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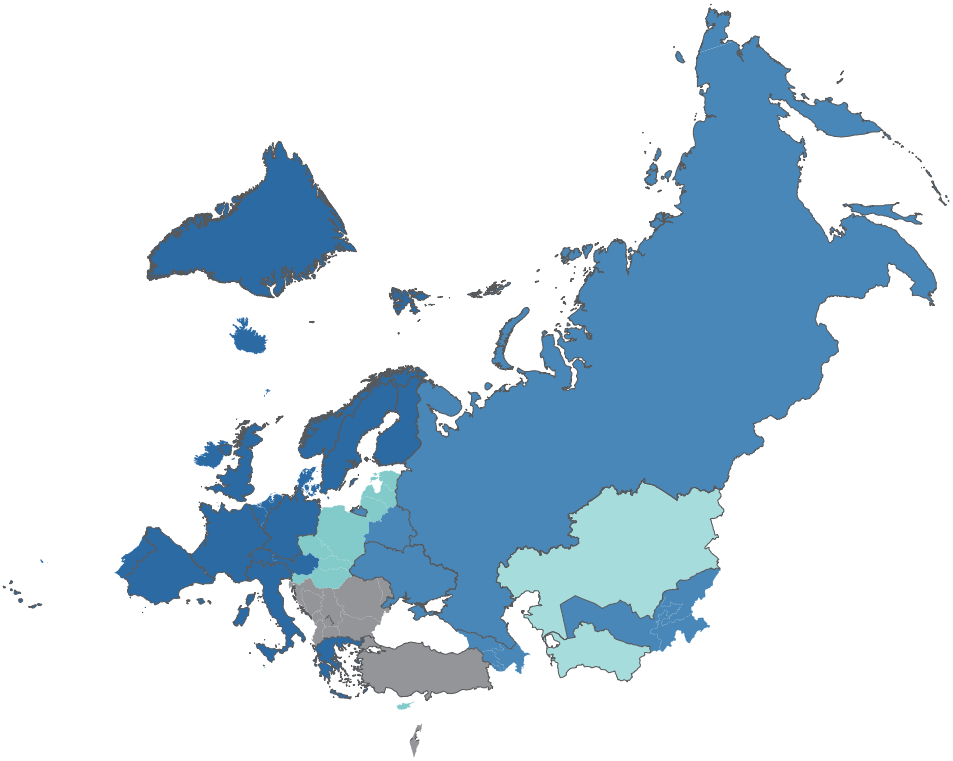

Monitoring mental health systems and services in the WHO European Region:

Mental Health Atlas, 2017

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Abstract

A stated objective of WHO's European Mental Health Action Plan 2013–2020 is to ensure better information and knowledge for service planning, development, monitoring and evaluation, including requesting Member States to report on the indicators in the Plan.

Progress towards achieving the internationally agreed mental health objectives and targets is monitored in the periodic WHO Mental Health Atlas, which collates global information on mental health policies, resources and services.

This booklet provides a snapshot of the situation in countries in the WHO European region with regard to a number of core mental health targets and indicators, derived from the WHO's Mental Health Atlas 2017.

Keywords

MENTAL HEALTH,
MENTAL HEALTH ATLAS,
WHO,
WHO EUROPEAN REGION

Contents

Acknowledgements

This publication is part of WHO's Mental Health Atlas 2017, which can be found at https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/.

Dan Chisholm, Programme Manager for Mental Health at the Regional Office for Europe, was responsible for overall coordination and preparation of the brochure. We thank the WHO interns Maike Kristin Lieser and Janika Mette.

Key findings

Reporting on mental health indicators

48 of 53 Member States in the WHO European Region submitted responses to the Mental Health Atlas questionnaire in 2017, representing a response rate of 90%. The data provided for different items varied; the rates of responses about the mental health workforce, hospital admissions and mental health training for non-specialists were notably low.

Mental health governance

Almost all countries have a mental health policy or strategy, but a considerably lower percentage are currently in line with human rights instruments (two-thirds of responding countries, against a global target of 80% by 2020).

For mental health legislation, almost all countries have a stand-alone or integrated mental health law, of which 65% were reported to comply with human rights instruments. As the global target for compliance is 50%, it is exceeded in the European Region.

Intersectoral collaboration and the involvement of key stakeholders, including service users and their families, is an indicator of good governance. 30 countries in the European Region reported some collaboration with advocacy groups of service users, families or caregivers, but only 18 fulfilled at least two of the criteria for strong collaboration (a formal agreement, dedicated funding and regular meetings).

Mental health resources

On average, governments in the WHO European Region spent US$ 22 per head of population on mental health services in 2016; however, this masks enormous variation among countries and sub-regions. For example, Newly Independent States (NIS) spent < US$ 1, while countries that joined the European Union (EU) before 2004 spent nearly US$ 200. 69% of overall spending was for government mental hospitals, to the detriment of community-based mental health service provision.

The mental health workforce in the European Region consists mostly of nurses and psychiatrists; other professions – including psychologists, occupational therapists and social workers – are underrepresented. Resources for child and adolescent mental health are in short supply. Again, the workforce varies among country groupings, from 20 workers per 100 000 population in the NIS to 156 in the EU before 2004.

Mental health services

Mental hospitals – many of them very large institutions – continue to provide most inpatient services, especially in central and eastern Europe and in central Asian countries. Large disparities exist among countries in terms of access to outpatient services, ranging from 70 000 population per facility in the EU (after 2004) countries to 2 million in countries in south-east Europe.

