivity of the evaluation of their impact.
3. Policy communication: publications and dissemination activities to specific policy-making audiences.

Policy communication was usually carried out via reports and work meetings. All of them were produced after the specific request by policymakers, produced in local language, and specifically tailored to the request.

Impact evaluation of these materials is complicated since no objective indicators are available. It has been suggested that useful results from epidemiological studies are those that could be translated into health policies. Some impact indicators suggested by the focus group conducted in Spain referred to previously were: creation/modification of policies/programs; inclusion of the results of the ESEMeD study in health plans.

The target value to achieve regarding policy communication was 2 yearly (6 during the whole EPREMED period). During the EPEMED project, a total of 5 reports were produced (4 of them for national offices and one of them for European office), a number slightly under our goal. The list of reports produced is listed in section I.5 of this report (“Scientific Publications”).

In order to estimate the impact of the results disseminated to policymakers, the Spanish health/mental health plans were scanned, searching for the inclusion of the ESEMeD results. Since Spain is divided in 17 Autonomous Communities, local and national health/mental health plans were scanned. Scan was performed in Spanish, using Google and the words: plan nacional de salud [national health plan], plan de salud [health plan], plan estrategico de salud [strategic health plan]. The search was repeated adding each Autonomous Community name (Andalucía, Aragón, Principado de Asturias, Islas Baleares, Islas Canarias, Cantabria, Cataluña, Castilla-La Mancha, Castilla y León, Extremadura, Galicia, Comunidad de Madrid, Murcia, Navarra, País Vasco, La Rioja, Comunidad Valenciana) or the word Spain. Searches were performed in: November 15th, 27th, 29th 2006; December 20th 2006; June 11th 2007. 10 out of the 17 Autonomous Communities had online health plans. Among scanned local health plans, 2 included ESEMeD data. The Spanish general health plan also included ESEMeD data.

Strengths of dissemination material delivered to policymakers were that they fitted their specific requests and that they were included, for example, in the Spanish national and some Spanish local health plans, suggesting an impact on health.
policies.

Among weaknesses we have the difficulty/subjectivity of evaluating their impact and that only Spanish health plans were evaluated.

4. Social communication: publications and dissemination activities through specialised or mass media addressing one or several of the intended audiences (civil society, patients and families).

Civil society, patients and families are a kind of audience commonly forgotten by researchers. This might be explained by the fact that this audience needs “translated results”, that is, results explained in an easily understandable way, many times far from the scientific vocabulary commonly used by researchers. Patients and families could be reached via national associations, translating results to fit audience specific needs.

Dissemination via mass media gives the opportunity to reach large civil society audiences, most of the time in country local languages. This is a kind of dissemination “translated” by journalists to fit common language and vocabulary, allowing non-professional audiences to be informed about mental health. Educational initiatives through mass media could help to reduce the stigma related to mental disorders. Also, mass media dissemination about mental health topics could increase citizens’ awareness of mental disorders.

However, it is important to notice that results disseminated via mass medias (such as newspapers, magazines, web pages, etc.) could produce some problems depending on the use that the media could make of results. This use may vary from informing to scandalising general population. For example, improper connections between mental disorders and social danger, which interfere with correct information, could promote stigma. Contrary, proper connections between mental disorders and need of care could reduce it.

After conducting the Spanish focus group and an in-depth interview to Ms. Teresa Marfull, who is the Manager of the Federación de Asociaciones de familiares y personas con problemas de salud mental de Cataluña FECAFAMM [Associations federation of family members and persons with mental health problems in Catalonia] (see Annex 11), important issues raised: information from epidemiological studies commonly does not reach patients and families; the health care system provides very limited space for informing patients and their families about new knowledge
derived from recent epidemiological studies; and there are no instances for common thinking.

Impact evaluation of dissemination activities targeted to this audience is probably the harder to perform. Again we have to deal with a lack of valid indicators. Some indicators suggested by the Spanish focus group were: duration of a given interview on TV, surface in cm2 of the newspaper or magazine new, number of newspapers or magazines edited each day/month; visibility index [number of documents or web pages (Google or PubMed) containing the key-words MHEDEA or ESEMeD, EPREMED, mental health number of assistants to meetings organised for this audience, and number of members of a given association. For logistic reasons it was not possible to use all of the proposed indicators. The ones used were: mean number of daily edited copies in a year and level national/international (for magazines, newspapers and web pages releases), estimated number of listeners (for radio interviews), number of participants and kind of them (for meetings).

The target value to achieve regarding social communication was 4-6 yearly (12-18 during the whole EPREMED period). During the EPEMED project a total of 14 social communications were done, covering newspapers, web pages and radio interviews (see section I.5 of this report).

5. Policy information research capacity: training activities organised in mental health policy information research by the Consortium.

Three workshops were organised:

1) The aim of the first workshop was to systematically demonstrate and empirically evaluate the main different types of coding systems for contrasts in linear regression models and non-linear probability models. Coding systems are employed to model the outcome differences between the categories or combination of categories of one or more predictors, and their possible interactions with other categorical and/or continuous predictors. The focus was on applicability and interpretation of the parameters. Post hoc testing and the graphical display of predicted values were extensively discussed. This workshop was held in November 2005 (21st – 23rd) in Barcelona.

2) The second course was aimed at giving an overview of different methods in health economic evaluation and informed the attendees about strength and
limitations of the methods presented. This workshop that was held in October 2006 (9th – 10th) in Leipzig.

3) The third workshop gave an overview of different methods in the measurement of health related quality of life (HRQL) as it is measured in the ESEMeD dataset (EQ-5D and SF-12). The workshop informed the attendees about strength and limitations of the instruments presented. This workshop took place in Barcelona, from 6th to 7th of November 2007.

Among strengths, workshops gave the opportunity to exchange knowledge among EPREMED researchers and trainees, helping to increase the knowledge of the group and to maximise the quality of statistical analyses in our scientific article production. A workshop documentation was produced that should give an overview of the content of the workshop and its main results. This documentation should serve as a reminder for all who have attended the workshop and an introduction to the topic for all who couldn’t attend. The documentation is available also on the EPREMED homepage that is available for the interested public visiting the website.

Workshops also were an opportunity to our collaboration with a scientist from the new member states and with colleagues from the WMH survey initiative, providing a unique opportunity for strengthening bonds among researchers.

Impact evaluation of this kind of activity is really hard. Workshops probably help to improve curriculum and abilities of assistants and also could help to promote new publications based on the new knowledge acquired. However, all of these are indirect and subjective outputs. In any case, as a way of estimating impact we can state that, in total, 3 workshops were organised and 39 persons participated (detailed evaluation can be found in section I.5, in the scientific communication section).

6. Policy information research capacity: newly engaged European junior researchers in the mental health policy information research field in the Consortium.

Exchange activities should be based on publication activities, i.e. a participant in the exchange programme should produce at least a draft version of a scientific article together with the host institution. A “Partnership quality commitment” that should serve as a guideline for the host and the sending organisation and as well for the scientist/student who is visiting an EPREMED partner was prepared and approved.
by the group. This commitment defines the duties of all participating parties in an exchange activity.

A total of 6 exchanges were carried out during the whole EPREMED project. The real impact evaluation is not possible at this time, since most of the manuscript are still under preparation or submitted (but not accepted yet).

7. Critical mass and interdisciplinarity: degree of representation of the different parties involved (academia and research institutions; administrations; pharmaceutical and other industries; patients and citizens representatives; etc.).

Although stakeholders different than scientists were not directly involved in the project planning or execution, we used focus groups to gain insight from policy makers (at European and national level), government representatives, representatives of medical practitioners, representatives of insurance companies, NGOs, representatives of patients and mass media. These focus groups provided a chance to communicate the EPREMED project results and to produce specific dissemination material tailored to their information needs. This task implied a significant effort devoted to make the results produced by the project circulate through channels different from the customary scientific journals and scientific meetings. More detailed information on this task can be found in the WP 4 report contained in this document.

8. The EPREMED webpage: a dissemination tool for all target audiences

The website of the project was made available early in 2005 and was working during the complete project period and will be maintained over the project period. The homepage was updated regularly and the information aimed at the other audiences (politicians, stakeholders, lay audience) was developed constantly. Most of the information was also available for the public only some information is only available for EPREMED members. The homepage served as a valuable source of information and was indispensable for facilitating the communication and information of the complete group. In addition, it served to make the information gathered in the project visible for a broader audience.

As a way of estimating its impact, we used the “Google analytics” tool. Since
the webpage was fully operative since last year, we performed the analyses from January 1st 2007 to June 19th 2008. In this time framework, the web was visited 1,256 times from 28 different countries/territories (in decreasing order they were: Spain, France, The Netherlands, Belgium, Germany, Italy, United Kingdom, United States, Canada, Russia, Bulgaria, Luxembourg, Switzerland, Niger, Slovenia, Portugal, Austria, China, South Africa, Ireland, Sweden, Finland, and others). The average time on the website was 2:31 minutes, and 28.5% were new visits. Among visits, 79.9% were direct visits, that is, persons using the web address, while 11.9% were visits from search engines (89.1% using the keyword EPREMED), and 8.4% from referring sites.

The webpage offers a unique opportunity for sharing knowledge and data about the ESEMeD study, and is opened to all audiences (in its public domain). However, it is important to acknowledge that the format of the material presented is more suitable for the scientific audience in the first place, followed by policymakers. It could be possible that information could be a little bit harder to understand for the civil society audience. In any case, this dissemination tool will be available even after closing the EPREMED project, making possible more dissemination tailored for the different audiences.

Deliverable 3: Report on the extent that each dissemination results varied according to the variables of user group, content, context, medium and information source.

Each dissemination result took into account variables of user group, content, medium, and information source. After meetings and focus groups with specific stakeholders and the experience of the 3-years EPREMED project, we gathered information in order to tailor activities and materials to their needs. In the following Table 1 there is a summary of main variations of each dissemination result.

Table 1. Main features of each dissemination result.
<table>
<thead>
<tr>
<th></th>
<th>Scientific production</th>
<th>Scientific communication</th>
<th>Policy communication</th>
<th>Social communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>User group</td>
<td>Scientific community (researchers, clinicians, academic community)</td>
<td>Scientific community (researchers, clinicians, academic community)</td>
<td>Policy makers</td>
<td>Civil society, patients, and families</td>
</tr>
<tr>
<td>Content</td>
<td>Wide range of specific topics on the epidemiology of mental disorders in Europe</td>
<td>Wide range of specific topics on the epidemiology of mental disorders in Europe</td>
<td>Requested specifically by policymakers (e.g. prevalence of mental disorders, unmet needs of care). In general, summary of the most relevant data, using mostly tables and figures for expressing results</td>
<td>Easily understandable results, mostly general figures about the most important results regarding the epidemiology of mental disorders at a national level</td>
</tr>
<tr>
<td>Context</td>
<td>National and international</td>
<td>National and international</td>
<td>National</td>
<td>National</td>
</tr>
<tr>
<td>Medium</td>
<td>Journal articles and book chapters mostly in English</td>
<td>Oral presentations, conferences, symposiums, round tables, posters, and workshops mostly in local languages</td>
<td>Reports and work meetings in local language</td>
<td>Mass media (magazines, newspapers, radio interviews, press and web releases, meetings with user groups</td>
</tr>
<tr>
<td>Information source</td>
<td>Data analyses of the ESEMeD dataset</td>
<td>Data analyses of the ESEMeD dataset</td>
<td>Data analyses of the ESEMeD dataset plus previous national reports on the topics requested</td>
<td>Data analyses of the ESEMeD dataset</td>
</tr>
</tbody>
</table>
Deliverable 4: Report on the recommendations to improve the procedures for future dissemination processes.

1. As DG Sanco requests, the dissemination process should be a part of any research project about epidemiology of mental disorders. A description of the dissemination strategy (describing target audiences, dissemination activities and materials) and a specific budget should be included at the beginning of any research project.

2. Different target audiences should be identified before dissemination.

3. Each target audience have specific needs regarding dissemination activities/material (topics, complexity, language, length). Such needs should be taken into account when disseminating to each of them.

4. Separate focus groups with members of target audiences could help to clarify their needs regarding the dissemination activities required.

5. Scientific community is the usual target of any dissemination process. However, efforts should be made to disseminate to a wider spectrum of scientific community (e.g. psychiatrists, psychologists, general practitioners, family physicians).

6. Dissemination to the scientific community is mostly carried out in English. Efforts should be made to produce dissemination in local languages.

7. Policy makers could be included in the preparation of research projects about epidemiology of mental disorders. Including them when elaborating a project allow them to suggest/include aims, promoting collaboration.

8. Patients and families are a hard-to-reach target audience, usually forgotten in dissemination strategies. Contacting with patients and family associations could favour dissemination to them.

9. Dissemination through mass media should be carefully done. The same information disseminated could produce very different outcomes (e.g. reduce or increase stigma). Therefore, among dissemination materials press releases could be prepared.

10. There is an urgent need for developing objective indicators for evaluating different kind of dissemination materials, especially for materials disseminated to policymakers, civil society and mass media.

11. Results disseminated through scientific manuscripts (journal articles) are the easiest to evaluate regarding their impact. For other activities/materials (books/book chapters, scientific communications, reports for policymakers, mass media reports, etc.) there are no standardised ways to evaluate their impact. Therefore impact indicators need to be specifically developed.

12. Developing indicators for evaluating the impact of a wide range of dissemination activities could help researchers and funding agencies to evaluate the outcomes of their projects.
Workpackage 6: Training and Mobility of
Researchers

Workpackage objectives and progress

The objective of Workpackage 6 is to increase the number of researchers in Europe with specialized knowledge in public mental health research that is aimed at providing information for the scientific community and policy making authorities. This objective is attained by providing training workshops for the research group and setting up an exchange programme for all researchers and students involved in the work of the EPREMED Consortium. For the purpose of increasing the skills and knowledge of the group it is necessary to facilitate communication within the group and with other interest groups. This information was made available by the homepage of the project and by specialized expert groups who are able to share their expertise with all interested parties. At the beginning of the work plan for all of the above mentioned activities was implemented. All activities are described in the following sections of the activity report.

Deliverables

- Report of the workshop activities
- Report of the exchange activities
- Report of the website activities
Report of workshop activities

For the workshop activities a list of possible topics in statistics and methods that could help to increase the knowledge of the group and to maximise the quality of statistical analyses in our scientific article production was created. After this list was produced, the members of the EPREMED consortium were asked to provide their feedback concerning which topics they would prioritise for the workshop. Then, a smaller group was involved in coordinating the organizational and scientific activities needed to provide this workshop to the EPREMED group.

The objective to provide the group with at least one annual workshop was reached by providing three EPREMED workshops during the project period.

**First workshop**

The first workshop was held in November 2005 (21\textsuperscript{st} – 23\textsuperscript{rd}) in Barcelona. The aim of this workshop was to systematically demonstrate and empirically evaluate the main different types of coding systems for contrasts in linear regression models and non-linear probability models. Coding systems are employed to model the outcome differences between the categories or combination of categories of one or more predictors, and their possible interactions with other categorical and/or continuous predictors. The focus was on applicability and interpretation of the parameters. Post hoc testing and the graphical display of predicted values was extensively discussed.

After a short introduction to the linear (fixed) model, the problem of categorical predictors and interaction terms, the following contrasts were discussed:

1. simple coding / dummy coding
2. effect coding
3. Forward and backward difference coding
4. Helmert and reverse Helmert coding
5. Orthogonal polynomial coding
6. User defined coding (problems of orthogonality)

All partners (ULPZ; IMIM-IMAS; ULEIC-DHS; ISS; TRIMBOS INSTITUTE; GASTHUISBERG; AP-HP; SJD.SSM; FSP) were involved in the preparation of the
programme, the statistical examples used and the literature review for the preparation of the workshop all partners were involved. The main work in the programme design and the organizational issues was done by ULPZ and IMIM-IMAS. The workshop was conducted by ULPZ and the produced documentation of the workshop was produced by ULPZ under the support of IMIM-IMAS.

Evaluation of workshop activities: The workshop was attended by 11 participants of four different countries and six different institutions. Only three institutions were not able to send participants. In the aftermath of the workshop all participants were asked about their impressions of the workshop. Most of the reactions towards the workshop were positive, praising the usefulness of the workshop for further work on the data, and its comprehensibility. It was criticised that it could have been more practical in terms of providing more examples on the already analysed data by the EPREMED group. It was proposed to give more examples on already analysed data if this is possible and to give more opportunities for the participants to show and discuss their own research work related to the workshop topic. All participants have made clear that different coding strategies provide a useful tool to analyse data from different countries and that they will certainly use these strategies in their upcoming statistical analyses. Participants have also stated that workshop provided new insights in a topic that help to use appropriate methods while comparing country specific data.

A workshop documentation was produced that should give an overview of the content of the workshop and its main results. This documentation should serve as a reminder for all who have attended the workshop and an introduction to the topic for all who couldn’t attend. The documentation is available also on the EPREMED homepage that is available for the interested public visiting the website.

**Second workshop**

The second EPREMED workshop that was held in October 2006 (9th – 10th) in Leipzig.

Title: Introductory Course to the economic evaluation of health care

The course was aimed at giving an overview of different methods in health economic evaluation and informed the attendees about strength and limitations of the methods
presented. On the first day of the course a brief introduction into economic evaluation was given followed by an introduction into the analysis of health outcomes. Health related quality of life instruments were presented (SF-12, EQ-5D) and methods to measure health (care) outcomes such as quality-adjusted-life-years (QALYs). Each theory session was followed by an exercise session, where examples of the presented methods were applied to available data sets. The second day of the course started with decision analysis and modelling (decision trees and Markov models). At the end of the course the presentation of health economic evaluation was introduced. Uncertainty analysis, cost-effectiveness acceptability curves, net-benefit approach were briefly introduced followed by a session where these approaches were applied to real data.

Programme
1. Basic concepts of economic evaluation: Measurement of costs
2. Basic concepts of economic evaluation: Measurement of health effects
3. Decision analysis and modelling
4. Uncertainty analysis in economic evaluation

All attendees were provided with all used workshop material and the data used for the exercises.