Progress towards the targets of the comprehensive Mental Health Action Plan

The ***Mental Health Action Plan*** includes four objectives, which are each operationalized by targets, which provide an opportunity to measure progress made by Member States to achieving the objectives by 2020.

Target 1.1

80% of countries will have developed or updated **policies** or **plans** for mental health that are in line with international and regional **human rights instruments**.

European Region, 2017: **66%**

Target 1.2

50% of countries will have developed or updated their **laws** for mental health in line with international and regional **human rights** instruments.

European Region, 2017: **65%**

Target 2

Service coverage for severe mental disorders will have increased by 20%.

European Region, 2017: **could not be calculated because of incomplete data**

Target 3.1

80% of countries will have at least two functioning national, multisectoral **promotion and prevention programmes** in mental health.

European Region, 2017: **78%**

Target 3.2

The rate of suicide in countries will be reduced by 10%.

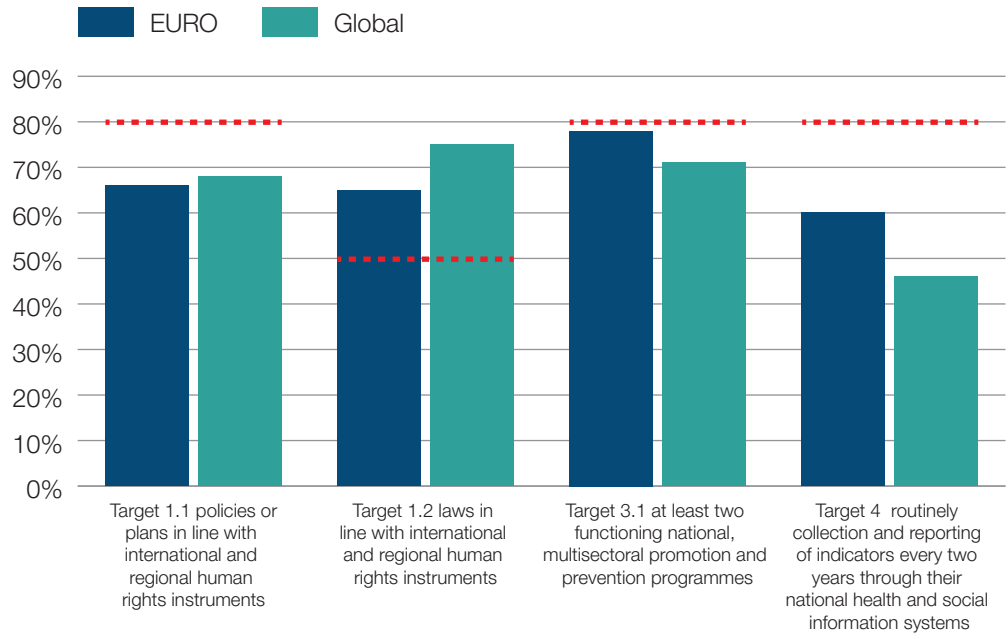
European Region, 2017: The age-standardized rate of suicide was 12.9 in 2016 (11.9 in 2015).

Target 4

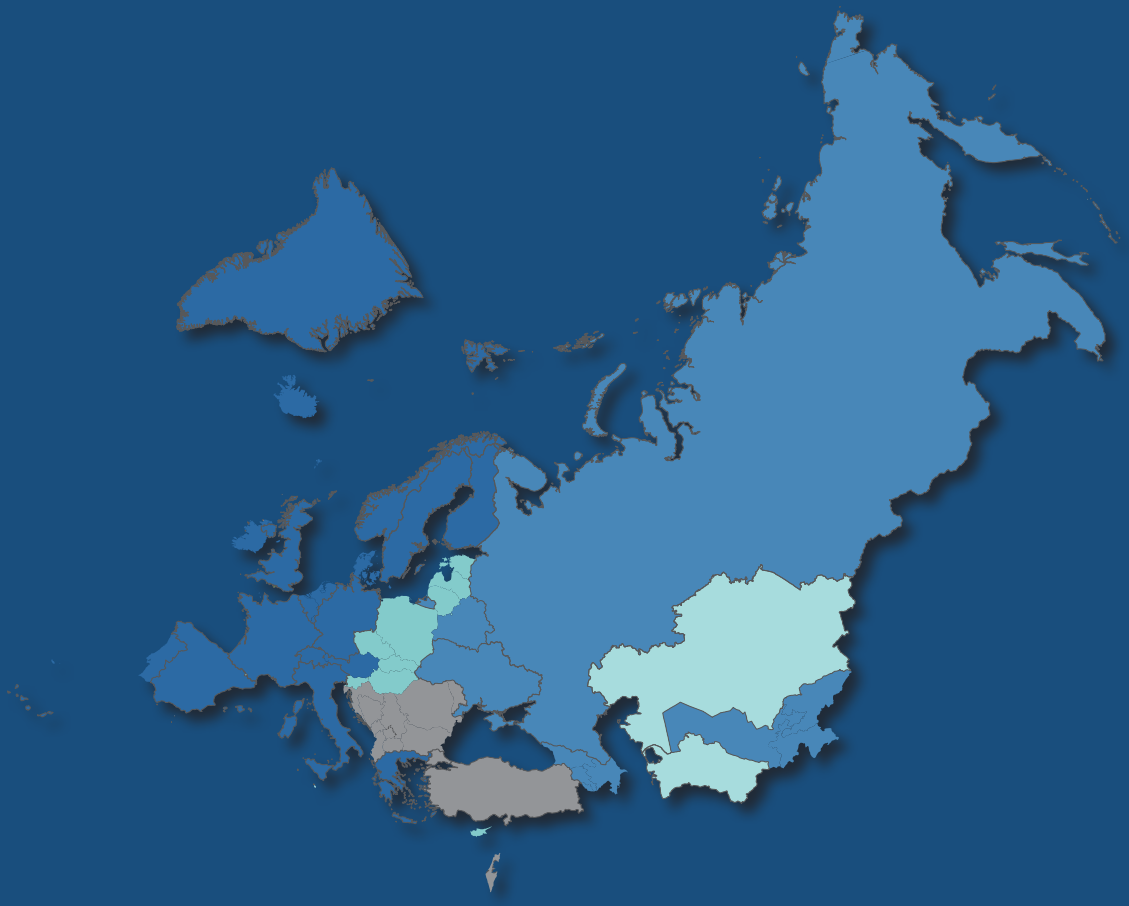
80% of countries will be **routinely collecting** and reporting at least a core set of mental health **indicators** every 2 years through their national health and social information systems.

European Region, 2017: **60%**

Fig. 1. Global and European progress towards mental health action plan targets



The red dotted lines refer to the global target levels



1. Introduction

In countries in the WHO European Region, mental disorders are the single largest contributor to the non-fatal disease burden (22.4% of years lived with disability) and the third largest contributor to the overall disease burden (8.7% of disability-adjusted life years) *(1)*. Both the *European Mental Health Action Plan 2013–2020 (2)* and the *Comprehensive Mental Health Action Plan 2013–2020 (3)* seek to reduce this large, growing burden of mental disorders by increasing the financing and delivery of evidence-based care while enhancing mental well-being and ensuring the protection of human rights of people with mental disorders and psychosocial disability. The vision and objectives of the *European Mental Health Action Plan* are fully aligned with the European policy framework for health and well-being, Health 2020 *(4)* and consistent with the guiding principles and vision of the Sustainable Development Goals (including the target "to promote mental health and well-being") *(5)*.

A stated objective of the *European Mental Health Action Plan 2013–2020* is to provide better information and knowledge for service planning, development, monitoring and evaluation. This includes requesting Member States to complete a questionnaire on the indicators of the *Comprehensive Mental Health Action Plan 2013–2020*. This booklet provides a snapshot of the situation of countries in the Region in relation to a number of core mental health targets and indicators, based on results of the survey for the *WHO Mental Health Atlas* in 2017 *(6)*. Progress in relation to four of the six global targets is provided here, based on data from the Mental Health Atlas 2017. Data on the other two global targets – service coverage for severe mental disorders and reduction of the suicide rate by 10% – are being generated in other surveys. The *European Mental Health Action Plan 2013–2020* does not include specific targets or indicators, but progress towards its objectives is described here if it is covered by the *Atlas* survey.

2. Methods

The *Mental Health Atlas* survey carried out in countries in the WHO European Region is part of a global effort to collect and report on mental health policies, resources and services. Further details of the development, testing and dissemination of the questionnaire, submission and data clarification and cleaning procedures can be found in the *Mental Health Atlas* 2017 *(6)*.

National data are summarized in country profiles, which are available at: https://www.who.int/mental_health/evidence/atlas/profiles-2017/en/. For this booklet, country data were aggregated and reported within four country groupings (Annex 1), in order to assess intra-regional variations. The four sub-regions are:

- the Newly Independent States (NIS) of the former Soviet Union, including Georgia as a former member and Ukraine as an associated state; these countries cover a large part of Central Asia and eastern Europe;
- countries forming the South-eastern Europe (SEE) Health Network, plus Turkey for the purposes of this booklet;
- countries that joined the EU after 2004, covering large parts of central and eastern Europe, which are not a part of the NIS or SEE; and
- countries that joined the European Union before 2004, plus Iceland, Monaco, Norway and Switzerland, representing most of western Europe, which are not a part of the NIS or SEE.

Frequency distributions and measures of central tendency (e.g. means, medians) were calculated as appropriate for these country groupings. Rates per 100 000 population were calculated for a range of data points on the basis of the official United nations population estimates for 2015 and the World Bank International Comparison Program database for gross national income in 2016 *(7)*.
When data were available and comparable, links were made to the Mental Health Atlas 2014 survey in order to identify patterns of change over time.

3. Results

3.1 Reporting on mental health indicators

Global Mental Health Action Plan target 4:

80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every 2 years through their national health and social information systems.