The workshop was attended by 10 participants of six different countries and six different institutions. Four institutions were not able to send participants. One colleague from Bulgaria has participated as a result of Toma Tomov’s recommendation. In addition two colleagues from the World Mental Health (WMH) Survey Initiative were joining the workshop, one from Columbia and one from Northern Ireland. This gave us the opportunity to our collaboration with a scientist from the new member states and with colleagues from the WMH survey initiative.

In the aftermath of the workshop all participants were asked about their impressions of the workshop. All reactions towards the workshop where positive, praising both its usefulness of the workshop for further work on the data, and its comprehensibility. Also the useful exercises and the materials provided were praised. The workshop materials allow all participants to redo all the exercises and refresh their knowledge if necessary. In addition, the material allows all interested project collaborators to do
the exercises without having attended the workshop. This was regarded as a good solution for both, those who attended and those who did not.

**Third workshop**

The third workshop of the EPREMED project took place in Barcelona, from 6\(^{th}\) to 7\(^{th}\) of November 2007.

The course gave an overview of different methods in the measurement of health related quality of life (HRQL) as it is measured in the ESEMeD dataset (EQ-5D and SF-12). The workshop informed the attendees about strength and limitations of the instruments presented.

The course started with a brief introduction to the topics of the workshop and presented the concepts of HRQL in mental health research. This introductory session was followed by a brief introduction to the Short-Form 12. Each theory session was followed by a exercise session, where examples of the presented methods were applied to available datasets. In the afternoon an excursus to measurement of change using SF-12 in a longitudinal surveys was given. The second day started with a presentation and an exercise about cross-national assessment of HRQL using different valuation methods. The second day ended with a presentation and an exercise about different types of item bias that might occur applying the EQ-5D in different countries. Two types of item bias were investigated: 1. Characteristic of the respondent: six countries, 2. Characteristic of the item: position in the questionnaire. Item bias is analysed employing 1- and 2-parameter Item Response Theory models.

**Programme**

1. Introduction to the workshop and concepts of HRQL in mental health
2. SF-12 – Introduction to the scale
3. Measurement of change with the SF-12
4. Introduction to cross-national assessment with the EQ-5D
5. Identification of item bias in EQ-5D:
   a) across six countries
   b) individual varying item order
The workshop was attended by 14 participants of six different countries and six different institutions. Three institutions were not able to send participants. One colleague from Bulgaria, one from Romania and three colleagues from Northern Ireland attended the workshop. This showed that our collaboration with scientist from the new member states had increased and in addition three colleagues from the WMH survey initiative joined our group for the workshop which also showed a great interest in these activities by other European scientists from the WMH survey initiative.

All workshop materials were posted on the non-public part of the website and circulated among the workshop participants.

All workshop participant stated that the topic was very well presented and useful for their further work. Additional requests were made to the speakers of the workshop in order to redo the workshop or parts of it in other countries.

**Report of exchange activities**

The exchange activities of the Consortium were defined in the first place. It was decided that the exchange activities should be based on publication activities, i.e. a participant in the exchange programme should produce at least a draft version of a scientific article together with the host institution. A “Partnership quality commitment” that should serve as a guideline for the host and the sending organisation and as well for the scientist/student who is visiting an EPREMED partner was prepared and approved by the group. This commitment defines the duties of all participating parties in an exchange activity.

**Exchange activities 2005**

With regard to the exchange activities it could be stated that all the basic information needed to initiate exchange activities was provided to the members of the group. The information was circulated and is posted on the webpage. Within the first reporting period only informal contacts within the group have taken place but no exchange activity has taken place. Some of the members of the group have shown their interest in one or both of the already offered exchange opportunities. ULPZ has offered two places for one or even more month (up to three) for people who are
interested in statistical methods and for people who are interested in health economic research.

The quality commitment produced for the exchange activities has involved all partners in the workpackage (ULPZ; IMIM-IMAS; ULEC-DHS; ISS; TRIMBOS INSTITUTE; GASTHUISBERG; AP-HP; SJD.SSM; FSP). Opportunities and job descriptions where offered by ULPZ. The information was made available on the webpage by IMIM-IMAS.

The preparation of the basic exchange information was sufficient to initiate the first informal contacts between partners but it was not successful to initiate more than one real exchange activities. Therefore, it was made clear to all EPREMED members that they have the obligation not only to provide offers for exchange activities but to facilitate the visit to other institutions for members of their own institution.

A first exchange took place between Harvard University and IMIM, Barcelona in order to finalize and update the project database. Gemma Vilagut visited Harvard for a two month period and worked together on the analysis of the validation of the CIDI (October to December 2005).

In order to increase the exchange activities of the group a regular call for participant was initiated that enabled the group to identify possible collaboration activities and possible exchange students or scientists who were willing to work on specific scientific papers together with other collaborators within the group. Each member of the EPREMED group was asked to provide a detailed list of topics they were working on defining all activities where exchange students or scientists were welcome to participate. These lists of job offers were posted on the webpage of the project and also circulated among all members of the group. The call for exchange activities was aimed to provide participants and opportunities for exchange activities and to facilitate the exchange for those people who showed their interest in visiting a member of the group.

With regard to the exchange activities it could be stated that all the basic information needed to initiate exchange activities was provided to the members of the group. The information was circulated and is posted on the webpage.
Exchange activities 2006

Within 2006 two exchange activities took place. Ana Fernandez visited the ULPZ from 1st August to the 31st of August. She worked together with Hans-Helmut König and Sebastian Bernert on a paper project titled “Burden of disease in three European countries. Comparing VAS and TTO valuations”.

Abstract of the paper

Objective: The purpose of this study is to analyse and compare the burden of disease in three European countries using different preference-based health state valuations based on the EQ-5D (TTO-based social index and VAS index). The different results will be compared regarding the method used.

Methods: A representative survey of the non-institutionalised population aged 18 and above was conducted in three European countries (Germany, Netherlands, Spain). A total of 11932 respondents were interviewed using the EQ-5D self-classifier. The EQ-5D index using 4 different tariffs was calculated using national tariffs based on the time trade-off (TTO) and the visual analogue scale (VAS), UK TTO tariff and the European VAS based tariff. Linear regressions were conducted to evaluate the factors associated to different EQ-5D indexes depending on the tariff used. Burden of disease was calculated by means of loss of quality-adjusted life years (QALYs) using the 4 methods by each country.

Results: Men report higher mean scores than women (p<0.001) in all countries and EQ-5D index mean scores decrease with age. The indexes calculated using the national tariff based on TTO were higher than those calculated using the UK social tariff and, also, slightly higher than the indexes calculated using the European tariff or the national tariff based on the VAS. The loss of QALYs estimated in Germany varied between 4 160 542 (national tariff based on TTO) and 6 417 373 (UK tariff based on TTO). In The Netherlands the loss of QALYs ranged from 1 164 490 (national tariff based on TTO) to 1 622 030 (national tariff based on VAS). In Spain the loss of QALYs ranged between 2 402 083 (national tariff based on TTO) and 2 833 364 (national tariff based on VAS).

Conclusions: The associations between socio-demographic variables and health state scores remains the same across countries regardless which index values were used. Using different valuation methods lead to different QALY losses. To overcome this problem in international surveys aimed to compare health state scores or QALYS it is advisable to use a single valuation method making these scores comparable.

The paper was reviewed by an expert group and was circulated among the EPREMED group. A first complete version of the manuscript is being elaborated.

A second exchange took place in Leicester. Susana Ochoa stayed, during part of July and August, at the University of Leicester. During her stay, coordinated by Prof.
Terry Brugha, analyses and reviews were conducted for the production of a manuscript.

The preparation of the basic exchange information was sufficient to initiate the first exchange activities. Nevertheless, it was made clear to all EPREMED members that they still have the obligation to provide offers for exchange activities and to facilitate the visit to other institutions for members of their own institution.

A third exchange activity was planned between IMIM-IMAS as the host institution and ULPZ as the guest institution. Due to organizational changes in the ULPZ institution the research visit was postponed to the last reporting period. Finally this exchange activity took place in February 2008 (see below).

Opportunities and job descriptions where offered by ULPZ, IMIM-IMAS and ULEIC. The information was made available on the webpage by IMIM-IMAS.

The continuation of the training and mobility activities beyond the funded project period was a major aim of the remaining project period 2007/2008. Since a well established informational structure was set up during the past project periods it needed to be maintained in order to keep data easily accessible, to maintain research co-operations, to support the production of scientific publication and to think about different ways to use the available information for different audiences. The already available infrastructure of the project should was a starting point for new research projects and applications for funds (new SANCO proposals were submitted in 2007 and 2008). In addition, the knowledge within the group could still be used by providing a workshop on different topics each year. These workshops should be provided by different institutions using there already available expertise in certain research areas. This approach should serve to minimize the financial and personal efforts to organize such a workshop. First negotiation between partners (ULPZ and IMIM) were done to provide another workshop later in 2008. Also exchange visits could be facilitated among the participating institutions based on already started or planned publication projects. ULPZ provided places for exchange visits also in 2008.
Exchange activities 2007

An exchange activity in 2007 took place, between IMIM, Barcelona, Spain and Trimbos Institute, Utrecht, The Netherlands. Martine Buist-Bouwman visited IMIM to get statistical support for her thesis including the following paper.

Title of manuscript: Psychometric properties of the World Health Organization Disability Assessment Schedule Version that was used in the European Study of the Epidemiology of Mental Disorders (ESEMeD)

Objective - To assess the factor structure, internal consistency, and validity of the WHO Disability Assessment Schedule (WHODAS) version used in the European Study of the Epidemiology of Mental Disorders (ESEMeD).

Method - In total 8796 adults were assessed using the ESEMeD WHODAS (22 severity and 8 frequency items). An Exploratory Factor Analysis (EFA) with promax rotation was done with a random 50%. The other half was used for confirmatory factor analyses (CFA) comparing models (a) suggested by EFA; (b) hypothesized a priori; and (c) reduced with four items. A CFA model with covariates was conducted in the whole sample to assess invariance across Mediterranean (Spain, France and Italy) and non-Mediterranean (Belgium, Germany and the Netherlands) countries. Cronbach’s alphas and discriminatory validity were also examined.

Results - EFA identified 7 factors (explained variance: 84.7%). The reduced model (six factors, four frequency items excluded) presented the best fit. The second order factor structure also fitted well. Measurement non-invariance was found for Embarrassment. Cronbach’s alphas ranged from 0.84 for Participation to 0.93 for Mobility. Preliminary data suggest acceptable discriminatory validity.

Conclusions - After excluding four frequency items, a two level hierarchical structure with six domains and one global disability factor was confirmed.

A SECOND exchange visit took place between 15th October 2007 and 29th February 2008. Ana Fernandez visited Jean Pierre Lepine and colleagues at the Hospital Fernand Widal during her Erasmus Mundus European Master on Dynamics in Health and Welfare study.

Together with the French team she produced a draft version of the following paper

Abstract
Introduction: The relationship between religiosity and mental health and well-being has been focus of interest since the beginnings of 20th century. Sociologists as Durkheim or psychologists as William James, argued for a connection between mental health and the religious life

Hypotheses and Aim: In the general population, we hypothetized that religiosity could have been a protective factor against the use of psychotropic medication. The aim of this paper is to check this hypothesis using data from the ESEMeD study, trying to give new data to the role that could play religiosity in the use of psychotropic medication
Measure: The religiosity variable was created by the combination of three different questions regarding religious beliefs: 1) *In general, how important are religious or spiritual beliefs in your daily life?* 2) *When you have problems or difficult in your family, work, or personal life, how often do you seek comfort through religious or spiritual means?* 3) *When you have decisions to make in your life, how do you think about what your religious or spiritual beliefs suggest you should do?* Participants were asked about their use of any psychotropic drug and the number of days taking it during the previous 12 months.

Analysis: Different logistic regressions were calculated to evaluate the association into the use of antidepressants or benzodiazepines (any 12 months use and regular use) and the religiosity variable. Models were adjusted by sex, age, and country, presence of any 12 mood or anxiety disorder, and any 12 month use of services. A second set of logistic regression models were carried out, stratifying by reported religion, that is: Catholicism, Protestantism and No reported religions, in order to test if there is any different effect regarding the most prevalent European religions.

Results and Discussion have to be finished by the workgroup.

**Exchange activities 2008**

An exchange visit took place in 2008. Florence Vorspan from Paris visited IMIM, Barcelona, Spain to work on the following paper (February 2008).

Title: Age of onset of alcohol use in six European countries. Description and associations with frequencies and ages of onset of anxiety and mood disorders.

AIMS: To describe the age of onset of alcohol use in six European countries (France, Italy, Spain, Belgium, Germany, The Netherlands). To investigate the association of various factors (country, sex, age groups and level of current alcohol use) with the age of onset of alcohol use.

DESIGN AND SETTING: In the ESEMED-who study, retrospective data were recorded in representative samples of the non-institutionalized populations of 6 european countries using the CIDI 3.0 during home interviews. Alcohol use section was filled by all respondents. Mood disorders was filled by subjects who answered yes to one of the screening questions, anxiety disorders section was fulfilled only by random selection of subjects that accomplish certain criteria.

PARTICIPANTS: A total of 21425 subjects could be evaluated except for the current alcohol use risk level (19723 subjects).

MEASUREMENTS: The level of risk of current alcohol use was evaluated with WHO criteria, alcohol abuse and dependence as well as lifetime mood and anxiety disorders were defined following DSM IV criteria.

FINDINGS: The age of onset of alcohol use was younger in Germany than in the 5 other countries (males14.5±0.2, females 15.6±0.3) in these six countries, but three common trends could be described. Men were reporting an age of onset 1.32 [1.15-1.49] years earlier than women. There was a significant relationship between current age and age of onset of alcohol use, the younger group of age 18-24 reporting an age of onset 3.23 [2.9-3.57] years earlier than the older group 65 and older. A
current higher risk level of drinking was associated with a younger age of onset of 2.38 [2.11-2.65] years. Subjects who were diagnosed with lifetime alcohol abuse or dependence described a younger age of first alcohol use: 1.54[1.24-1.85] years earlier. No difference was found in age of onset of alcohol use according to lifetime mood or anxiety disorders.

CONCLUSIONS: Germany had a younger age of onset of alcohol use than Belgium, France, Italy, Spain and The Netherlands. This country is also the only one where selling alcoholic beverages to a person of 15 years old is legal. Three common trends are shared by these 6 countries: a sex effect, a cohort effect and an effect of current drinking level. As a younger age of alcohol use is associated with a higher risk level of alcohol use and more alcohol dependence, it would be ethical to discuss the possibility to increase the age of legal drinking.

A second exchange visit in 2008 was aimed at improving the website quality. Sebastian Bernert from the University of Leipzig, Germany visited IMIM, Barcelona, Spain. The main tasks of the visit were related to the following topics:

To redesign the website for the aimed audience: Policy makers, stakeholders, researcher and interested lay people.

To create a welcome startpage of the website, i.e. to write a statement for the welcome page that addresses the main things from the project description (proposal)

To update of country information, i.e. implement existing information in website, to produce a proposal for a unique form of presentation for the country information in all countries. To search press releases, videos (national and international) and to create template for the graphical information display of the information in the country information text – a unique form for all countries (Prevalence major disorders, Service use, etc.) should be created.

Redesign presented information (public)

Find headings – flashlights to increase or attract the visitor’s attention

To optimise finding of EPREMED site via Google or other search engines, i.e. add content tags (keywords, description, text ...) in the HTML-programming code, to create a list of keywords, to tag pictures/graphics with keywords related to the text. To write an EPREMED project description for the header in the HTML code.

To organize a link exchange national and international

To create an international and national link list

For dissemination purposes it is necessary to implement a hit counter on the website and to analyse the previous hit statistics of the provider – hits, time on website, how many pages of the website were clicked. This hit counter was implemented in February 2008.
All main tasks were done during the exchange visit or in the weeks after. The structure of the website was rearranged to simplify the design in order to make it user-friendly and easier to understand. A statement to welcome the website visitors was written and put in place. Country information was updated and a uniques form for all countries was used to present this information on the website. All information was updated accordingly. The finding of EPREMED via Google or other search engines was optimised by adding content tags, keywords and other texts to the EPREMED homepage. More links were made available in the according section of the homepage. Finally a hit counter was activate in order to analyse the traffic on the homepage.

**Website activities**

**Website activities 2005**

The draft version of the project homepage was prepared and presented at the first in-person meeting of the group in Barcelona in February 2005. All EPREMED consortium members were asked to provide the necessary information required to put in place the webpage as a source of all necessary information on the project. After that, the homepage went online and was updated with all information on a regular basis (www.epremed.org).

Web-based information management. During the first reporting period a webpage was made available in the internet. The information provided on this homepage ranges from the most recent datasets, all information on project tasks, published papers and publications in preparation, the materials relevant for the different Work Packages, i.e. information on exchange opportunities offered within the group, and links to other associated projects. The webpage was updated regularly.

All materials provided on the webpage were produced by members of the group, therefore, all members of the group were involved in the arrangement of the content of the webpage (ULPZ; IMIM-IMAS; ULEIC-DHS; ISS; TRIMBOS INSTITUTE; GASTHUISBERG; AP-HP; SJD.SSM; FSP). The webdesign and the update of the EPREMED homepage was done by IMIM-IMAS under the support of ULPZ.
A frequently visited and informative project homepage was produced and put in place. All materials produced within the first project period are available on this source of information. The availability of all project materials, including all datasets, on this homepage facilitated the access to necessary information at any time. The easy access to the homepage via internet made it possible to provide all necessary information regardless where and when it is needed. The webpage was used extensively by all members of the consortium and this information was available also for the interested audience.

**Website activities 2006**

The main task for 2006 was to create a public part of the homepage in order to make all necessary information available for a broader public audience. In order to make the public information understandable the scientific knowledge was transferred in a language that is easy to understand for the different audiences we are trying to reach. In addition, the web based information management was optimised and updated on a regular basis to provide all members of the group with the necessary and most recent information of the project.

In 2006 the webpage has been established as an easy accessible source of information for all project members. This complete resource of project information avoided the coordinating centre of being asked by too many persons the same questions or to provide materials that were available on the webpage of the project. The regularly updated materials for the webpage ensured the quality of the materials posted there. Therefore, the homepage provided the most recent updates of the database, publication issues, analysis questions and other materials that change occasional. Therewith, it provided an valuable platform for exchange and communication among the project members.