2014: **49%** 2017: **60%**

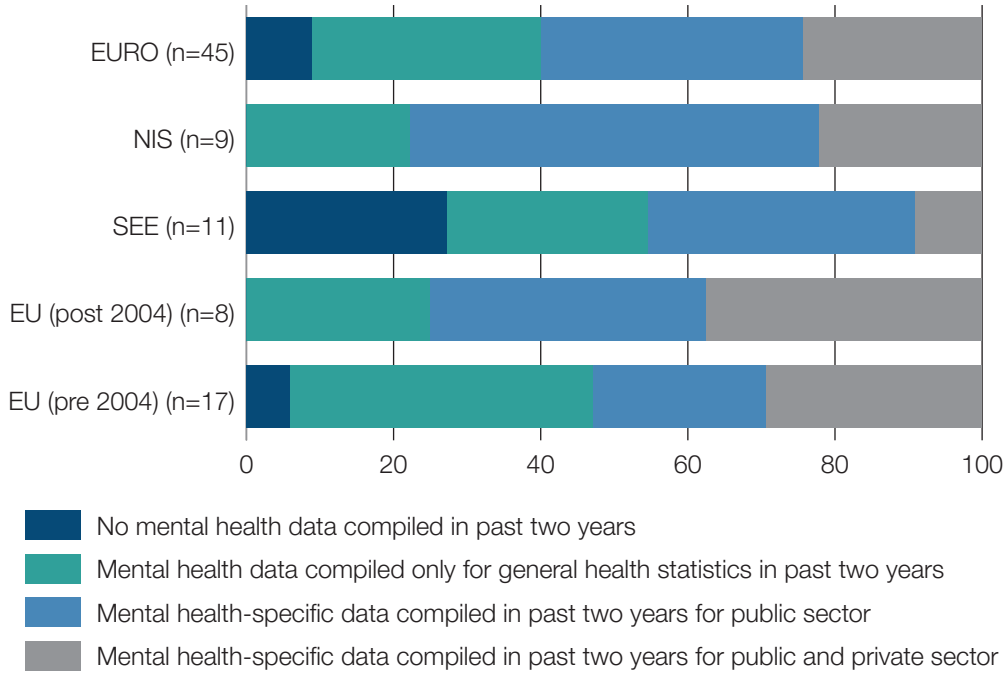
European Mental Health Action Plan objective 7: Mental health governance and delivery are driven by good information and knowledge.

- 48 of 53 Member States in the European Region (90%) submitted at least a partially completed questionnaire; the combined population of responding countries represented 97% of the population of the WHO European Region.
- To assess the ability of countries to report on a defined set of mental health indicators, a score was designed, with the following indicators: (i) stand-alone mental health law (yes or no), (ii) stand-alone mental health legislation (yes or no), (iii) multisectoral collaboration (data on at least one collaboration), (iv) mental health financing (data on at least one type of treatment coverage or government health expenditure), (v) mental health workforce (data on at least for some types of worker, (vi) outpatient care, (vii) inpatient care, (viii) uptake of services (data on at least one outpatient or inpatient patient group) and (ix)) promotion and prevention (data on at least one programme).

Only one third of countries could provide data for all items; however, nearly all (96%) provided responses for at least seven items. Reporting rates were notably lower on the mental health workforce (81%) and on service uptake (50%), indicating difficulty in obtaining aggregated national estimates for these variables from service providers or sectors.

- 4 countries (9%) stated that no mental health data had been compiled in a report for policy, planning or management purposes in the past 2 years; however, 78 % of NIS countries reported having compiled and reported data in the past 2 years, coming closest to global target 4.
- Overall, 60% of Member States in the Region compiled specific data on mental health in the public and/or private sector in the past 2 years, representing appreciable improvement over the rate of 47% in 2014.

Fig. 2. Availability and reporting of data on mental health, by country grouping



Values in parentheses are the numbers of countries that reported on this indicator

3.2 Mental health policy and legislation

Global Mental Health Action Plan target 1.1:

80% of countries will have developed or updated their policies or plans for mental health in line with international and regional human rights instruments

2014: **74%** 2017: **66%**

3.2.1 Mental health policies and strategies

- **Four of five** of all responding countries stated that they have a stand-alone mental health policy or plan. With the countries that have policies and plans for mental health integrated into those for general health and disability, 94% of all countries have a mental health policy or plan.
- **Two thirds** of responding countries stated that their policy complies fully with international human rights instruments (by endorsing all five items on a self-rated human rights checklist constructed for this purpose).
- 38% of responding countries in the EU (post-2004) reached this criterion, but two thirds complied with four of five items. Furthermore, two of three of these countries had updated their policy or plan within the past 5 years.
- In the survey performed in 2014, 74% of the 47 responding countries endorsed all

checklist items. The European Region is therefore stepping back on its way to the global target of 2020.

- A mental health plan or strategy for children and adolescents was available in 60% of countries; most (82%) had developed or updated such plans in the past 5 years.
- There is now a national suicide prevention strategy in 26 countries in the WHO European Region (54%), which represents a significant advance on 2014, when only 16 countries reported having such a strategy. 19 of the 26 countries reported having developed or updated their national suicide prevention strategy since 2013.

Nevertheless, the WHO European Region has the second highest rate of suicide globally (12.9 per 100 000 population in 2016), making reaching the global target of a 10% reduction a pressing priority.