All materials provided on the webpage were produced by members of the group, therefore, all members of the group were involved in the arrangement of the content of the webpage (ULPZ; IMIM-IMAS; ULEIC-DHS; ISS; TRIMBOS INSTITUTE; GASTHUISBERG; AP-HP; SJD.SSM; FSP). The webdesign and the update of the EPREMED homepage was done by IMIM-IMAS under the support of ULPZ. The materials for the public part of the homepage were provided by all partners.
The public part of the homepage was accessible for the public audience by the end of the second reporting period. A number of telephone conferences to place discussing the possible content and style of the public part of the EPREMED homepage. Each of the countries provided some basic information on mental health for this part of the website. The information was kept simple in order to be understandable for a wider audience, i.e. that also interested lay persons can inform themselves on our homepage.

**Website activities 2007 and 2008**

Missing country information missing was made available early 2007. This country specific data that served as an easy accessible and easy understandable information base for different audiences. The purpose was to provide everyone interested with country specific data on mental health such as prevalence rates of the most common mental disorders, suicide rates, access and provision of services, cost of mental disorders and medication use in different European countries. The web information managements main task for 2007/2008 was to complete and update the public part of the homepage. In addition, a strategy was put in place to make this source of information better-known to a wider audience, especially lay persons. This was made through easier finding the EPREMED website using websearch engines, such as Google. Finally the webpage was kept updated regularly in order to maintain it as a valuable source of information for all project members.
Summary of WP6 achievements

- Organize and conduct workshop activities
  - Each year a workshop was organized and conducted for the EPREMED members and external members. All workshops were attended by members for the consortium and external participants. All participants rated the workshops as an useful and valuable source of information. The workshop helped the project to increase the knowledge of young scientist in the field of mental health epiemology, health economics and statistical analysis. This helped also to increase the scientific quality of publications in the project.

- Implementation of exchange activities
  - Alltogether 6 exchange activities took place during the EPREMED project. 4 visits were aimed at producing or finalizing a scientific paper and a thesis. At first it was difficult to find partners for exchange activities but this was overcome by the increased publication activities and the need for face-to-face cooperation within the period of producing a scientific paper. The exchange activities helped the project to increase the overall paper production In addition, exchange activities provided an information and working platform for supporting young scientists in their publication activities.

- Completion and working of a project website
  - The website of the project was made available early in 2005 and was working during the complete project period and will be maintained over the project period. The homepage was updated regularly and the information aimed at the other audiences (politicians, stakeholders, lay audience) was developed constantly. Most of the information was also available for the public only some information is only available for EPREMED members. The homepage served as a valuable source of information was indispensable for facilitating the communication and information of the complete group. In addition, it served to make the information gathered in the project visible for a broader audience.
IV: ANNEXES
Annex 1: Amendments to the Contract Agreement (WP1)
Annex 2: EPREMED Consortium Agreement (WP1)

BETWEEN

1. INSTITUT MUNICIPAL D’ASSISTENCIA SANITARIA – Institut Municipal d’Investigació Mèdica (IMAS-IMIM), Health Service research unit ("the EPREMED COORDINATOR"), established in Doctor Aiguader 80, 08003 Barcelona, Spain, represented by its legal/statutory/authorised representative(s), Dr Antó, Director.

AND

2. Katholieke Universiteit Leuven (K.U.Leuven), established in Oude Markt 13, B-3000 Leuven, Belgium, and represented by the K.U.Leuven R&D department, having its offices at Groot Begijnhof 58-59, B-3000 Leuven, Belgium, represented by the legal/statutory/authorised representative(s), Prof. Dr. ir. K. Debackere, Managing Director and Mr. P. Van Dun, Director.

AND

3. Universitat Lepzig (ULPZ), established in Ritterstrasse 26, 04109 Leipzig, Germany, represented by its legal/statutory/authorised representative(s), Mr Gutjahr-Loser, Chancellor.

AND

4. University of Leicester (ULEIC.DPSY), established in University Road, Leicester, LE1 7RH, United Kingdom, represented by its legal/statutory/authorised representative(s) Dr Peter A. Gillespie, Director of Research Administration.

AND

5. Istituto Superiore de Sanita (ISS), established in Viale Regina Elena 299, 00161 Roma, Italy, represented by its legal/statutory/authorised representative(s), Prof. E. Garaci, President.

AND

6. Stichting Trimbos Institute – Netherlands Institute of Mental Health and Addiction (NIMHA), established in Da Costakade 45, 3500 AS Utrecht – Netherlands, represented by its legal/statutory/authorised representative(s) prof J.A. Walburg, director.

AND

7 Université Paris 7 Denis Diderot (UP7 DD) , 2 Place Jussieu 75251 Paris cedex 05 France, represented by its legal/statutory/authorised representative(s), Benoît Eurin, President.
AND

8 Sant Joan de Déu, Serveis de Salut Mental (SJDSSM-CSMA), established in Dr Antoni Pujades, 42, 08830 Sant Boi de Llobregat, Spain, represented by its legal/statutory/authorised representative(s) Mr Perez Sarrado, Manager,

AND

9 MGEN (Mutuelle Generale de l'éducation nationale) Public Health Foundation (FESP-MGEN), Université Paris V, Paris France, represented by its legal/statutory/authorised representative(s), Jean-Michel Laxalt

Hereinafter together referred to as "a Founding Partner" or "the Founding Partners" and relating to the Project entitled EPREMED under the “Health & Consumer Protection”, Directorate general.

WHEREAS:

A The European Community represented by the Commission of the European Committees ("the Commission") has accepted a proposal for the EPREMED Project as part of the Programme of Community action in the field of public health (2003-2008) above have entered into with the Commission contract number SANCO-2004123 ("the EU Contract").

B The EU Contract Parties wish to supplement, between themselves, the provisions of the EU Contract in line with the EU Contract, Article I.2.

C The Founding Partners wish to define certain of their rights and obligations inter se in respect of the carrying out of the EU-RTD CC.

D The terms of this Agreement shall complement but not conflict with the requirements set out in the EU-RTD CC.

NOW IT IS HEREBY AGREED AS FOLLOWS:

Definitions

In this Consortium Agreement, the following expressions shall have the following meanings:

"Consortium Agreement" shall mean this agreement entered into in respect of the Project by the Parties.

"EU Contract" shall mean contract number SANCO-2004123 entered into for the undertaking of the EPREMED Project. EU Contract shall as applicable also mean any Contract amendment. Words defined in the EU Contract have the same meaning in this Consortium Agreement.

"Data" shall mean information being collected, produced, recorded or processed pursuant to the contract or this Consortium Agreement.
“Data Controller” shall mean the parties to the Consortium Agreement.

“Data Processor” shall mean the person who processes the data on behalf of the Data Controller.

“Data Subject” shall mean an individual who is the subject of personal data.

“Defaulting Party” shall mean a Party breaching its obligations or withdrawing from the Project.

“Party” or “Parties” shall mean a party or the parties to this Consortium Agreement.

“Personal Data” shall mean data that relates to a living individual who can be identified from that data, or from those data and other information which are in the possession of, or are likely to come into the possession of the Data Processor.

“Processing” shall mean any operation or set of operations which is performed upon personal data such as collection, recording, organisation, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, blocking, erasure or destruction and “process” shall have the appropriate corresponding meaning.

“Project” shall mean the EPREMED Project.

“Project Share” shall mean from each EU Contract Party that Party’s share of the total cost of the EPREMED Project as shown in the EU Contract.

Steering Committee” shall mean the committee established in accordance with EU Contract, Annex I, article 4.6.3.

“Scientific Advisory Committee” shall mean the committee established in accordance with EU Contract, Annex I, article 4.6.5.

“subcontractor” shall mean a legal entity, or an international organisation which has concluded a subcontract with one of the EU Contract Partners to provide
services, supplies or good for the specific needs of the Project.

**Duration**

This Consortium Agreement shall come into force as of the date of the last signature hereto by the Parties but shall have retroactive effect as from 1st January 2005 and shall continue in full force and effect until and including 31st December 2007, by which time the Project should have been completed, unless earlier terminated in accordance with clause 18 or complete discharge of all obligations for the carrying out of the Project undertaken by the Parties under this Consortium Agreement, whichever is the earlier.

**The EPREMED Project Management Team**

In addition to the EPREMED Coordinator's functions pursuant to the EU Contract, the EPREMED Coordinator shall assume the following functions:

- administration, preparation of minutes and provision of a joint chairman of the Scientific Steering Committee, and follow-up of its decisions;
- transmission of any documents and information connected with the Project between the Parties concerned;
- managing the budget of the Project and using its best endeavours to maintain Project timelines.

Except for the capacity as representative of the Contractors the EPREMED Coordinator shall not be entitled to act or to make legally binding declarations on behalf of any other Party.

If one or more of the EU Contract Parties is late in submission of EPREMED Project Deliverables, the EPREMED Coordinator may submit the other EU Contract Parties' Project Deliverables to the Commission.

**Steering Committee**

The signature of this Agreement shall establish a Steering Committee, chaired by the Coordinator or his representative composed of one official representative of each Party. At the date of this Consortium Agreement the Steering Committee shall consist of Dr. Jordi Alonso (IMAS-IMIM), Prof. Koen Demyttenaere (GHB), Prof. Matthias C Angermayer (ULPZ), Dr Traolach Brugha (ULEIC.DPSY), Dr Giovanni de Girolamo (ISS), Dr Ron de Graaf (NIMHA), Pr. Jean Pierre Lépine (INSERM), Dr. Josep Maria Haro (SJDSSM.CSMA), and Dr. Viviane Kovess (FESP-MGEN).

Notwithstanding that each party shall use all reasonable endeavours to maintain the continuity of its representation, each party shall have the right to replace its representative and/or to appoint a proxy by giving prior written notification to the other Parties.
The Steering Committee shall be chaired by the EPREMED Coordinator or representative.

The Steering Committee shall meet in principle up to one time per year in person at the joint request of its chairmen or at any other time by tele-conference when necessary at the request of one of the Parties. Meetings shall be convened by the chairman with at least seven (7) calendar days prior notice with an agenda.

Minutes of the meetings of the Steering Committee shall be transmitted to the representatives of the other Parties without delay. The minutes shall be considered as accepted by the other Parties if, within fifteen (15) calendar days from receipt, no Party has objected in a traceable form to the Coordinator.

The Steering Committee shall be in charge of overall direction of the Project. To that end, except where the Steering Committee has delegated its responsibilities to a sub-committee, the Steering Committee shall be responsible for:

- making proposals to the Parties for the review and/or amendment of the terms of the EU Contract;
- agreeing publication and dissemination plans with regard to the Project, in accordance with Clauses 14 and 15;
- assisting the EPREMED Coordinator to prepare reports on the EPREMED Project.
- making proposals to the Parties (other than the Defaulting Party) to service of notices on a Defaulting Party in accordance with Clause 10.7 and to assign the Defaulting Party’s tasks to specific party(ies).

3.7 In voting, each member of the Steering Committee shall have one vote. A quorum shall be a minimum of 7 Parties. Decisions shall require a majority of at least 75% of the parties attending the voting. In the event of a tied vote, the project Coordinator (as chair) will have an additional vote.

**Scientific Advisory Committee**

- A Scientific Advisory Committee will be established to provide advice on the project as per the Steering committee request and to provide additional perspectives about mental health data and policy research information needs.
- The Scientific Advisory committee shall consist of: EPREMED scientific representatives, external researchers experts in the field; scientific representatives from Bulgaria, lead by Dr. Toma Tomov (Dept. of Psychiatry, Medical University, Sofia, Bulgaria) and from Turkey, lead by Dr. Kultegin Ogel (UMATEM, Bakirokoy Ruh ve Sinir Hastalıkları Hastenesi,
Istanbul, Turkey). These members will be invited at least to one annual meeting a year.

- Also other experts could be invited to the Scientific Advisory Committee once approved by the Steering Committee.

Work Package Leaders

- A Work Package Leader will be determinate for each work package pursuant to the EU Contract Article 4.6.4. and will be the responsible for securing the completion, the timeliness and the quality of all the deliverables.
- The work package leader will have responsibility for day-to-day management of specific work related to individual work package and will be in direct contact with involved partners and will report to the project management team deliverables and financial periodic reports as required.
- The work package leaders shall consist of: Institut Municipal d’Investigació Mèdica (IMIM) for WP1 and WP2, University of Leicester (ULEIC-DHS) for WP3, MGEN (Mutuelle Generale de l’education nationale) Public Health Foundation (FESP-MGEN), Université Paris 5 (ESP) for WP4, Sant Joan de Deu-Serveis Salut Mental (SJD.SSM) for WP5 and University of Leipzig (ULPZ) for WP6.

Responsibilities of Each Party

General Responsibilities

Each EU Contract Party undertakes to each other Party to perform and fulfil, promptly, actively and on time, all of its obligations under the EU Contract.

Each party to this Consortium Agreement undertakes to each other Party to perform and fulfil, promptly, actively and on time, all of its obligations under this Consortium Agreement.

Towards the Coordinator and the Steering Committee

Each Party hereby undertakes to use reasonable endeavours to supply promptly to the EPREMED Coordinator all such information or documents as the Coordinator and the Steering Committee need to fulfil obligations pursuant to this Consortium Agreement.

In particular, contractors shall submit their cost statements to the Commission through the Coordinator, or any further clarifications required regarding this issues. In addition, the Coordinator shall submit the corresponding integrated cost statements in euro.
Towards each other

Each Party undertakes:

- to notify each of the Parties promptly of any significant delay in performance;

- to use reasonable endeavours to inform other Parties of relevant communications it receives from third parties in relation to the Project.

Each Party shall ensure the accuracy of any information or materials it supplies hereunder or under the EU Contract and promptly to correct any error therein of which it is notified. The recipient Party shall be entirely responsible for the use to which it puts such information and materials.

In addition to the obligations specified in the EU Contract Annex I Article 4.6.8, each Party agrees not to use knowingly, as part of a deliverable or in the design of such deliverable or in any information supplied hereunder or under the EU Contract, any proprietary rights of a third party for which such Party has not acquired the right to grant licences and user rights to the other Parties in accordance with the EU Contract, unless all of the other Parties have accepted such use in writing, such acceptance not to be unreasonably withheld.

Each Party shall be fully responsible for the technical supervision of its subcontractors and shall enter into appropriate arrangements for such purpose with its subcontractors. These arrangements shall as appropriate require the obligations in this Consortium Agreement also apply to, and (where they apply) be fulfilled by, such subcontractors. Each Party shall use reasonable endeavours to enforce such arrangements and obligations as necessary and shall endeavour to ensure such arrangements enable an affected Party to enforce the relevant obligation.

Acting in good faith, when a Party believes that for carrying out the Project or Use of Knowledge from the Project

- it might require Access Rights to another Party's or an subcontractor's Pre-Existing Know-How or to another Party's or an subcontractor's Knowledge which is not from the Project, or

- another Party or an subcontractor might need Access Rights to that Party's Pre-Existing Know-How or Knowledge which is not from the Project,

it will promptly notify such other Party or subcontractor of the Pre-Existing Know-How or Knowledge not from the Project required. Failure to so notify another Party or an subcontractor shall not be a breach of this Consortium
Agreement unless such failure is due to an action in bad faith.

When a Party is unable to grant Access Rights which it reasonably believes that another Party will require, it will promptly notify such other Party.

**Costs – Payment**

The project final budget distribution is as described in Annex II of the EU Contract.

In the absence of anything to the contrary in the agreed budget, each Party to this Consortium Agreement shall bear its own costs in connection with the making of the Proposal, the negotiation of the EU Contract and the carrying out of the Project.

The EPREMED Coordinator agrees to distribute all payments required of it, under the budget, according to EC payments

**Confidentiality**

As respects all information of whatever nature or form as is:

- disclosed to a Party in connection with the submission to the Commission of a proposal for a project pending the signing of the Contract; or
- disclosed to a Party in connection with the Project after the signing of the Contract,

each Party agrees such information is communicated on a confidential basis and its disclosure may be prejudicial to the owner of the information, and undertakes that:

(a) it will not during a period of five (5) years from the date of disclosure to the Party use any such information for any purpose other than in accordance with the terms of the EU Contract and of this Consortium Agreement; and

(b) it will during the period of five (5) years treat the same as (and use reasonable endeavours to procure that the same be kept) confidential and not disclose the same to any other third party without the prior written consent of such owner in each case;

provided always that:

(i) such agreement and undertaking shall not extend to any information which the receiving Party can show that it:

was at the time of disclosure to the Party published or otherwise generally available to the public, or
has after disclosure to the Party been published or become generally available to the public otherwise than through any act or omission on the part of the receiving Party, or

was already in the possession of the receiving Party, without any restrictions on disclosure, at the time of disclosure to the Party, or

was rightfully acquired from others without any undertaking of confidentiality, or

was developed independently of the work under the Contract by the receiving Party;

(ii) nothing in this Clause 8.1 shall prevent the communication of information

• as is needed to be communicated to comply with applicable laws or regulations or with a court of administrative order provided that insofar as reasonably possible the complying Party shall have informed the owner of the information of such need and shall have complied with such owner's reasonable instructions designed to protect the confidentiality of such information; or

• subject to Clause 8.2, to any Affiliate or to any other third party (including the Commission) insofar as needed for the proper carrying out of the EU Contract and/or this Consortium Agreement;

As respects any permitted communication of any of the information referred to in Clause 8.1 by the recipient Party to a third party (including but not limited to its Affiliates) such Party will use its reasonable endeavours to procure due observance and performance by such third party of the undertakings referred to in Clause 8.1, (a) and (b) and all relevant undertakings in the EU Contract.

Except for any disclosure of information which is necessary in order to carry out the Project, all information arising out of the Project shall be treated by the Parties in the strictest confidence and will not be published or otherwise disclosed in any way to, or used for the benefit of any third party except as permitted by any agreed publications plan or agreed dissemination plan. In particular, no Party shall publish any material or information arising out of the Project in any scientific journal unless permitted by any publications plan agreed pursuant to Clause 14.

Liabilities

Liability towards each other

In respect of information or materials supplied by one Party to another hereunder or under the EU Contract, the supplier Party shall be under no obligation or liability other than as stated in Clause 9.3.2 and no warranty
condition or representation of any kind is made, given or to be implied as to the sufficiency, accuracy or fitness for purpose of such information or materials, or, subject to Clause 9.3.3, the absence of any infringement of any proprietary rights of third parties by the use of such information and materials and the recipient Party shall in any case be entirely responsible for the use to which it puts such information and materials.

**Indemnification of each other**

Each Party shall indemnify each of the other Parties, within the limits set out in Clauses 9.3 and 9.6, in respect of liability resulting from acts or omissions of itself, its employees or its agents provided always that such indemnity shall not extend to claims for indirect or consequential loss or damages such as but not limited to loss of profit, revenue, contracts or the like.

**Claims of the Commission**

If the Commission, in accordance with the provisions of the EU Contract, claims any reimbursement, indemnity or payment of damages from one or more of the EU Contract Parties or where the Commission states the claim is to be solely for the account of a certain considered Parties:

each EU Contract Party whose default has caused or contributed to the claim being made shall indemnify each of the other Parties against such claims provided always that the total limit of liability of that Party to all of the other Parties collectively in respect of any and all such claims shall not exceed that Party’s Project Share.

in the event that it is not possible to attribute default to any EU Contract Party the Steering Committee will decide how the consortium will proceed to assume this responsibility.

**Liability towards Third Parties**

Subject always to such other undertakings and warranties as are provided for in this Consortium Agreement and the EU Contract, each Party shall be solely liable for any loss, damage or injury to third parties resulting from its carrying out its parts of the Project and from its Use of Knowledge and/or Pre-existing Know-How.

**Third Parties**

Each Party shall be fully responsible for the performance of any part of its share of the Project, or other EU Contract obligation, in respect of which it enters into any contract with a third party (e.g. a Subcontractor) and shall ensure (i) such contracts enable fulfilment of the EU Contract; (ii) the other Parties’ Access Rights are the same as would have been the case had the contracting Party performed its share of the Project and/or those obligations itself; and (iii) the third party shall not have access to any other Party’s Knowledge or Pre-Existing Know-How without that Party’s prior written consent.
Each Party shall in writing inform the other Parties if it intends to enter into a contract referred to in Clause 9.5.1 (giving the rationale therefore) if such an event has not been detailed in the EU Contract Annex I and the contract is other than for a minor or trivial part of its share of the Project. Such Party shall consider in good faith comments made, in relation to such contract.

Each Party hereby grants Access Rights to all Affiliates of any other Party as if such Affiliates were Parties provided all such Affiliates grant Access Rights to all Parties (and their Affiliates) and (without prejudice to the Parties' obligations to carry out the Project and to provide Project Deliverables) fulfil all confidentiality and other obligations accepted by the Parties under the EU Contract or this Consortium Agreement as if such Affiliates were Parties.

Each Party shall ensure that it can grant Access Rights and fulfil the obligations under the EU Contract notwithstanding any rights of its employees, or persons it engages to perform part of its share of the Project, in the Knowledge or Pre-Existing Know-How they create after the Project Commencement Date.

Defaults and Remedies (1)

In the event of (i) a substantial breach, but not in case of force majeure, by a Party of its obligations under this Consortium Agreement or the EU Contract which is irremediable or which is not remedied within one month of written notice from the other Parties requiring that it be remedied, or (ii) if Clause 18.3 applies, or (iii) if the Commission terminates the EU Contract in respect of a Party, the other Parties may jointly terminate this Consortium Agreement with respect to the Defaulting Party concerned by not less than one month's prior written notice.

Such termination shall take place with respect to such Defaulting Party as of the date of such notice, subject to the provisions in 9.6.3.1 and 9.6.3.2 below.

Notice of such termination pursuant to 9.6.1 (i) or (ii) above shall be given to the Commission and the Commission shall be requested to terminate the EU Contract with respect to the Defaulting Party or to state it does not object to the withdrawal from the Project of the Defaulting Party in accordance with the EU Contract, provided always that:

the Access Rights granted to the Defaulting Party pursuant to this Consortium Agreement shall cease immediately;

the Access Rights granted and the obligations to grant Access Rights pursuant to this Consortium Agreement or the EU Contract by the Defaulting Party shall remain in full force and effect;

the Defaulting Party shall:
(a) be responsible for and pay all reasonable direct cost increase (if any) resulting from the assignment referred to in this Consortium Agreement in comparison with the costs of the tasks of the Defaulting Party as specified in the Contract Annex I at the date of termination of this Consortium Agreement with respect to the Defaulting Party; and

(b) be liable for any so resulting additional direct cost incurred by the other Parties, up to a total amount which taken together with any liability to the Commission under clause 9.3 shall not exceed twice that Party’s Project Share in respect of the Defaulting Party.

The Defaulting Party shall be deemed to have agreed as the case may be to the termination or its withdrawal from the Project pursuant to the EU Contract with the proviso that such deemed agreement shall be without prejudice to the rights of the Defaulting Party to appeal against such termination or withdrawal as the case may be.

**Force Majeure**

A failure in the performance of this Consortium Agreement cannot be imputed or assumed to a Party to the extent it is due to “Force Majeure”.

The expression "Force Majeure" shall mean any unforeseeable and insuperable event affecting the Party fulfilling its obligations hereunder.

Each Party will notify the other Parties in writing of any "Force Majeure" or Force Majeure as soon as possible. The Parties shall discuss in good faith the possibilities of a transfer of tasks affected by the event. Such discussions shall commence as soon as reasonably possible. If such Force Majeure event is not overcome within 6 weeks after such notification, the transfer of tasks shall be carried out.

**Access**

**Protection of Knowledge**

If, in the course of carrying out work on the Project, a joint invention, design or work is made (and one or more Parties are contributors to it), and if the features of such joint invention design or work are such that it is not possible to separate them for the purpose of applying for, obtaining and/or maintaining the relevant patent protection or any other intellectual property right, the Parties concerned agree that they may jointly apply to obtain and/or maintain the relevant right together with any other parties concerned.

The Parties concerned shall seek to agree between them and the other parties concerned arrangements for applying for, obtaining and/or
maintaining such right on a case-by-case basis. Where the parties concerned are solely Parties, so long as any such right is in force, the Parties concerned shall be entitled to use and to license such right without any financial compensation to or the consent of the other Parties concerned.

For the avoidance of doubt, joint ownership of an invention, design or work shall not affect the obligations arising under this Consortium Agreement or the EU Contract.

In respect of a country either specified by the Commission or agreed by the Parties, a Party shall notify the other Parties (via the Coordinator if practical) if it does not intend to seek adequate and effective protection (as required by the EU Contract of the EU Contract Parties) of certain of its Knowledge from the Project or if that Party intends to waive such protection. If another Party (or Parties) informs the notifying Party in writing within one calendar month of such notice that it wishes to obtain or maintain such protection, the notifying Party may assign to such other Party(ies) all necessary rights which it owns or find other agreements. Such assignment or agreements shall ensure the Access Rights of all Parties will be unaffected except that the Party(ies) shall not enforce the resultant rights acquired pursuant to the assignment or agreement against the Party which assigned its rights. For the avoidance of doubt, the Party which assigned its rights shall have at least the same Access Rights as the non-involved Parties.

General principles relating to Access Rights

All Access Rights for carrying out of the Project and for Use are granted on a non-exclusive basis.

Save in exceptional circumstances, no transfer costs shall be charged for the granting of Access Rights

Recognising the Parties' obligations to act in good faith and in accordance with Clause 8.1(ii) the Parties agree the Access Rights for using Knowledge in subsequent research activities are to be as follows:

Parties are deemed to be granted a right to use free of charge Knowledge from the Project for internal research; third party research, provided the third party does not have direct access to confidential Knowledge from the Project generated by other Parties (as examples - producing research results which are available to the third party but which contain hermetically-sealed Knowledge from the Project; using Knowledge from the Project for in-house testing or diagnosis purposes in doing research).

- In the case of research in collaboration with and/or for a third party where the third party needs Access Rights to confidential Knowledge from the Project of another Party, the researching Party shall in a traceable form (before starting or committing to start the research) inform the third party of such need, and shall use reasonable endeavours to inform the owner of that Knowledge of such need in a traceable form. If the owner has
been so informed, he shall (i) not unreasonably delay his
decision on whether or not to refuse to grant the needed third
party Access Rights and (ii) not unreasonably refuse to grant
such rights on fair and reasonable terms but may, in good
faith, so refuse on the grounds of business interest.

12 Principles Relating to the Processing and Access to Personal Data

12.1 The Parties to this Consortium Agreement warrant that the Personal Data
have been collected in accordance with notice and consent requirements of
the applicable law of the country in which collected and that the process
set up, hereby, to implement the Project and any Processing of the
Personal Data comply with that applicable data protection law of that
country.

12.2 Where applicable, the Parties to this Consortium Agreement shall register
the Project with the relevant data protection authority in the territory in
which the Personal Data are collected and, where required and provided
notice that they have received consent necessary to do so lawfully in the
country in which the Personal Data are collected.

12.3 The Parties to this Consortium Agreement shall ensure that any Data
Processor shall process the Personal Data in relation to the Project in
compliance with the relevant applicable data protection rules.

12.4 Without prejudice to the obligations referred to in Clause 12.3, the Parties
to this Consortium Agreement shall ensure that:

12.4.1 all Personal Data is processed accurately and securely;

12.4.2 in no circumstances prior to the termination of this Consortium
Agreement transmit, despatch, convey or communicate to any
third party Personal Data from which a living individual can be
identified and shall only transmit, despatch, convey or
communicate to third party anonymised data from which no living
individual can be identified.

12.4.3 if any of the Data is inaccurate or misleading, correct, alter or
delete the inaccuracy (as appropriate) and provide the data
subject with a revised version of the Data if required.

12.5 All Data that is not Personal Data shall be stored for a period of five years
after collection at the coordinator’s premises and under its responsibilities
and shall be accessible by the members of the Scientific Advisory
Committee under appropriate secrecy and non-use agreement.

12.6 The Personal Data shall only be used by the Parties to the Consortium
Agreement for the purpose of the Project or as otherwise authorised by the
Data Subjects, and no Personal Data may be taken or used for any other
purpose.
12.7 The Parties to this Consortium Agreement shall, and shall ensure that Data Processors implement appropriate technical and organisational measures to protect Personal Data against accidental loss, alteration, unauthorised disclosure or access.

13 Publications

13.1 The Parties agree that their representatives on the Project Steering Committee may negotiate in good faith a detailed publications plan.

13.2 All the Parties shall act in accordance at all times with any agreed plan.

14 Dissemination of Data Results of Project

14.1 The Parties agree that their representatives on the Project Steering Committee shall negotiate in good faith a dissemination plan.

14.2 All the Parties shall act in accordance at all times with any agreed plan.

14.3 Notwithstanding the above, the EPREMED Coordinator may at any time disclose information arising from the Project to any governmental or regulatory body

15 No partnership or agency

Nothing in this Consortium Agreement shall create a partnership or agency between the Parties or any of them.

16 Assignment

No Party shall, without the prior written consent of the other Parties, assign or otherwise transfer partially or totally any of its rights and obligations under this Consortium Agreement. Such consent shall not be unreasonably withheld when such assignment or transfer is in favour of an Affiliate of that Party.

17 Termination

17.1 No Party shall be entitled to withdraw from this Consortium Agreement and/or participation in the Project unless:

17.1.1 that Party has obtained the prior written consent of the other Parties (such consent not to be unreasonably withheld), and in respect of the EU Contract Parties also of the Commission, to the withdrawal from, or termination of, the EU Contract; or

17.1.2 that EU Contract Party’s participation in the EU Contract is terminated by the Commission pursuant to the provisions of the EU Contract Article II.11.2; or

17.1.3 the EU Contract is terminated by the Commission for any reason whatsoever, provided always that a Party shall not by withdrawal or termination be relieved from
17.1.4 its responsibilities under this Consortium Agreement or the Contract in respect of that part of that Party's work on the Project which has been carried out (or which should have been carried out) up to the date of withdrawal or termination; or

17.1.5 any of its obligations or liabilities arising out of such withdrawal or termination.

17.2 If any Party's participation in the EU Contract is terminated by the Commission pursuant to the provisions of the EU Contract Article II.11.2, or a Party withdraws from the Project, then, without prejudice to any other rights of the other Parties of the Contract shall apply correspondingly.

17.3 If any Party enters into bankruptcy or liquidation or any other arrangement for the benefit of its creditors the other Parties shall, subject to approval by the Commission, be entitled to take over the fulfilment of such Party's obligations and to receive subsequent payments under the Contract in respect thereof.

17.4 In such event all rights and obligations under the Contract and this Consortium Agreement shall in good faith be redistributed among the remaining Parties and the affected Party on the basis of the work performed by the affected Party prior to the occurrence of the above circumstance.

17.5 The provisions of Clauses 8, 9, 11, 12, 13, 14, 18 and 19 shall survive the expiration or termination of this Consortium Agreement to the extent needed to enable the Parties to pursue the remedies and benefits provided for in those Clauses.

17.6 Termination of the Consortium Agreement and/or cessation of licences granted to the Defaulting Party in accordance with Clauses 9.7.3.1 and 9.7.3.2 shall not terminate any sublicenses granted or agreed to be granted or offered by the Defaulting Party in accordance with Clauses 11 and 12 prior to the date on which such termination of the Consortium Agreement and/or cessation of licences becomes effective, provided that the Party or Parties which generated the Knowledge or Pre-Existing Know-How so sublicensed shall have the right to have an assignment of the Defaulting Party's rights under such sublicences.

17.7 For the avoidance of doubt, termination or withdrawal shall not affect any rights or obligations incurred prior to the date of the termination.

18 Language

This Consortium Agreement is drawn up in English which language shall govern all documents, notices and meetings for its application and/or extension or in any other way relative thereto.
19 Notices

Any notice to be given under this Consortium Agreement shall be in writing to the following addresses and recipients. It shall be deemed to have been served when personally delivered, or, if transmitted by telefax, electronic or digital transmission when transmitted provided that such transmission is confirmed by receipt of a successful transmission report and confirmed by mail.

19.2 IMAS-IMIM (IMIM), Career del Doctor Aiguader 80, 08003 Barcelona, Spain, marked for the attention of Jordi Alonso, Fax No. +34 9322140 02.

19.3 For technical and scientific matters:
K.U.Leuven, University Hospital Gasthuisberg (UHG), Herestraat 49, 3000 Leuven, Belgium, marked for the attention of Prof. Koen Demyttenaere, Fax nr. +32 16348700.

For legal, administrative and financial matters:
ir. Maria Vereeken, K.U.Leuven R&D, Groot Begijnhof 58-59, B-3000 Leuven, Belgium. Tel.: +32 16 32 65 04, Fax: +32 16 32 65 15, Email: maria.vereeken@ird.kuleuven.be

19.4 Universitat Lepzig (ULPZ), Ritterstrasse 26, 04109 Leipzig, Germany, marked for the attention of Prof. Matthias C. Angermeyer, Fax No. +49 (341) 9724-539.

19.5 University of Leicester (ULEIC.DPSY), University Road, Leicester, LE1 7RH, United Kingdom, marked for the attention of Terry Brugha, Fax No. +44(116)2256312.

19.6 Istituto Superiore di Sanita (ISS), Viale Regina Elena 299, 00161 Roma, Italy, marked for the attention of Prof. E. Garaci, Fax No. 0039-064938706

19.7 Trimbos Institute – Netherlands Institute of Mental Health and Addiction (NIMHA), 725, Da Costakade 45, 3500 AS Utrecht – Netherlands, marked for the attention of Ron de Graaf, Fax No. 31-302971111

19.8 For technical and scientific matters: Hôpital Fernand Widal, 200 rue du Faubourg Saint Denis, 75475 Paris Cedex 10, France, marked for the attention of Professeur Jean-Pierre LEPINE, Fax No. 00 33 1 40 05 49 33

For legal & administrative matters:
Muriel MAURICE, Université Paris 7 Denis Diderot, Bureau de la Valorisation et des Relations Industrielles (BVRI), 2 Place Jussieu 75251 Paris cedex 05 France Email: muriel.maurice@paris7.jussieu.fr

19.9 Sant Joan de Déu, Serveis de Salut Mental (SJDSSM.CSMA), Dr Antoni Pujades, 42, 08830 Sant Bois de Llobregat, Spain, marked for the attention of Dr. Josep Ma Haro Abad, Fax No +34 (93)6520051.
19.10 MGEN (Mutuelle Generale de l'education nationale) Public Health Foundation (FESP-MGEN), Université Paris V, Paris France marked for the attention of Vivianne Kovess, Fax No 33140472191.

or to such other address and recipient as a Party may designate in respect of that Party by written notice to the others.

20 Applicable Law and Jurisdiction

This Consortium Agreement shall be construed according to and governed by the laws of Belgium and shall be subject to the exclusive jurisdiction of the Court of Brussels.

21 Entire Agreement - Amendments

21.2 This Consortium Agreement and the EU Contract constitute the entire agreement between the Parties in respect of the Project, and supersede all previous negotiations, commitments and writings concerning the Project including any memorandum of understanding between the Parties (whether or not with others), which relate to the Project.

21.3 Amendments or changes to this Consortium Agreement shall be valid only if made in writing and signed by an authorised signatory of each of the Parties.

22 Counterparts

This Consortium Agreement may be executed in any number of counterparts, each which shall be deemed an original, but all of which shall constitute one and the same instrument.

AS WITNESS the Parties have caused this Consortium Agreement to be duly signed by the undersigned authorised representatives.