Status of suicide prevention

Comprehensive Mental health Action Plan
target 3.2: **–10%** suicide rate by 2020
Suicide rate in 2016: **12.9**/100 000 population
National suicide prevention strategy: **54.2% = 26** countries; 62% increase over 2014
Suicide prevention strategy updated since 2013: **76% = 19** countries

Fig. 3. Existence of mental health policies or plans and compliance with human rights instruments

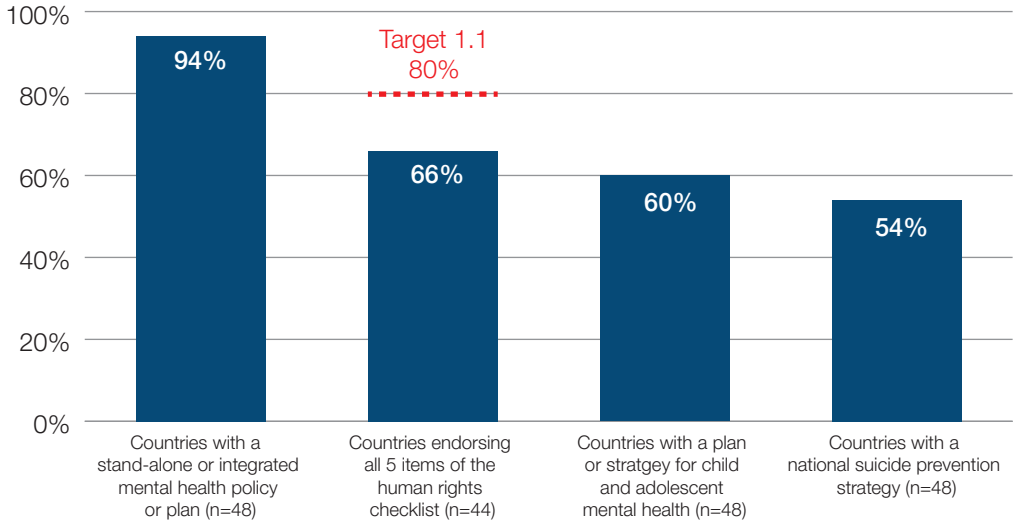
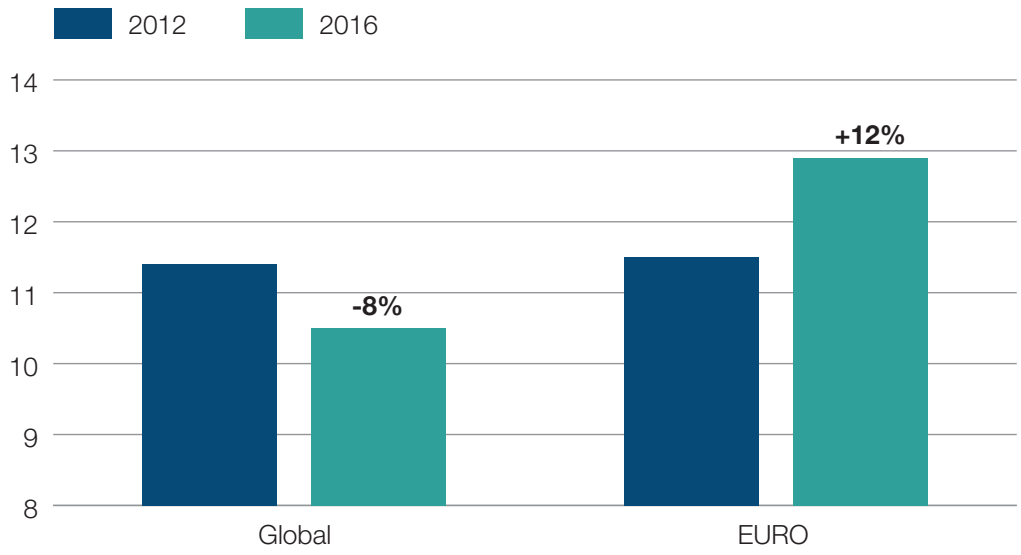


Fig. 4. Trends in age-standardized suicide rate per 100 000 population



Global Mental Health Action Plan target 1.2:

50% of countries will have developed or updated their laws for mental health in line with international and regional human rights instruments.

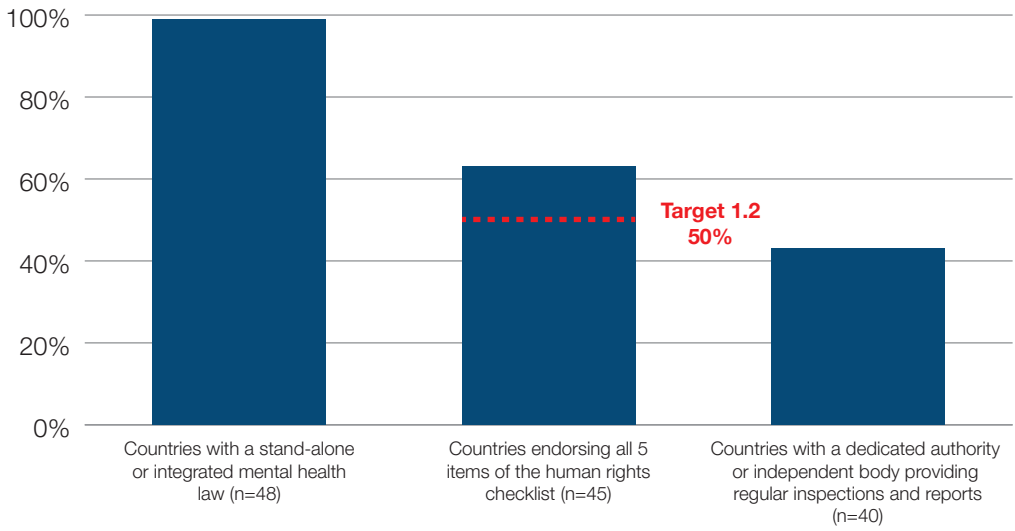
2014: **54%** 2017: **65%**

European Mental Health Action Plan objective 2: People with mental health problems are citizens whose human rights are fully valued, respected and promoted.