Authorised to sign on behalf of
<INSERT NAME OF PARTY>
Annex 3: WMH Initiative Work Groups (WP1)

**Adult Effects of Childhood Adversity**
Chair: Elie Karam egkaram@dm.net.lb

**ADHD**
Co-Chairs: Ronald Kessler kessler@hcp.med.harvard.edu
John Fayyad jfayyad@inco.com.lb

**Burden of Disease**
Chair: Dr. Jordi Alonso jalonso@imim.es

**CIDI Validity, Reliability and Cultural Differences Across Countries**
Chair: Oye Gureje gureje.o@skannet.com.ng

**Clinical Reappraisal**
Chair: Josep Maria Haro jmharo@sjd-ssm.com

**Drug Dependence**
Chair: Jim Anthony janthony@msu.edu

**Family, genetic factors, and mental health**
Chair: Kathleen Merikangas kathleen.merikangas@nih.gov

**Gender**
Chair: Ronald Kessler kessler@hcp.med.harvard.edu

**Impact of Mental and Addictive Diseases**
Co-Chairs: Bedirhan Ustun ustunb@who.ch
Somnath Chatterji chatterjis@who.ch

**Mental-Physical Comorbidity**
Chair: Michael Von Korff vonkorff.m@ghc.org
**Methodology**
Chair: Beth-Ellen Pennell bpennell@isr.umich.edu

**National Reports**
Chair: Sergio Aguilar-Gaxiola sergioa@csufresno.edu

**Nosology**
Chair: Ayelet Meron Ruscio ruscio@psych.upenn.edu

**Personality Disorders**
Chair: Giovanni de Girolamo giovanni.degirolamo@ausl.bologna.it

**Services**
Chair: Phil Wang wang@hcp.med.harvard.edu

**Social Class**
Chair: Sing Lee singlee@cuhk.edu.hk

**Suicide**
Co-Chairs: Gui Borges guibor@imp.edu.mx
Annex 4: Green Paper Consultation Process: summary report key messages (WP1)

The key messages contained in the Green Paper include:

- Mental health is crucially important for key EU policy objectives (e.g. health, quality of life, economic and social welfare, transition into a knowledge society). However serious challenges can be identified.

- The mental health of the EU-population is not as good as it should be (e.g. high suicide rates in some Member States, increased diagnosis of conduct disorders in children and young people, and a rise in working days lost to the economy due to mental ill health).

- There is now a considerable and growing body of evidence on interventions to promote mental health and to prevent mental ill health and it is important to ensure this evidence is better known and more widely utilised and integrated into policies and programmes.

- People with mental ill health or disability experience stigma and discrimination and their fundamental rights are not always respected. Stigma can impede recovery by affecting individual's willingness to seek help and can contribute to social exclusion. The EU has a clear mandate to act in this field.

- There is a need to improve information collection to facilitate the effective monitoring of mental health service systems. In addition, more and better information is required on the determinants of mental health and further research needed into the effectiveness of interventions in an EU context.

First Thematic Consultation Meeting: Promotion and Prevention in Mental Health

Key points raised at the first thematic meeting included:

- Recognition of the broad relevance of mental health and wellbeing at all levels across the social, societal and policy spectrum, and therefore the competencies of the EU.

- Member States have varied structures for delivering the mental health promotion agenda, and could benefit from culturally and politically sensitive collaborative approaches to this agenda.

- There are many challenges in facilitating transferability of programmes, information and outcomes between Member States. There is willingness and momentum within a diverse stakeholder group to negotiate these.

- A wide range of actions were suggested for the EU level.
Second Thematic Consultation Meeting: Social Inclusion and Fundamental Rights in Mental Health.
The key themes of the second thematic meeting included:
– Recognition that social exclusion in relation to mental ill health was significant, and both literal effect and perceived risk of stigma or social exclusion detrimentally affects people’s willingness to engage services and health promotion.
– Ending social exclusion is a function of civil society, and not solely a function of health policy.
– A range of initiatives are in place in Member States to address social exclusion, and the stigma associated with mental ill health. These originate in health and health promotion, but also in right based contexts. NGOs play an important role both in setting and delivering this agenda.
– In addition to the concern about the effect on individuals in society, there was concern about the rights of individuals with mental health disorders whilst receiving treatment, on a voluntary or involuntary basis.
– The meeting felt strongly that there was a role for the emerging Fundamental Rights Agency in addressing social exclusion and affirming

Third Thematic Consultation Meeting: Information, Data and Knowledge in Mental Health
The key themes of the third thematic meeting included:
– Through the EU Public Health programme, proposals for mental health indicators have been put forward, to cover demographic and socio-economic data; mental health status; determinants; and mental health systems.
– Consistent, cyclical data collection and analysis is vital to the monitoring of interventions under the proposed strategy, and for the ongoing demonstration of efficacy for continued investment.
– Cross-referencing of data in health as well as other areas of interest is vital, as data on mental health and wellbeing can often be extrapolated from other measures
Annex 5: Publication Guidelines (WP2)

Scientific publications agreement for EPREMED
(amendment proposal, February 6, 2006)

Aim:
The aim of this agreement, within the EPREMED, is to maximise the scientific impact of the ESEMeD/MHEDEA 2000 project by facilitating the production of high quality scientific papers and reports in a timely manner, disseminating them in the most efficient way, and assuring the appropriate acknowledgement of authorship, collaboration and financial support.

Specific objectives:
1. To stimulate scientific presentation and output of papers based on the ESEMeD project in the context of EPREMED and to assure that publications based on the project material are accurate and objective, and do not compromise the scientific integrity of this collaborative study.

2. To assure that all the investigators have the opportunity to participate and be recognised in the study-wide international EPREMED papers.

3. To assure that the scientific publications of EPREMED adequately cover the deliverables committed to by the consortium (i.e., those stated in the EU Commission).

4. To establish procedures that allow the EPREMED Steering Committee of to exercise review responsibility for the project publications in a timely fashion.

5. To maintain current lists of all publications and presentations based on the ESEMeD/MHEDEA 2000 project, and to distribute such lists to the project investigators periodically.

Steering committee (SC) members
According to the EPREMED Consortium Agreement, this group includes investigators representing each of the partner institutions of the EPREMED. Members of the SC are: Jordi Alonso, chair; Matthias C. Angermeyer; Traolach S. Brugha; Koen Demyttenaere; Giovanni de Girolamo; Ron de Graaf; Josep M. Haro; Jean P Lépine; and Viviane Kovess.
Publication Policy:

1. **Type of publications:**
Papers comprise of National and European (or international) publications. In terms of format there are: Publications (papers and abstracts), Presentations (invited presentations at meetings with no abstracts, press releases, lectures, seminars, etc.) and Reports. European (international) publications and reports will be the main focus of the SC. The SC may not review national publications and presentations. Nevertheless, the SC chair should receive at least the reference and an abstract (in English) of all National publications for archive purposes.

2. **Publications plan:**
Each investigator should produce a list of the papers in which s/he wishes to have a leading role. This list should be prioritised. That is, the most important paper for the candidate authors should be placed on the top of the list. The list should be sent to the chair of the SC. The SC will produce a list of titles and main candidate authors and will circulate it to all members of the Steering Committee. In cases where several investigators wish to lead the same paper and have not been able to agree, the SC will recommend one investigator as a leader (either initially or after comparing the paper proposals -- see below, 9. Arbitration).

3. **Assigning publications to investigators**
All the investigators of the ESEMeD/MHEDEA 2000 Scientific Committee are eligible as authors of the EPREMED publications. The members of the ESEMeD/MHEDEA 2000 Scientific Committee are: Jordi Alonso; Matthias C. Angermeyer; Sebastian Bernert; Ronny Bruffaerts; Traolach S. Brugha; Giovanni de Girolamo; Ron de Graaf; Koen Demyttenaere; Isabelle Gasquet; Josep Maria Haro; Steven J. Katz; Ronald C. Kessler; Viviane Kovess; Jean Pierre Lépine; Johan Ormel; Gabriella Polidori; and Gemma Vilagut.

Additionally, one student/research collaborator per investigator (exceptionally, more) may be eligible as an author, but the manuscript will be assigned to the corresponding Scientific Committee member.

To increase the diversity of authors as well as to stimulate more timely manuscript production, the SC will assign publications (a maximum of 2 at a time), provided that the deadlines for manuscript completion are respected (see below, 5. Manuscript preparation). A candidate author will not be assigned a third paper until the first one has been submitted to a journal.

Where investigator(s) of centre(s) not included in the Steering Committee of EPREMED want to participate in the elaboration of a manuscript, the leading author should announce this circumstance when submitting the outline to the SC.
4. Manuscript proposal
For papers and abstracts, candidate authors should send to the SC the following outline:

I. Title
II. Lead author and other authors
III. Outline including rationale and hypotheses
IV. Type of Publication (Journal article, Abstract, others)
V. Brief analysis plan
VI. Analysis responsibility (central or local)

Analysing data locally is clearly encouraged in order to enhance the project’s publication rate. For papers based on local analyses, the EPREMED analysis centre has the right to request additional information and analyses prior to approval (see below, 6. Manuscript approval).

5. Manuscript preparation
Once an investigator is granted leading authorship for a paper, manuscript completion is normally due in 6 months. A first draft consisting of, at least, Introduction, Methods and Results sections should normally be discussed by the authors within 3 months. The penultimate (complete) draft version normally becomes due 3 months after the first draft and is distributed to the SC with a request for comments. An additional 3-month period may be acceptable if the manuscript seems to be sufficiently completed.

Failure to meet reasonable deadlines can result in the SC reassigning the paper topic to another member of the Steering Committee or an agreed investigator who is willing and able to take over the work.

6. Manuscript approval of (international) papers
Technical approval of the IMIM data analysis centre should be sought before completion of the final draft paper and if necessary additional time allowed to conduct further analyses. Technical approval or rejection will typically be completed in 1 month.

At the same time, the final draft of all international manuscripts have to be circulated among all the EPREMED Steering Committee (SC) members. Typically the SC then has 3 weeks to review the final pre-publication draft of each international manuscript. The review process will involve all the Steering Committee members, among whom one or more investigators are expected to produce formal (written) comments.

In exceptional cases, if the SC or one or more of its members finds it impossible to approve a manuscript, the following alternative acknowledgement should appear on the front (title) page of the draft for submission for publication: ‘Acknowledgement: This study made use of data collected by the ESEMeD/MHEDEA 2000 Investigators and the content is the sole responsibility of the authors’.

7. Authorship:
Authorship will be limited to the maximum number of investigators involved in the analysis and writing of a paper plus the statement ‘and the ESEMeD/MHEDEA 2000
Scientific Committee’ (or a similar expression). Lead author and other authors will already be named at the outline manuscript assignment stage (see above). In addition, the complete list of the project investigators (including all members of the ESEMeD/MHEDEA 2000 Scientific Committee) should be included in the appropriate place in the paper.

A student/researcher of the institutions of the Consortium can be considered a first author if none of the Steering Committee members volunteers to lead and draft a paper. External consultants will be allowed to be authors but only in exceptional cases, and with the agreement of the other authors of the paper, be elected to be the first author. Provided that there is a substantial contribution, investigators reviewing the manuscript can be included as additional authors of a paper at their written request.

8. **Statement of acknowledgement:**
The SC will propose a standard reference to acknowledge the financial and other types of support received for the project implementation and analyses. This reference will be included in all EPREMED publications.

9. **Arbitration:**
The SC should arbitrate in the case of overlap of content of candidate papers as well as in the case of conflict of order of authorship and in any other circumstance where the general interest of the EPREMED is challenged. In the case of disagreement that the SC is unable to resolve, arbitration would be transferred to an agreed independent distinguished senior scientist (to be approached by the SC chair and then agreed to in this document).

In this part of the report we set out the findings of the research, the general methods used having been described above. Some additional information on particular methods used will be found in this section. A concluding section follows.

REPORT OF THE METHODOLOGY REVIEW.

A systematic review of systematic reviews and meta-analyses of psychiatric epidemiological observational studies

Prepared by the Department of Health Sciences, University of Leicester, Leicester, UK (Terry Brugha, Ruth Hancock, David R Jones) and EPREMED Principal Investigators.

Introduction

Systematic reviews, and where appropriate, meta analysis have potentially great value in combining evidence from studies using different research methods to inform policy and decision makers with more accurate evidence syntheses. Such methods have been extensively used to summarise treatment evidence in the fields of clinical psychology and psychiatric therapeutics. Little is known of the use of such methods in non-randomised psychiatric epidemiology studies in populations, which play a vital role in aetiological research, planning and policy making. There are various examples of reviews of the use of Systematic Reviews and Meta-Analysis in various fields which could be of use, including for example a recent systematic review of systematic reviews and meta-analyses of animal experiments with reporting guidelines (Peters et al, 2006).

Systematic review methods have been developed for use in medical research including observational epidemiological studies (Sutton et al, 1999). However the field of mental and behavioural disorders may pose particular challenges to systematic reviewers because of the relatively fragile understanding of mental
compared to physical health outcomes, particularly when assessed in the general population (Brugha et al, 1999; Kessler et al, 2004). Such outcomes, compared to substance and organically induced disorders, are particularly difficult to assess outside clinical facilities in the community because it is not practical to collect repeat observations of behaviour over time by clinically experienced investigators. Observational studies also assess determinants that employ similar theoretically based constructs: adversity, personality, functioning, which could give rise to heterogeneity across different studies. The potential challenge of heterogeneity to study comparability may be due to the range of different measures used to assess such constructs (Thompson, 1988) as well as to differences in study design and in particular sample design.

We anticipated that the synthesis of results could apply to two kinds of epidemiological studies:
- Methods for synthesising associations with disorder (i.e. risk factors); and
- Methods for synthesising prevalence estimates.

Of these, it could be more difficult to make reliable inferences from syntheses of prevalence estimates because of their potential sensitivity to differences in sampling and in methods for measuring whether diagnostic criteria for a given disorder are met, which may result in excessive heterogeneity across different studies.

We report findings of a systematic review of systematic reviews of studies of functional mental disorders that make use of representative epidemiological samples. We aimed to review the uses, good and bad, of synthetic methods in published reviews, giving reasons with examples for the recommended use of such methods. Our objective was to review all methods, not all the literature in which such methods are used.

The review of synthetic methods focuses on studies in which the health outcomes include the following ICD-10 Categories:
- The functional psychoses (F2),
- Mood disorders (F3),
- Neurotic disorders (F4).
Studies of ‘hard outcomes’ for which there are sufficiently clear and established synthetic review methods (survival, suicide, organic brain disorder such as dementia and brain damage, drug or alcohol misuse) were excluded.

Methods

Embase, Medline and Psychlit were searched from 1996 to July 2005 to identify reviews of psychiatric epidemiological studies (including n= 2 or more primary population studies) that employ synthetic methods such as meta-analysis or that give reasons for not doing so. Search terms were designed to be over inclusive to avoid missing any articles.

Abstracts were obtained for all papers identified in the electronic searches (see table 2 for search terms used), and reviewed separately for inclusion, according to criteria drawn up by one of the authors. Detailed exclusion criteria will be included in a full separately published report. Any disagreements were discussed by the two investigators, and a consensus reached on whether they should be included. Full text articles were retrieved for all articles identified as potentially relevant from the abstracts, as well as those where their relevance was unclear. The full text papers were reviewed by one investigator to establish whether they met inclusion criteria. Where it was unclear whether articles should be included, a separate reviewer (TSB) also read the paper, and a consensus was reached on its inclusion.

Table 2: Search terms used to identify systematic reviews

<table>
<thead>
<tr>
<th>To identify:</th>
<th>Search terms</th>
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<tbody>
<tr>
<td>Studies of psychiatric illness</td>
<td>Mental disorders (exploded term) OR mental illness OR mental disease OR psychiatr*</td>
</tr>
<tr>
<td>AND</td>
<td></td>
</tr>
<tr>
<td>Observational studies</td>
<td>Birth cohort OR longitudinal study OR cohort analysis OR epidemiologic methods OR follow up studies OR follow-up studies OR prospective studies OR incidence stud* OR ep* OR epidemiology OR epidemiological</td>
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</table>
Summary Findings

This review found a number of deficiencies in the conduct and reporting of systematic reviews and meta-analyses of observational psychiatric epidemiology studies that may have serious implications for decisions made on the basis of these reviews. Of 61 reviews found, method of abstraction was not mentioned in 41. There was no mention of study quality in 17 reviews and no mention of publication bias in 36. Bias was not mentioned in 30 and confounding was not mentioned in 26. In 41 studies that performed a meta-analysis only 31 tested heterogeneity. Many of these deficiencies are simple and potentially remediable. In 25 reviews heterogeneity was statistically significant, which is probably a less easily remedied limitation.

Suggestions for how the quality of such systematic reviews could be improved need to be discussed.

Heterogeneity was sometimes significant in meta-analyses of studies of association with mental disorder but in half of the reviews in which it was tested it occurred for some but not all risk factors and in a minority heterogeneity was completely absent. Those studies that detected significant heterogeneity made some allowance for this in analysis, through the use of random effects models, or removing results which were outliers, or through controlling for moderator variables.

Statistically significant heterogeneity was always found in reviews of prevalence studies and was difficult or impossible to address.

<table>
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<tr>
<th>studies</th>
<th>Systematic reviews or studies using synthetic methods</th>
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<tr>
<td>AND</td>
<td>Meta analys* OR quantitative review* OR quantitative synthes* OR review synthe* OR research synthes* OR “Systematic review” (Keyword) OR quantitative overview</td>
</tr>
</tbody>
</table>
Discussion of findings

These findings call for far greater caution in the interpretation of comparisons of prevalence estimates, which are often reported in the scientific literature, as these may mislead policy makers and the wider community of those concerned about the burden of mental disorder in the general population.

A major obstacle facing reviewers, which many acknowledge or discuss, is the wide variation in the use of instruments to measure outcomes and in sampling methods used. One review confined itself to studying the association with one reliable risk factor, gender, using only adult regional or national general population samples and the reviewers divided the available studies into two groups of studies, each group comprising studies using just one outcome measure (Fryers et al, 2004). Significant heterogeneity was observed in the group using only the GHQ-12 to measure outcome, but was no longer significant when one outlier was removed. No heterogeneity was observed in the second group in which the only outcome studied was the 12 month prevalence of depression on the CIDI. All other systematic reviews found in our study included studies using different instruments and or definitions of disorder or failed to specify how outcomes were defined or measured. Heterogeneity was not significant in four studies of associations all of which addressed a relatively reliable risk factor (season of birth, complications of pregnancy and labour, gender) and an outcome (schizophrenia) that could be considered to be a ‘harder’ outcome to define and measure. However there were also reviews of schizophrenia studies in which heterogeneity was either significant or was not reported. No other discernable explanation could be adduced for the absence of heterogeneity in the few remaining association reviews reporting it.

Recommendations – Synthetic Methods:
Currently there are no recommended guidelines for good quality reporting of meta-analyses of observational studies in psychiatric epidemiology. However we found useful in structuring our evaluation of reviews the principles outlined in general purpose guidelines as used across medicine (Sutton, A. J., Jones, D. R., Abrams, K. R., Sheldon, T. A., and Song, F., 1999).

Systematic review and meta-analysis in this (psychiatric) field share many issues with the use of these techniques in other fields in which the results of observational as opposed to experimental primary studies are to be synthesised. In particular,
although meta-analysis may improve the precision of estimates - of prevalence, or of odds ratios for association - it does so at the potential cost of conflating results of different primary studies subject to different types and degree of bias, rendering greater precision largely worthless (Sutton et al, 1998; Egger et al, 2001). Some of these biases may be associated with the use of varying definitions and or measures of outcomes and perhaps exposure variables; *in such cases coordinated studies across several centres, using uniform approaches, will almost always be preferable if feasible, as employed in ESEMed* (Alonso et al, 2004; Demyttenaere et al, 2004). Other between study differences arising because of differing populations and contexts between studies may be of interest and importance to identify and quantify. Thus the exploration and explanation of sources of heterogeneity is important here as elsewhere; meta-analyses are better deployed as exploratory tools rather than to establish definitive estimates. Where they are appropriately employed, reference to guidelines and checklists for their implementation should promote quality in their execution (Stroup et al, 2000; Sutton, A. J., Abrams, K. R., Jones, D. R., Sheldon, T. A., and Song, F., 1998; Egger, Matthias, Smith, George Davey, and Altman, Douglas G., 2001; Centre for Reviews and Dissemination. The University of York, ; The Cochrane Collaboration, 2007). Reviewers should also consider whether a quantitative synthesis method such as meta-analysis is the correct approach to studies using heterogeneous methods and a minority of reviewers reported their decision not to use such synthetic methods. Some combinations of research objectives, evidence types, contexts and resources may of course be better matched by alternative approaches (Boaz et al, 2006). Boaz and colleagues indicate wide-ranging interest in synthesis methods of different types in different fields and psychiatric epidemiologists might want to consider which would be useful in the challenging area of the study of mental disorders in populations.

Reference List


Annex 7: Policy Report on Syntheses of Data Using ESEMeD and other European Sources (WP3)

Introduction

In this report we describe two uses of synthetic methods that bring ESEMeD data together with other primary data sources in order to produce new findings of importance to policy makers. As explained earlier, this section provides reports on mental health expectancy and on the effects of parenting on adult mental health outcomes. The decision to study these two examples arose partly from the lessons gained in the review of synthetic methods:

1. Combining ESEMeD mental disorder rates and life tables from the same countries.
2. Combining ESEMeD findings on retrospective associations between mental disorder and perceived quality of parenting with prospectively gathered birth cohort data gathered independently in Europe.

1. Mental health expectancy: a synthesis of life table data and survey data on rates of mental disorder

Health expectancies, of which the most common is disability-free life expectancy (DFLE), provide a means of dividing life expectancy into life spent in various states of good and bad health. Health expectancies extend the concept of life expectancy to morbidity and disability, thus adding a quality assessment to the quantity of life lived. Health expectancies can thus address whether or not lengthening of life expectancy is being accompanied with an increase in time lived in bad health. Although health expectancies, including trends over time, are available for over 50 countries, the most commonly presented are disability-free life expectancy (DFLE) or health life expectancy (HLE) based on self-perceived health. Despite the burden of mental disorders, mental health expectancies are still relatively rare and have
generally been confined to life expectancies free of dementia or cognitive impairment.

Health expectancy combines information on mortality and morbidity into a single summary measure.

Mental Health Expectancies were calculated (Sullivan, 1971) by combining mortality data from population life tables and age specific prevalence of the mental disorders obtained from the ESEMed national surveys. Life tables for men and women separately for each of the six countries (Belgium, France, Germany, Italy, the Netherlands and Spain) corresponding to the study period (2001-2003) were obtained from the European Health Expectancy Monitoring Unit (EHEMU) Information System (www.ehemu.eu).

The life tables originate from Eurostat and use the Eurostat methods for the first age interval (birth to 1 year) as described in the EHEMU calculation guide. A combined life table for 2002 for the six countries was calculated from the combined death and population counts and then employing the Eurostat methods as before.

We defined common mental disorder (CMD’) as any ESEMed depression diagnosis (Major Depression or Dysthymia) or any Generalised Anxiety Disorder (GAD). (Tables for other specific anxiety disorders are possible).

ESMEMD prevalence tables were generated for age, age group for all 6 ESEMed Countries. We produced results at up to age 55 only (no subjects excluded) to ensure that bias from omitting the institutional population is negligible.

Main findings

As for disability, women spend more absolute years with common mental disorders (and each disorder individually) and a greater proportion of remaining life with them. Indeed both the number and proportion of LE with CMD at age 25 were double those for men (11.3 years (20%) v 5.0 years (10%), all countries combined).
At younger ages the countries were more similar on their values of total life expectancy than they were on life expectancy with each disorder.

However this cross-national variability in life expectancy with each disorder was reduced and the countries showed greater variation in total life expectancy.

LE with each disorder showed greater variability across the countries than did total life expectancy.

Figures 1a and 1b: Life expectancy at birth by gender in the six ESEMed countries, 1995-2004
Figure 2. Proportion of life expectancy (%) with and without common mental disorders (CMD) at age 25 by gender and country.
2. Prevention of Mental Disorder: the role of parenting - a synthesis of cross sectional and prospective longitudinal data sets.

EU Public Health is required to focus attention on prevention (UK Presidency, 2005; Mental Health Green paper). Published outputs from the ESEMed dissemination process have already shown that the relationship between parental child-rearing styles and mood disorders is mostly homogeneous across the six ESEMed countries (Heider et al, Psychiatry Res. 2006 Jun 30;143(1):89-98). The Parental Bonding Interview (PBI) dimensions maternal and paternal care had the strongest associations with mood disorders. However this is a cross sectional study; respondents were interviewed once only in adulthood (some would have been elderly). Therefore the direction of any association is not known: it is possible that survey respondents with depression viewed in a biased negative way the quality of their parenting and that parenting is not causal.

The team conducting WP-3 also conducted new secondary analyses of longitudinal date collected from birth that allows such cause and effect questions to be tested objectively. The PBI (a subset of the exact same questions) has been used in prospective data collection in one such birth cohort (in Great Britain). Synthesis methods were used as follows. The birth cohort and ESEMed findings were examined jointly with a view to generating guidance on the potential impact of such information for future prevention research and policy. Synthesis methods were used as follows. Because different sampling and different outcome measures were used combining the two datasets was advised against because there would be far too much heterogeneity. A qualitative approach (as referred to in the earlier synthetic methods review) was recommended. The ESEMed findings of Heider et al were reported in terms of odds of developing a mental disorder in adulthood when poor parenting (for example over protection), based on PBI questions, is reported at the time of the survey interview (any age from 16 years upwards). The UK birth cohort data (paper submitted for publication) included the collection of PBI items and items on current mental health at age 16 and mental health outcomes collected in later waves of interviews at later stages of adulthood.

Findings.

As in the study reported by Heider et al poor parenting reported at age 16 did predict poor mental health later in adulthood. The key analysis question for our
purposes was: would the odds of poor mental health in later adulthood be reduced when prior mental health also assessed at age 16 was adjusted for and if so by how much? The overall finding was that the odds of later mental disorder were hardly reduced and remained statistically significant following such adjustments. It was concluded therefore that Heider’s findings across the 6 EU ESEMed countries would also be likely to stand up following adjustment for mental health measured at the same time and cannot be dismissed as being merely secondary to prior poor mental health.

Therefore, it can be inferred that quality of parenting is a significant determinant of adult mental health across the ESEMed countries. It follows that consideration should be given to introducing and evaluating training programmes in parenting. This recommendation has been taken up in England in 2008 (http://www.umds.ac.uk/phpnews/wmview.php?ArtID=1823) with the award of £30M.
Annex 8: Policy Report of the Policy Information user Dialogues (WP3)

The methods used to furnish the following report findings have been fully described in the first part of the present report.

In this section we provide three sets of findings:

a. Data supplied from WP-4 based on dissemination workshops with policy advisers within the ESEMed countries
b. Data supplied by members of an EU Public Health Network advisers to national governments
c. A summary of mental health policy information development in England since the 1980s based on regular general population surveys of psychiatric morbidity.

a. Findings provided through the WP-4 workshops with policy information users.

The following information was supplied by WP-4 mainly through the use of Focus Group Meetings. In particular information was sought regarding prior estimates of expected findings in relation to information crucial to key policy making decisions. An experienced research assistant organised each of the meetings and arrangements differed somewhat from one country to the next.

Two meetings took place in France

These indicated that policy advisers did not know in detail what it is that they want or need. They appreciated the opportunity to meet and consider the available evidence on rates of mental disorders in the population and on possible determinants. It was for them educational.

Some indication of what policy advisers in government would wish to have information upon could be gleaned from an examination of their existing and previous approaches to this task. A recent review of mental health policy conducted for one national government was substantially prepared by the WP4-Leader who
therefore also cited ESEMed epidemiological findings. This review was triggered by a public attention being brought to bear suddenly during a crisis following a homicide by another psychiatric patient. The public were complaining about how difficult it is for people with mental health needs to access services and yet there are so many psychiatrists. Thus governmental policy officials did not draft the resulting detailed policy paper themselves but turned to the above outside adviser for expertise in order to assist them. They have on other occasions tended to approach practicing clinical psychiatrists (hardly any of whom would be known as active epidemiological investigators). In the past they have focused on severe mental illness and hospitalisation, closing psychiatric hospital beds, shifting patients from mental to general hospitals. If there is an interest in outpatient care it is only to look at patients with severe mental disorder. The most recent policy paper was the first to focus on primary care.

Contact with Belgian officials suggested that as in France they were interested in Use Of Care. Their preference was for data that is provided in the same format as they receive data on physical health, such as Cardio Vascular Disease, Diabetes, Cancer etc. They probably would prefer to keep separate information on anxiety and depression – combining them (into a category of Mixed Anxiety and Depression favoured by UK Policy Advisers) seemed less appealing: indeed it was felt that they might be suspicious of a combined measure. They would also want alcohol and drug misuse kept separate.

Focus Group Meeting in Belgium.

Belgian Policy makers want to be included in the preparation of new studies, but they were not specific about what this meant. They wanted more collaboration between policy advisers and researchers. They said they were interested. However when an opportunity to meet was set up they did not send policy makers but instead sent their data and information technical advisers. They wanted dissemination to the broader public.
Todo el párrafo llevaba interrogantes en comentarios anteriores del Dr. JA.

Belgian Policy makers were interested in:

- Why is prevalence of mental disorders high?
- Are all depressions the same (and in need of treatment) and they wanted information by severity from mild to severe)
Belgian Policy makers wanted more emphasis on prevention programs: suicide, cost effectiveness, (how many would need to be in a programme to prevent one case?) idem

Belgian Policy makers wanted more knowledge on treatment gaps:
Accessibility of services, what happens in the pathways to service use (what happens to the patients), information on use of antidepressants, coordination between medical and non medical care (e.g. psychology) healthcare.

Focus Group Meeting in Spain.

The primary purpose of the Spanish focus group was to develop indicators to evaluate the impact of the disseminated materials, which was a national meeting in Barcelona. It omitted any discussion of the information needs of policy makers.

The Italian focus group was organised in Rome on March 7th, 2008 (see Annex 9) The focus group was attended by mental health policy makers, regional health policy makers, patient groups, NGOs, psychiatrists, professionals of mental health services, media, etc. It provided a chance to note the relative low access to care for mental problems. For example, representatives of general practitioners and psychiatrists considered that one of the unresolved problems of Italian public mental health services is that these services are almost exclusively addressed to the care of severe mental disorders.

The representatives of the diverse groups attending the focus group actively participated in it by suggesting further dissemination strategies in which they could become active and expressed their interest and availability to participate in further programs on this subject.

Discussion of findings

In two of the countries in which focus groups did not take place, existing epidemiological data had been collected prior to ESEMed and were being relied upon (other contacts suggest that there is a high level of mental health policy dialogue). In one of these two countries there may have been sensitivities about the findings being different from previous prevalence findings. In a second country there were concerns about achieving plans for a new wave of research which made it difficult to arrange meaningful dialogue.
In conclusion the meetings that took place provided a small amount of information on the information needs and preferences of policy makers in two of the six ESEMed countries.

Additional findings provided through the WP-3 dialogues and correspondence with governmental policy information advisers within the ESEMed Countries.

During the second year of EPREMed, WP-4 supplied informal information to WP-3 regarding the desirability among policy makers to be given information based on a simplified global indicator of mental health. Such information is already obtainable from ESEMed and WHO WMH outputs that include in addition to specific disorder outputs the concept of ‘any disorder’ in results tables. This indicator is included in secondary analyses developed during the second year, listed in the phase 3 section below.

b. Policy information needs reported by EU Public Health Network Governmental Advisers

Individual reports on each of the 6 ESEMed countries (Netherlands, Italy, France, Germany, Spain, Belgium) that were completed using ESEMed and national Life Table data on healthy life expectancy were also made available for communication and dissemination with policy makers during 2007. Response to requests for need for information to inform policy making were obtained from 3/6 EU Member countries using the EU public health network (one further country also commented on the ESEMed HLE report). We do not reveal the identities of these policy advisers.

In each case we asked the following question:

Q. What information on the mental health / disorders of the population would be most helpful to you in answering the most pressing or important question/s that you are currently responsible for?

Findings on information needs from representative working for the named government:

Belgian government (a survey provider not directly involved in policy making):
Prevalence of different mental disorders in the population;
Sub-groups at higher risk for developing specific disorders;
Mental health care services available for these problems.

Danish government (responsible for compiling scientific findings as a basis for political decisions concerning health issues [Denmark was not involved in ESEMed]):
Prevalence broken down by age, sex, SES etc. to identify target groups for tailored prevention measures

Spain (an expert who provides data and studies ad hoc to the health policy and planning units, based in a regional unit)
Prevalence of several mental disorders by age, gender and geographical area
General indicators of mental health status
Indicators of severity / dependence of mental disturbances

Discussion of findings from the Public Health Network.
Perhaps not surprisingly these public health specialists were interested in obtaining standard epidemiological estimates but the purpose of this in terms of developing mental health policy was unclear. This may reflect their lack of knowledge of mental disorders, determinants and treatment evidence base.


As already stated, the WP3 co-ordinator has had prior experience of working as a full time Policy Adviser in Central Government for an 18 month period in the mid 1990’s and is familiar with the needs, pressures, constraints, opportunities and reliance on policy information faced by professional policy makers. The WP n°-3 leader also took part in a series of meetings with Key Cross Governmental policy makers in England (in 2007 and in 2008 but also by way of background to this in 2005), which provide invaluable insights into the potential role of both health and other government policy makers in relation to the mental health of the population.
This represents the outcome of a decade of policy information collection and analysis inside and outside UK Health and associated Government Office.

A brief note on the historical background to the development of mental health policy in England may be helpful. During the 1980s and 1990s two highly influential senior psychiatrists became full time policy officials in the Department of Health London. They were responsible for mental health legislation, mental health offenders, severe mental illness and common mental disorder in primary care. Others followed particularly during the 1990s a period of rapid policy development and the period during which mental health became a topic for periodic national morbidity surveys (along side general health, income and occupation, crime and other key topics). Although the presence of such specialist professional policy makers has since waned, their impact and that of the survey programme has since been shown to be significant.

The following examples of activities have all made use of the national survey programme of psychiatric morbidity (children, working age and older adults, homeless and prison populations):

Early in 2005 the Prime Minister’s central policy unit brought together government departments responsible for welfare, employment, education, health, home security and the Treasury to formulate new policies designed to reduce rates of depression, dependency on unemployment benefit by altering welfare regulations and legislation and by investing new ring-fenced funding to deploy cognitive behavioural psychotherapists in primary health care throughout England (commissioning beginning in March 2008).

In 2007 the Government Chief Scientist initiated a Forsight Project on Mental Health and Wellbeing bringing together expertise from across government and the academic community to commission reviews, conduct policy development workshops and to map out objectives and policy strategy for the next 30 years.
Annex 9: Focus Group Reports (WP3 and WP4)

Title: France Focus Group
Date: November 21, 2006
Venue: MGEN, Paris, France

Participants:
- Xavier Briffault: scientist, prevention health agency officer: INPES (Institut National de Prévention et d’Education pour la Santé)
- Christine Chan Chee: MD, health agency officer: INVS (Institut de Veille Sanitaire)
- Alain Jourdain: public health teacher ENSP (Ecole Nationale de la Santé Publique)
- Jean Charles Pascal: Psychiatrist (Fédération Français de Psychiatrie)
- Stephanie Wooley: user representative (Association France-Depression)

Regrets:
- Serge Kannas: MNSAM (Mission nationale d’appui en santé mentale)
- M. Lepoutre: MNSAM
- Magali Coldefy: DREES (direction des études, de l’évaluation et de la statistique)
- Nadine Richard: DGS (Direction Générale de la Santé)
- Michel Gentile: DHOS (direction de l'hospitalisation et de l'organisation des soins)
- Nicole Garret Gloanec Pédô Psychiatre
- Marc Brodin: CNAMTS (Caisse Nationale d'Assurance Maladie des Travailleurs Salariés)
- Claudine Blum Boisgard: RSI - Régime Social des Indépendants
- Isabelle Ferrand: HCSP (Haut Comité de la Santé Publique)

General objectives:
To define, using multidisciplinary focus groups with each of the stakeholders, key messages from the results relevant to their areas of interest and expertise.

Presentation of Results

Representatives of the various stakeholders (scientific community, practitioners’ representatives, policy-makers, civil society, and mass media) were invited to participate in a focus group. The participants were emailed three scientific papers in
French language and a power point presentation in which ESEMED results were discussed.