3.2.2 Mental health legislation

- 78% of all responding countries have a stand-alone mental health law, an increase of 7% in comparison with 2014. 47 of 48 countries have either a stand-alone law or a legislation on mental health that is integrated into general health or disability law.
- In approximately half of these countries (45%), the law is enforced by a dedicated authority or independent body, which provides regular inspections of mental health facilities and reports at least annually to stakeholders. In some sub-regions, the proportion is considerably lower: for example, only 22% of SEE countries have such an authority.

Fig. 5. Existence of mental health legislation, its compliance with human rights instruments and enforcement



3.3 Resources for mental health

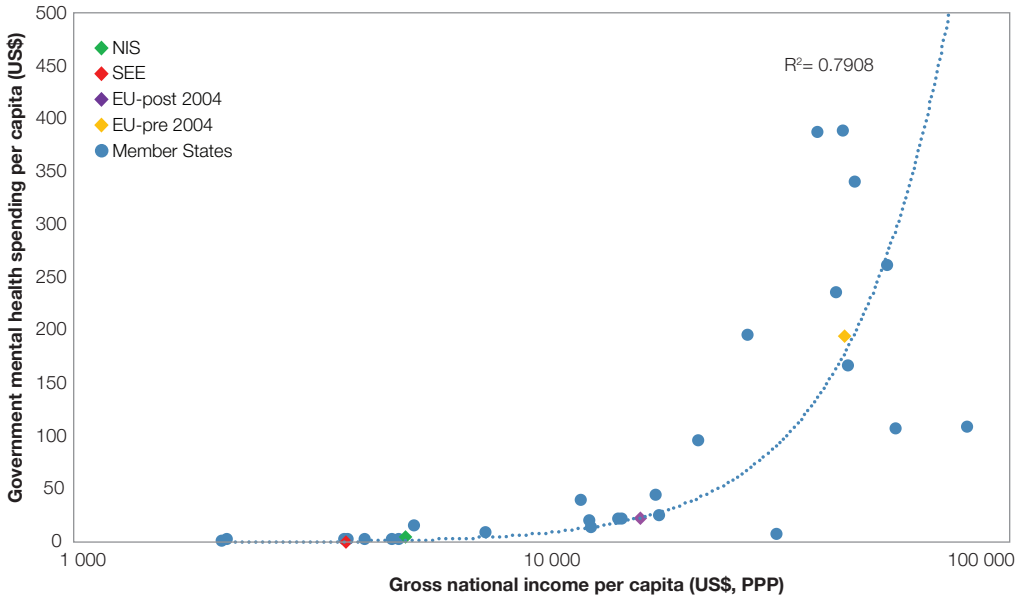
Global Mental Health Action Plan objective 2: To provide comprehensive, integrated, responsive mental health and social care services in communities.

European Mental Health Action Plan objective 3: Mental health services are accessible, competent, affordable and available in the community according to need.

3.3.1 Government spending on mental health

- On average, US$ 22 per capita were spent by governments on mental health programmes and services in 2016; however, this masks wide variation in expenditure, even at the level of the European sub-region. The range of median spending by country grouping extends from < US$ 1 in NIS countries to nearly US$ 200 in the EU (pre-2004).
- This absolute level of spending corresponds to a self-reported value of 4% of total health expenditure on mental health (range: 2.7% [NIS] to 5.7% [EU, pre-2004]). As a proportion of overall health expenditure by governments in the WHO European Region according to the WHO Global Health Expenditure database (8), the reported figures amount to just 1%.
- A large proportion of the reported spending (69%) was for government mental hospitals. In NIS countries, 90% of reported mental health expenditure was allocated to these institutions. This illustrates a large challenge for the European Region in moving towards community-based services.

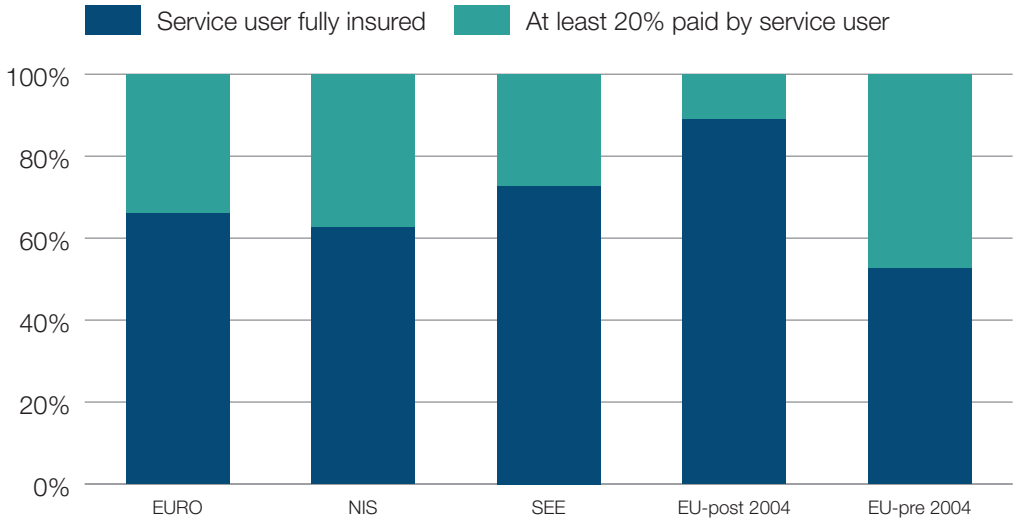
Fig. 6. Association between mental health expenditure per capita and gross national income (n=27), quadratic regression



3.3.2 Payment for care

- Access to the best possible treatment also depends on its cost. In the European Region, no country reported on whether payment for service use or psychotropic medicines is made entirely out of patients' pockets. 92% of people are fully insured, which in principle means that they pay nothing at points of service.
- The proportion of people who have to pay at least 20% for psychotropic medicines varies. In the EU (pre-2004), 47.4% of people in need of medication contributed financially to obtain them. In contrast, in EU (post-2004) countries, 11.1% did so.
- This indicates a gap in the financial protection of patients with mental disorders who are prescribed medication.