The focus group commenced with a Power Point presentation by Vivianne Kovess in which the relevant finds for France were highlighted. Topics included:

- Prevalence
- Risk Factors
- Co morbidity
- Disability/Impairment
- Use of Mental Health Services
- Psychotropic drug utilization

In general, the dissemination of the ESEMED results in France occurred in the scientific community through national papers and by a presentation that was given at a large conference organised by France Depression (User Group) in which participants included policy makers and other relevant stakeholders; in addition seemed study was quoted in the “National plan for Mental health and Psychiatry” implemented during the last years in France. The participants all agreed that the ESEMED results were important and that it was necessary to disseminate results in French to various stakeholders via local publications, web sites and presentations.

Questions

*Does this information help you to set, modify or consolidate health information?*

The results lay the groundwork for very important further research. The project highlights the high prevalence of depression and concerns regarding mental health care in France and opens up the possibly of further research to clarify or augment these findings. The list of topics for further study included: suicide and suicide prevention, psychotropic medication use, reasons for high depression and anxiety rates, misuse of anti-depressants, early intervention programs in school, and risk factors.

Data clearly indicates that the French have a higher prevalence of depression than other European countries and this was a concern to the group. There was a great deal of discussion in the group around the issue of whether it was an accurate interpretation of the data and to look into why this is so.

*Does this information help you in the organization of the health system?*

For the participants one aspect of the study that is important is the interaction between primary care and psychiatry and the apparent lack of links between them. The study illustrated that the link between general practitioners and physiatrists was poor and to the group this was a major issue of concern. The role of my non-medical professionals was also a concern as the data shows it is not well supported in France. Over psychotropic drugs consumption may also results from these.
**Which information would enable you to support changes in policy?**

For this particular focus group, there were few policy makers in attendance and those attending were in charge of collecting data more than policy design. For this reason, we have organised a second focus group with policy makers.

**Key Messages relevant to their areas of interest and expertise**

- Analysis of the reasons for high depression and anxiety rates
- Delays in treatment time
- Respective roles of the general practitioners and psychiatrists and lack of coordination
- Suicide and suicide prevention
- Over Psychotropic medication use
- Misuse of anti-depressants
- Social Risk factors
- Role of non-medical practitioners to be implemented

**Is the information presented in a format that enables you to use it at different levels (national/regional/local)?**

In France, it is only possible to use ESEMED data to describe the national level, as the French sample does not allow sub-division of data at a regional or local level. This is potentially a problem since planning is allocated by region. However, the possibilities to compare to neighbour countries within EU is considered as very helpful for health care planning and research.

**The following were some dissemination strategies proposed.**

**Dissemination to Scientific/academic community:**

- publications in scientific journals
- presentation of results at congresses and scientific meetings
- development of a working group and research collaboration
- inclusion of the results in academic/research programs

**Dissemination to physician groups:**

- publication in a journal targeted to physicians i.e. BEH (*Bulletin Epidemiologique Hebdomadaire*) *Le quotidien du medecin*
- publication in a medical journal in France with high visibility

**Dissemination to policy makers:**

- short technical reports
- longer project reports
- communication between researchers and policy makers in advance of further studies in order to agree objectives and to promote collaboration

**Dissemination to patients/families, user groups and civil society:**

- communication of the results in mass media such as newspaper, magazines
- article in a lay publication targeting patients, families, NGOs, and User groups
- links to ESEMED and EPREMED web site on the web sites of various organizations (NGOs, User group etc)
• use of user groups and NGOs to disseminate results to wider audience
• attending meetings or making oral presentations with patients and user groups about the results as these groups are able to pressure policy makers into implementing changes or new programs
Title: France Focus Group  
Date: March 8, 2007  
Venue: Hopital St. Anne, Paris, France

Participants:
- Serge Kannas: praticien hospitalier : Mission nationale d’appui en santé mentale – MNSAM
- Emmanuelle Salines : Ministère de la Santé: DREES (direction des études, de l’évaluation et de la statistique)
- Julien Mousques : IRDES (Institut de Recherche et Documentation en Economie de la Santé)
- François Beck (Responsable du Département des Sciences Humaines)
- Hélène Mauduit : Journalist APM - APM International
- Christine BRONNEC : Chargée de mission DHOS

Regrets:
- Fill in names

General objectives:
To define, using multidisciplinary focus groups with stakeholders of various government departments and the media, key messages from the results relevant to their areas of interest and expertise.

Presentation of Results

Representatives of the various stakeholders (scientific community, practitioners’ representatives, policy-makers, civil society, and mass media) were invited to participate in a focus group. The participants were emailed three scientific papers in French and a power point presentation in which ESEMED results were discussed.

The focus group commenced with a Power Point presentation by Vivianne Kovess in which the relevant findings for France were highlighted. Topics included:

- Prevalence
- Risk Factors
- Co-morbidity
- Disability/Impairment
- Use of Mental Health Services
- Psychotropic drug utilization

In general, the dissemination of the ESEMED results in France occurred in the scientific community through national papers and by a presentation given at a large conference organised by France Depression (User Group) in which participants included policy makers and other relevant stakeholders; in addition the ESEMED
study was quoted in the “National plan for Mental health and Psychiatry” implemented during the last few years in France.

The participants viewed the focus group as a form of continuing education. They felt that this type of format for the presentation of research results needed to be repeated, as it was the most effective way of transmitting research results to government officials. They would also like to build a knowledge base of expertise that they could use as an information source as they felt that as civil servants they lack the expertise to interpret these results on their own and need the scientific community to assist them.

In France, this was the first time that government and public health officials were able to have a discussion with a research scientist to discuss research results. The information stakeholders are looking for is what has been done, what are the results, and where can they find the information. The dissemination of results via a focus group was thought to be more effective then simply sending them printed material of which they do not have time to read.

In the group, a journalist provided insight into the type of information journalists wanted and needed. Mental health issues are not clearly understood by journalists and by the public at large and to remedy the situation journalists need to be provided with information (i.e. press release) that they then can disseminate to a larger audience.

Questions

Does this information help you to set, modify or consolidate health information?

The data shows that the French have a higher prevalence of depression than other European countries. This was a concern to the group and a great deal of discussion occurred around this issue and whether it was an accurate interpretation of the data.

The consensus was that the information would not lead to changes in policy, as the results are already well known in France. The more important question is what the French system needs to change in order to resolve some of these issues. Does the health system stay as it is or does the government implement changes i.e. does it implement policy changes to try to increase the referrals between general physicians and psychiatrists?

Does this information help you in the organization of the health system?

For the participants one aspect of the study that was important was the interaction between primary care and psychiatry and the lack of links between them. The lack of linkage can result in the over consumption of psychotropic drugs. The study illustrated that the link between general practitioners and physiatrists was poor. There were also discussions on the organisation of the psychiatrist professions and whether there needed to be changes. France has one of the highest rates of psychiatrists in the world yet access to care is poor. The role of my non-medical professionals was also a concern as the data shows it is not well supported in France and there is an absence of referrals to psychologists.
Which information would enable you to support changes in policy?

The group felt that the results are already known in France and the possibility for them to lead to policy change is minimal. For them the real question is what does the system in France need to change.

One area that was felt the study could be used to implement change is to look at the low referral rate to psychologists and to explore ways of rectifying this situation. How do you integrate psychologists? One solution was to change the payment method of psychologists who are not currently covered under the French social security system. The low referral rate could be a consequence of the high fee and lack of reimbursement under the French system.

It was agreed by all that the level of care provided by general practitioners is very good in France but under the French health care system a GP’s is not compensated for counselling. The group discussed the case in Canada where GP’s have a separate billing code for counselling services and whether France needs to implement such as system.

Key Messages relevant to their areas of interest and expertise

- Analysis of the reasons for high depression and anxiety rates
- Respective roles of the general practitioners and psychiatrists and lack of coordination
- Role of non-medical practitioners

Is the information presented in a format that enables you to use it at different levels (national/regional/local)?

In France, it is only possible to use ESEMED data to describe the national level, as the French sample does not allow sub-division of data at a regional or local level. This is potentially a concern since planning is allocated by region. However, the possibility to compare to neighbouring countries within EU is considered as difficult as it is not easy to transpose results to policy but overall the group was interested in European comparisons.

The participants indicated a number of areas where they needed assistance from research scientists in acquiring and interpreting research data to allow them to make use of it. At sessions like this one, they are able to gather a great deal of knowledge in a short period. They also felt that they needed to be educated on epidemiology and wanted to be able to rely on research specialists who can help government interpret and respond to studies like this. They would also like to see a permanent forum created where scientists can engage with policy makers and continued round table discussions. They recommended that at the level of the ministry that there is continuing education for their staff. It was also felt that new educational programs such as a MSc. were needed. Improvements must be made to better the interaction between researchers and policy makers.

Journalists view:

There is a deficiency in communication between psychiatrists and psychologists and almost no communication between research epidemiologists and government officials. There needs to be interaction between stakeholders, as was the case with the France Depression seminar. However, the concern is that the majority of
participants at seminars such as those are people who are already interested in the topic. There is also the issue that talking and writing about mental health is still considered taboo. The misunderstanding is that journalists are not interested in mental health and thus the lack of press but in reality, they do not write anything about it, as there is no information made available to them.

Suggestions:

- Press release with a clear message at the beginning with discussion of France results
- 2 -3 pages maximum
- 3-4 topics
- use of care, prevalence, risks etc
- use press magazines
- small articles in lay press
- French journalists are not interested in European comparisons as they are very French centered - you can make some comparisons such as in France there is a high number of psychiatrists and in England there is less – journalists like these type of European comparisons
- Comparisons should be used to reinforce message
- Presentation and display needs to be very strong
- need to make decision makers aware of this including cabinet makers who make decisions
- need to diffuse results to the grand public
- another reunion such as this would be very useful

The following were some dissemination strategies proposed.

**Dissemination to Scientific/academic community:**

- development of a working group and research collaboration
- inclusion of the results in academic/research programs

**Dissemination to physician groups:**

- publication in a journal targeted to physicians i.e. *BEH (Bulletin Epidemiologique Hebdomadaire) Le quotidien du medecin*

**Dissemination to policy makers:**

- short technical reports
- communication between researchers and policy makers in advance of further studies in order to agree objectives and to promote collaboration

**Dissemination to patients/families, user groups and civil society:**

- communication of the results in mass media such as newspaper, magazines
- article in a lay publication
Report of the Italian ESEMeD Focus Group
(Rome, 7th March 2008)

Introduction

The ESEMeD focus group was held at the National Centre of Epidemiology, Surveillance and Health Promotion (CNESPS), National Institute of Health (ISS), Rome, on the 7th March 2008, at the invitation of Dr Antonella Gigantesco and Dr Angelo Picardi - Mental Health Unit - CNESPS - ISS.

I. OPENING OF THE FOCUS GROUP

A. Opening statements and organizational matters

1. Dr Stefania Salmaso, director of the CNESPS, opened the focus group at 11a.m., welcoming all participants.

2. Dr Antonella Gigantesco, as moderator, reviewed the agenda and the goals of the meeting, emphasising the active involvement by all participants as an essential ingredient to fully meet the objectives of the focus group.
   Dr Angelo Picardi and Dr Ilaria Lega, Mental Health Unit, CNESPS, were involved as co-facilitators.
   The session was recorded with an audio recorder.

B. Attendance

The focus group was attended by representatives of the following stakeholders:

1. Mental health policy makers: Dr Teresa Di Fiandra, Prevention and Communication Department, Ministry of Health;

2. Regional health policy makers: Dr Gianfranco Palma, Director of the Mental Health Department “ASL Roma E”, as representative of Dr Augusto Battaglia, Assessor of the Lazio Regional Health Department;

3. Patient groups: Maria Adele Nicolosi Masone, Lazio Regional Coordinator of IDEA Foundation – Institute for research and prevention of depression and anxiety; Anna Pappalardo, National President, and Patrizia Arizza, Press Office, of the non-profit Italian Association against Anxiety Disorders, Agoraphobia and Panic Attacks;

4. Non-governmental organizations (NGOs): Ughetta Radice Fossati, Vice-president, and Beatrice Bergamasco Rocca, Advisor, of the Project Itaca - Association of volunteers for mental health;

5. General practitioners association: Dr Giulio Nati, Regional President of the General Practitioners Italian Society;
6. Psychiatrists (professional associations/University): Prof Massimo Biondi, Psychiatry Professor, Director of the Department of Psychiatry, La Sapienza University, Rome, Member of the Board of the Italian Society of Psychopathology; Prof Lorenza Magliano, Department of Psychiatry - II University of Naples;

7. Professionals of public mental health services: Dr Gianfranco Palma, mentioned above, and Dr Loredana Gibaldi, Direction of the Mental Health Department “ ASL Roma E”;


II. PHASE 1. PRESENTATION OF THE MAIN ESEMeD TOPICS

Dr Giovanni de Girolamo, coordinator of the ESEMeD and EPREMED project’s Italian arm, gave a brief Power Point presentation of the main ESEMeD topics. As requested, the presentation paid attention to the European perspectives as well as to the Italian specificities and to the main possible explanations of these peculiarities.

III. PHASE 2. DISCUSSION

1. Dr. Antonella Gigantesco and Dr Angelo Picardi introduced the second phase of the focus group, suggesting a round-table approach. The participants were invited to discuss which conclusions they have drawn from the presented ESEMeD results:

   a. In the opinion of all the representatives, the Italian annual prevalence of common mental disorders identifies a group of disorders widely disseminated in the general population. The data on the European and Italian population levels of unmet needs for mental health care and the data on delay and failure in treatment seeking after first onset of mental disorders were debated by all participants. There was broad recognition of the need for more effective strategies to manage common mental disorders in public health services.

   b. Representatives of general practitioners and psychiatrists considered that one of the unresolved problems of Italian public mental health services is that these services are almost exclusively addressed to the care of severe mental disorders. The transition from “services on demand” to true public mental health services, able to intercept mental health needs of general population, was recommended. The same representatives underlined the importance of a synergy between general practitioners and specialized mental health services, with the aim to offer an integrated care to the patients, who could benefit of a specialised intervention. Accessibility of mental health services was judged as actually inadequate. Addressing the important issues of the “minimally adequate treatment” and of allocation of resources, the representative of general practitioners expressed particular concern about the insufficient availability of evidence-based psychosocial interventions in the Italian national health system.

   c. Representatives of academician psychiatry emphasised the importance of providing medical students with information about the prevalence of
common mental disorders and the related disability, considering also the negative effect of mental disorders on the course of physical disorders.

d. Representatives of patients, relatives and NGOs attached great importance to educational initiatives on common mental disorders directed to the general population in order to reduce the stigma and thereby the unmet need for mental health care. Noting that this sort of action is a fundamental part of their mission, the mentioned representatives asked for a greater institutional formative support.

e. Representatives of media drew attention to the role of the media in disseminating information on mental health and increasing citizens’ awareness on mental disorders. Therefore they asked for institutional initiatives dedicated to journalists’ education on mental health. The same representatives pointed out the improperly emphasized connection between mental disorder and social danger as one of the most important critical issues that interfere with correct information. A general agreement was recorded on the weight of the value of correct information in reducing stigma.

2. The provided information globally consolidated health information of the participants.

3. The phenomenon of the low services consultation rate was unanimously judged as the most useful information in order to support actions and decisions in health policy.

4. Numerous strategies were suggested in order to effectively disseminate the presented information at different levels:

   a. The representative of mental health policy makers and representative of psychiatrists suggested disseminating to the mental health public services and general practitioners the information presented in the same format used in the focus group that was judged as adequate for health professionals.
   
   b. Representatives of general practitioners highlighted the importance to use the general practitioner as a precious vector to reach citizens: brochures and posters, summarizing in a simplified form the main ESEMeD results, could be made available in their clinical practice.
   
   c. Representatives of academician psychiatry underlined the importance to add on the numerous international ESEMeD publications some articles in Italian language on the Italian most important psychiatry and general medicine journals.
   
   d. Representatives of patients, relatives and NGOs asked for a brief Italian report of the main ESEMeD data with the aim to further disseminate the presented information to patients, relatives and volunteers.

5. Representative of the Ministry of Health guaranteed that the ESEMeD results and the mental health issues emerged in the focus group are taken into account in the action of the Ministry of Health, at national and international level.

IV. ADOPTION OF THE REPORT OF THE MEETING

The last 20 minutes of the focus group were used to produce a summary of the discussion. It was agreed that the definitive report would have been sent to all participants by e-mail for a further approval.

V. CLOSURE OF THE FOCUS GROUP
All the representatives expressed their satisfaction with the results of the present meeting and their interest and availability to participate in further programs on this subject.
Belgium focus group

Attendance: 60 people half of them were journalists, a dozen of psychiatrists, psychologists, Health ministry representatives, as well as patient organisations (depression ligue) and scientists from Scientific Institute of Public Health.

The European Study of the Epidemiology of Mental Disorders

- One in four Belgians has (had) a mental disorder
- One in nine Belgians had a mental disorder in the past year
- In Europe, Belgium has a dense and widespread accessible network of mental health care facilities, but patients oftentimes don’t seek professional help
- Belgians with a mental disorder don’t seek help very quick, and when they do, they don’t get appropriate treatment

Background
The European Study on the Epidemiology of mental Disorders is the most profound study that investigates the prevalence of mental disorders in six European countries (Belgium, the Netherlands, Germany, Spain, Italy, and France). The main goal of the study is to map the mental health of the general populations of these countries. In Belgium, the study was coordinated by Professor Koen Demyttenaere (Dept Psychiatry of the University Psychiatric Center Katholieke Universiteit Leuven), together with Ronny Bruffaerts and Anke Bonnewyn. The fieldwork was coordinated by Professor Herman van Oyen together with Stefaan Demarest (Scientific Institute of Public Health, Brussels). The study is part of the World Mental Health Surveys, coordinated by the WHO and Harvard University. The ESEMeD project in Europe was coordinated by Jordi Alonso (IMIM, Barcelona). The ESEMeD project was supported by the European Union, the World Health Organization, and GlaxoSmithKline (GSK).