Fig. 7. Source of payment for psychotropic medicines, by country grouping

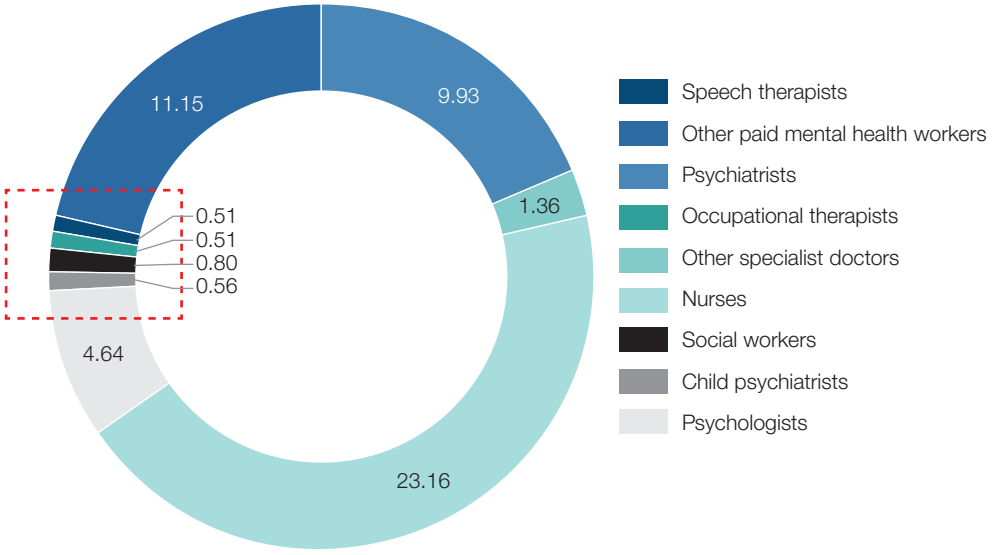


3.3.3 Mental health workforce

European Mental Health Action Plan objective 7. Staff numbers, distribution and their causes are known.

- Only half the countries could provide a detailed breakdown of the numbers of mental health workers. Despite the importance of this information for assuring the quality and effectiveness of mental health services, no clear statement can be made about staff distribution and development in the European Region.
- The absolute number of workers per 100 000 patients varied enormously, from a median of 20 (NIS) to 156 (EU (pre-2004)). For example, the range was 3.8 (NIS) to 20 (EU pre-2004) for psychiatrists and 1.2 (NIS) to over 50 (EU pre-2004) for psychologists.
- Nurses comprise the largest group of mental health workers, accounting for almost half of the total workforce (45%). In contrast, child psychiatrists, social workers, occupational therapists and speech therapists together account for less than 2.5%.
- 7 of 10 workers in government mental health services work in mental hospitals, again highlighting the lack of community-based services.
- In comparison with 2014, the reported numbers of psychiatrists (–1%) and nurses (–13%) per 100 000 population decreased in the European Region.

Fig. 8. Distribution of the mental health workforce (n=25) (median values per 100 000 population)



3.3.4 Collaboration with service users, families and caregiver advocacy groups

European Mental Health Action Plan Objective 4: International cooperation is established between governments and professional stakeholders to benchmark training, competencies and standards of care.

Objective 6: The expertise of service users and family members is used to allocate resources for their care.

- 30 countries in the European Region reported collaboration with service users and family or caregiver advocacy groups. Of those, 18 countries collaborate more strongly as they fulfil two of the following criteria: (i) formal agreement or joint plan, (ii) dedicated funding and (iii) regular meetings at least once a year.
- A high proportion of countries with strong collaboration is seen especially in the EU (pre-2004) (10 of 14 responding countries).

3.4 Mental health services

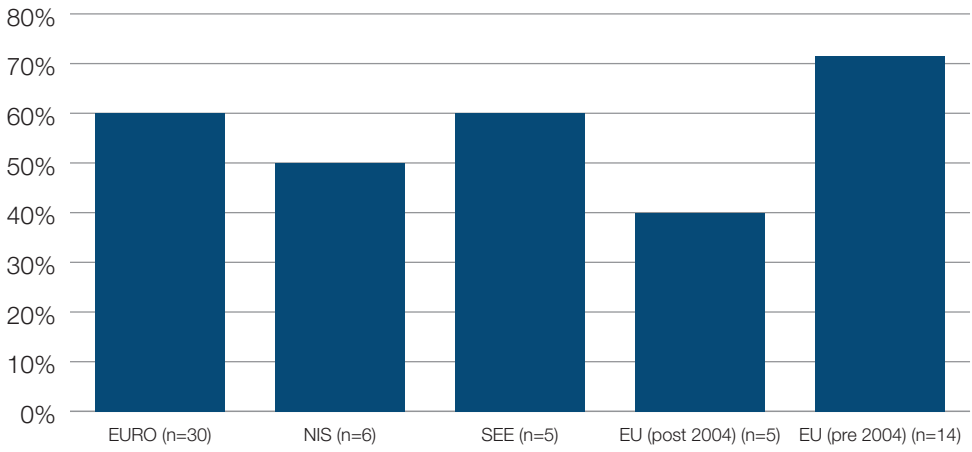
The most cost-effective treatment of mental disorders is delivered through a mix of services, with a high proportion of community-based, non-specialized services and a smaller proportion of specialist services for severe cases. The comprehensive availability of these services is measured by the numbers of facilities and beds. This in turn determines its effective utilization in terms of admissions and length of stay in inpatient facilities and of visits to outpatient facilities.

- Primary health care is the first point of access to mental health services in many jurisdictions. Its capacity can be built up by training staff in this sector. Countries were asked to describe training in mental health care for general health care staff. As 74% of countries did not provide any data on this question, no further analysis was possible.

3.4.1 Inpatient care

- In all types of inpatient facility – mental hospitals, psychiatric units in general

Fig. 9. Formal collaborations with service users and family or caregiver advocacy groups, by country grouping



hospitals, forensic inpatient units, mental health community residential facilities and mental health inpatient services specifically for children and adolescents – 93 beds are available per 100 000 population.

- Mental hospitals in SEE countries are nearly twice the size of those in the EU (pre-2004), as indicated by the median number of beds (SEE: 300; EU (pre-2004): 166).
- EU (pre-2004) countries have the fewest beds in mental hospitals (28 beds per 100 000 population), whereas EU (post-2004) countries reported the highest rate (40 beds per 100 000 population). EU (pre-2004) countries, however, had the most beds in psychiatric units in general hospitals (22 beds per 100 000 population) and mental health community residential facilities (60 beds per 100 000 population).
- These figures reflect changes in the inpatient services from 2014; for example, the number of beds in psychiatric wards in general hospitals increased from 11 to 12 per 100 000 population, most prominently in SEE countries (+32%), whereas there were fewer beds in EU (pre-2004) countries, from 30 to 22 beds per 100 000

Box 1. Mixes of mental health services, exemplified by beds per 100 000 population in Azerbaijan and France

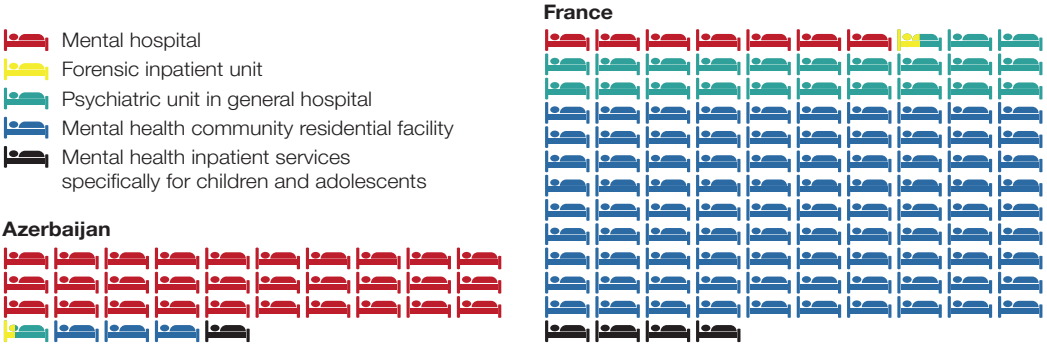
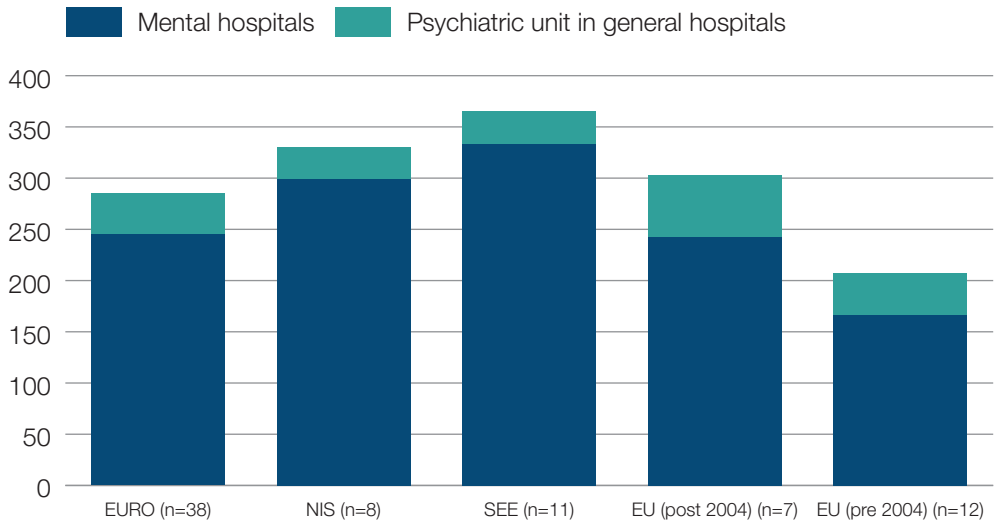


Fig. 10. Median number of beds per facility, by country grouping



population, indicating the transition from mental hospitals to community-based treatment.

3.4.2 Admissions