Methods
About 22,000 respondents participated in this study. In Belgium, 2419 persons, older than 18 participated in the ESEMeD study. All results were weighted in order to have a population-representative study. Interviews (with an approximate duration of 90”) were administered between April 2001 and June 2002, and ran by collaborators of the Scientific Institute of Public Health). The following research questions were investigated:

- What is the prevalence of mental disorders (among others, depression), anxiety disorders (among others, panic disorders), and alcohol disorders;
- What is the impact of mental disorders on daily functioning of persons with these disorders
- What is the prevalence of the use of psychotropic agents (such as anxiolitics or antidepressants)
- What is known on the help-seeking process in persons with mental disorders?
Results

- One in four Belgians has (had) a mental disorder ever in their life (more than 2,000,000)
- One in nine Belgians has (had) a mental disorder in the past year (more than 800,000 Belgians)
- Depressions and anxiety disorders are the most common mental disorders
- About 40% of the mental disorders are chronic in nature
- Women are more likely to have mental disorders (especially depression)
- Depression is more common among women, divorced persons, non-working persons, and younger cohorts
- Persons with mental disorders do not seek professional help very often. Only one in three seeks professional help within the past 12 months. Most persons have contact with their general practitioner;
- One in two waited at least one month before seeking because of
  - “Problems will disappear soon without any help” (53%)
  - “I have to deal with my problems myself” (50%)
  - “these problems are only temporary” (44%)
  - Financial restraints (32%)
  - The lack of knowledge of where to seek help (31%)
- Among those who sought help, the vast majority was prescribed medication. One in five did not get follow up after a first contact with a professional.
- Mental disorders have an important impact on daily life. Persons with one disorder had about 8 days per month work loss. Those with more than one disorders (e.g. those with a depression and an anxiety disorder) reported up to 12 work loss days per month.
- Of 100 depressed Belgians, 43% seeks help, of which
  - 4 do not receive any help
  - 4 receive psychological treatment
  - 14 received medication treatment combined with psychological treatment
  - 21 receive medication

Conclusions and some reflections for the future

- The ESEMeD projects seeks to map mental health in Western Europe, and seeks to investigate daily functioning of persons with mental disorders. After all, 'mental disorders' and 'quality of life' are concepts with a gradually greater importance in society
- Seen the dramatic findings on service use and treatment, there is a great need towards improvement strategies:
  - On the level of informing general populations
    - On the existence of mental disorders and what might be helpful in the case of mental disorders
    - On the stigmatising ideas persons may have of persons with mental disorders
  - On the level of (continuous) education and formation of psychologists and medical doctors
  - On the level of screening, assessing, and treating persons with mental disorders
  - On the level of service provision: trying to bridge the high density of services and the low proportion of persons seeking professional help.
- In a recent publication of the United Nations, attention is called towards all governments on this globe to put more emphasis on the existence of mental disorders, including research, formation, treatment, and early recognition.
Annex 10: Database of Target Audiences:
IMHPA Coalitions (WP4)

Belgium:
Emmanuelle Demarteau, Walloon Region
Lucia Schneiders, German community
Christiane Bontemps, Institut Wallon pour la Santé mentale
Dr. Philippe Hennaux, Ligue bruxelloise francophone pour la Santé mentale
Paul Arteel, Vlaamse Vereniging Geestelijke Gezondheid (VVGG)
Guy Peeters, Union nationale des mutualités socialistes
Hermann Janssens, Union nationale des /Mutualités Chrétiennes
Geert Messiaen and Sandrine Vandermaesbrugge, Union nationale des mutualités libres
Marc Hollevoet, Union nationale des mutualités neutres
Françoise Delchevalerie, Pasifou
Mr. Bienkonski, Psytoyens
Rafaël Daem, Uilenspiegel

France: none

Germany:
the German Network for Workplace Health Promotion (WHP)
the Federal Association of Company Health Insurance Funds (BKK)
the German Federation of Institutions for Statutory Accident Insurance and Prevention (HVBG)

Italy:
Dr Giuseppe Dell’Acqua, Director, Department of Mental Health
Azienda Triestina per i Servizi Sanitari Professor Pierluigi Morosini,
Laboratori di Epidemiology and Biostatistics, Istituto Superiore di Sanità
Dr Renato Piccione, PreSaM Ms Ughetta Radice
Fossati Orlando, Chairperson of the Executive Board, Progetto Itaca
Dr Elvira Reale, Head, Centro Studi Ricerca e Formazione “Prevenzione salute mentale donna”Azienda sanitaria Locale Napoli
Professor Tullio Seppilli, President, Fondazione Angelo Celli
Dr Renzo De Stefani, Director, Department of Psychiatry, Azienda Provinciale per i Servizi Sanitari, Provincia Autonoma di Trento

Spain:
Miquel Casas, Psychiatric Unit of the Vall d’Hebron Hospital
Joan Colom, Substance Abuse Program, Health Department
Pilar Duro, Substance Abuse Program, Health Department Jose Garcia,
Institut Pere Mata Antoni Gual, Alcohol Unit of the Hospital Clinic
Lluís Lalucat, CSMA Les Corts
Cristina Molina, Mental Health Program, Health Department
Josep Ramos, Mental Health Services of the Sant Joan de Deu Hospital
Mercè Saperas, CASD Mollet
Lídia Segura, Substance Abuse Program, Health Department Professional workforce
✓ The Netherlands:
Ernst Bohlmeijer, Trimbos-instituut (Netherlands Institute for Mental Health and Addiction)
Jan Bouwens, Netherlands Institute for Health Promotion and Disease Prevention (NIGZ)
Frans Clabbers, Ministry of Health, Welfare and Sport
Milou Leunissen, Radboud University of Nijmegen
Katrien de Ponti, Dutch Mental Health Association (GGZ Nederland)
Bert Prinsen, Netherlands Institute for Care and Welfare (NIZW)
Jeroen Zonneveld, Dutch Federation of Health Education and Prevention (NVPG)
Annex 11: The Voice of Families and Patients: Interview to Ms Marfull (WP5)

Manager of the Federación de Asociaciones de familiares y personas con problemas de salud mental de Cataluña FECAFAMM [Associations federation of family members and persons with mental health problems in Catalonia].
Date: January 29th 2007.
Place: FECAFAMM, Barcelona.

General objectives (the same ones of the focus group)

1. To evaluate the utility of epidemiological data about mental disorders for planning and managing sanitary services.
2. To evaluate the dissemination of the results of epidemiological studies about mental disorders to patients and their families.

1. Background of the interviewee.

FECAFAMM was born on 1996 and, currently, it is made up of 42 federated associations representing a total of 4,000 families with mental health problems in the Autonomous Community of Catalonia.

FECAFAMM provides instruments for improving knowledge and autonomy of patients with mental health problems, promotes services to improve autonomy of patients with mental health problems, and promotes social understanding of problems affecting patients and families with mental health problems.

A detailed description of FECAFAMM could be consulted at: http://www.familiaresmalaltsmentals.org

2. Knowledge about the ESEMeD study and other epidemiological studies carried out in Spain. The interviewee knew the ESEMeD study through personal communications with one of the Spanish researchers (Josep Maria Haro).

3. Dissemination of the results of epidemiological studies about mental health carried out in Spain to patients and families.

The dissemination of the results of epidemiological studies about mental health in Spain is to patients and their families is null. The interviewee suggested that patients and families believe that no research is carried out regarding their
mental health problems. Patients know that there is specific health care for mental health problems, that there are policies for mental health care but they believe that no one investigate about their problems.

Information from epidemiological studies does not reach patients and families. The health care system provides very limited space for informing patients and their families. There are no instances for common thinking.

FECAFAMM promotes social mobilisation (with mental health agents such as families, users, and council), through meetings in health advisory boards promoted by the local council, to work on mental health topics. It also promotes training for families, coordinates and supervises self-help groups, and provides supervision for mental health professionals that give mental health care to patients. They also support families by direct attention to their complaints.

For patients and families, mental health centres are the main source of information about mental health problems. If there are needs regarding specific topics, FECAFAMM contacts with a professional from a mental health centre asking for a conference about the topic needed.

In the opinion of the interviewee, there are no formal ways to disseminate information about mental health epidemiology to patients and families. It was suggested, as ways of disseminating it, to schedule seminars, to produce simple and brief publications, to produce leaflets, and to create a call centre for patients. A key-place for distributing this information could be mental health centres.

It could also be useful to prepare dissemination material (in a very brief and simple language) for delivering to presidents of patients and families associations.

4. The information that is useful to create/modify policies/programs in mental health.

Compared to patients and families not informed, those informed about their mental health problems could collaborate with the health system. Informed patients and families could make pressure on policy makers.
Annex 12: Educational Workshops (WP6)

Three educational workshops were carried out as part of the training program:

1st EPREMED Workshop:
Coding and contrasts in linear and non-linear models
21.- 23. 11. 2005 in Barcelona

<table>
<thead>
<tr>
<th>First EPREMED workshop about statistical methods</th>
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<tbody>
<tr>
<td><strong>Title:</strong> Coding and contrasts in linear and non-linear models, Barcelona</td>
</tr>
<tr>
<td><strong>Time:</strong> Monday, 21st - Wednesday, 23rd November 2005</td>
</tr>
<tr>
<td><strong>Place:</strong> INM, Barcelona, Spain</td>
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<tr>
<td><strong>Programme:</strong> The workshop is addressed to all people who have basic knowledge in regression models. We assume that everyone who has understood the very basic principles of regression models will be able to follow the workshop and will benefit. Coding systems are basic requirements for most analyses we will do while comparing our six country data. Therefore, we assume that this topic is of interest for almost all members of the EPREMED project who will analyse data. In the morning sessions of the workshop we will provide you with the theoretical knowledge of coding systems and in the afternoon there will be training sessions on the computer.</td>
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<tr>
<td><strong>Documentation:</strong> Textbook: &quot;Coding of contrast and interactions in non-experimental research&quot;</td>
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</table>

Brief description of the workshop

The aim of this workshop is to systematically demonstrate and empirically evaluate the main different types of coding systems for contrasts in linear regression models and non-linear probability models. Coding systems are employed to model the outcome differences between the categories or combination of categories of one or more predictors, and their possible interactions with other categorical and/or continuous predictors. The focus will be on applicability and interpretation of the parameters. Post hoc testing and the graphical display of predicted values will be extensively discussed.

After a short introduction to the linear (fixed) model, the problem of categorical predictors and interaction terms, the following contrasts will be discussed:
7. simple coding / dummy coding
8. effect coding
9. Forward and backward difference coding
10. Helmert and reverse Helmert coding
11. Orthogonal polynomial coding
12. User defined coding (problems of orthogonality)

For point 1-5 of these schemes partial interaction coding and the necessary interactions contrasts will be discussed.

For non-linear probability models like, for instance, logit models, a straightforward interpretation of the probability change with respect to a particular contrast unfortunately does not exist. The problems of interpreting contrasts and interaction of contrasts with respect to both the logit and the probability change will be worked out. Emphasis will be placed on the theoretical justification of base-values for which the probability change and components of change should be estimated.

For all the analyses, software tools for the STATA system will be provided and how the contrasts can be defined “manually”. In addition to the UCLA Webbooks (http://www.ats.ucla.edu/stat) on Regression with STATA (SAS or SPSS) we recommend the following books:

Multiple Regression: Testing and Interpreting Interaction Effects.

Regression Models for Categorical Dependent Variable Using Stata. (2 ed.).
College Station ,TX.
**2nd EPREMED Workshop:**

**Introductory Course to the Economic Evaluation of Health Care**

Leipzig, 9 – 10 October 2006

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**Preliminary program**

**Day one**

09:00   **Introduction to economic evaluation**
        Types of economic evaluation, cost analysis

10:30   **Coffee break**

11:00   **Introduction to economic evaluation**
        Exercise

12:30   **Lunch break**

13:30   **Analysis of health outcomes**
        Quality of life, utilities, QALYs

15:00   **Coffee break**

15:30   **Analysis of health outcomes**
        Exercise

17:00   **End of day 1**
19:00 Dinner

**Day two**

09:00 Decision analysis and modelling
   Decision trees, Markov models

10:30 Coffee break

11:00 Decision analysis and modelling
   Exercise

12:30 Lunch break

13:30 Presenting results of economic evaluation
   Uncertainty analysis, cost-effectiveness acceptability curves, net-benefit approach

15:00 Coffee break

15:30 Presenting results of economic evaluation
   Exercise

17:00 Course ends
# 3rd EPREMED Workshop

## Health related Quality of life measures in the ESEMeD dataset

**Barcelona, 6 – 7 November 2007**

### Preliminary Programme

<table>
<thead>
<tr>
<th>Time</th>
<th>Tuesday, November 6&lt;sup&gt;th&lt;/sup&gt;</th>
<th>Wednesday, November 7&lt;sup&gt;th&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 – 10:45</td>
<td>Presentation Introduction to the workshop and Concepts of HRQL in mental health research</td>
<td>Presentation Introduction to cross-national assessment with the EQ-5D</td>
</tr>
<tr>
<td>10:45 – 11:30</td>
<td>Presentation SF-12 – Introduction to the scale</td>
<td>10:30 – 11:00 Coffee break</td>
</tr>
<tr>
<td>11:45 – 12:15</td>
<td>Coffee break</td>
<td>11:00 -12:30 Exercise</td>
</tr>
<tr>
<td>13:30 – 14:30</td>
<td>Lunch break</td>
<td>13:30 – 15:00 Presentation</td>
</tr>
<tr>
<td>14:30 – 16:00</td>
<td>Presentation Measurement of change with the SF-12</td>
<td>15:00 – 15:30 Coffee break</td>
</tr>
<tr>
<td>16:00 – 16:30</td>
<td>Coffee break</td>
<td>15:30 – 17:00 Exercise</td>
</tr>
<tr>
<td>16:30 – 18:00</td>
<td>Exercise Measurement of change</td>
<td>End of workshop</td>
</tr>
</tbody>
</table>

### Brief Outline

The course will give an overview of different methods in the measurement of health related quality of life (HRQL) as it is measured in the ESEMeD dataset (EQ-5D and SF-12). The workshop will inform the attendees about strengths and limitations of the instruments presented.

The course will start with a brief introduction to the topics of the workshop and a presentation on the concepts of HRQL in mental health research. This introductory session will be followed by an exercise session, where examples of the presented methods will be applied to available datasets. In the afternoon an exercise on measurement of change using SF-12 in a longitudinal survey will be given. The second day will start with a presentation and an exercise about cross-national assessment of HRQL using different valuation methods. The second day ends with a presentation and an exercise about different types of item bias that might occur applying the EQ-5D in different countries. Two types of item bias will be investigated: 1. Characteristic of the responder: six countries. 2. Characteristic of the item position in the questionnaire. Item bias is analysed employing 1- and 2-parameter Item Response Theory models.

**Note:** All attendees are kindly asked to bring their own laptop computers to the workshop since we are planning to do some computer exercises. MS Excel or Calc (open office) should be installed on these computers.
Annex 13: EPREMED Website Description (WP 6)

http://www.epremed.org

1) A sample of the EPREMED public webpage is here presented:

Project Presentation:

Our homepage

Welcome to the website of the EPREMED study group (European Policy Information Research for Mental Disorders).

These pages include information on the current work of the group, the involved partners, results of already published scientific papers and information on the aim and structure of the project.

Although the importance of mental health as a major source of diseases is increasingly recognized in the world, information on the distribution of mental disorders, their determinants and their social and economic consequences, and the possibilities to prevent them are still limited in Europe. Consequently, mental health policy information research is insufficiently based on the most accurate and up-to-date scientific evidence.

The aim of this project is to improve the understanding of mental health burden, determinants, services, needs, as well as to increase and improve the practices and potential of mental health policy information research in Europe.

We would like to invite you to explore our website and get yourself informed about mental disorders and the work of the EPREMED study group.

If you have any feedback or comments, send us an e-mail at epremed@intm.es

World Health Report, 2001
World Health Organization

Methods and Instruments
Official Documentation

EPREMED Results by Topic:

Prevalence Of Mental Disorders

Mental disorders are frequent in European countries. The lifetime prevalence of any mental disorder in the 6 ESEMEd countries was 35.9%, 14.7% reported a lifetime history of any mood disorder, 14.5% any anxiety disorder and 4.9% a lifetime history of any alcohol disorder. In the last 12 months, the prevalence of any mental disorder was 11.5%, 4.5% reported any mood disorder, 8.4% any anxiety disorder and 9.7% any alcohol disorder. Major depression and specific phobias were the most common single mental disorders. Mental disorders were more common in females, unemployed, disabled persons, or persons who were never married or previously married. Younger persons were also more likely to have mental disorders, indicating an early age of onset for mood, anxiety and alcohol disorders.

Some differences in rates exist between participating countries. Out of the 6 countries, France had the highest prevalences (e.g. 12-month prevalences of any mental disorder 18.3%, any mood disorder 6.5%, any anxiety 13.1%) and Italy the lowest figures (e.g. 12-month prevalences of any mental disorder 9.4%, any mood disorder 3.4%, any anxiety 6.0%).

Used for this summary:

Use of services and Treatment

Although mental disorders are frequent in the ESEMeD countries, the rate of people who consult a medical professional for their mental health problems is considerably low. Among those who had a 12-month mood disorder, only between 35.0% in Italy and a 60.03% reported having consulted a general medical professional due to problems with emotions or mental health. Among users of services, general medical professionals were the most frequently consulted in all countries (86.36% on average), while the use of a mental health specialist ranged from 30.4% in France to 52.2% in Spain.

In all countries, a consistent pattern of consultation was found with the highest lifetime rates being observed for respondents with mood disorders and the lowest for those without any mental disorder. The presence of comorbid disorders was associated with increased consultation rates. In contrast, consultation rates for those with alcohol-related disorders were relatively low compared to those found for the other disorders.

Despite similar patterns of consultation, the overall use of health care varies considerably in the different ESEMeD countries. Up to now, no simple relationship between health care system characteristics and the use of services can explain these differences. It seems that a complex model of health care system variables (e.g., financing, referral system) moderates the use of services within and between countries.

EPREMED Results by Country

ESEMeD Countries

Information specific to some ESEMeD countries mental health will be obtained by following the links embedded in the clickable map of Europe or the links below. Information for the ESEMeD countries that is currently lacking will be incorporated soon.

This section is currently being designed and it’s only partially functional. Building on the ESEMeD Study results and previous research, a synthesis of the overall ESEMeD results and a snapshot of the mental health of the studied European countries mental health status are provided.
2) A sample of the EPREMED private webpage is here presented: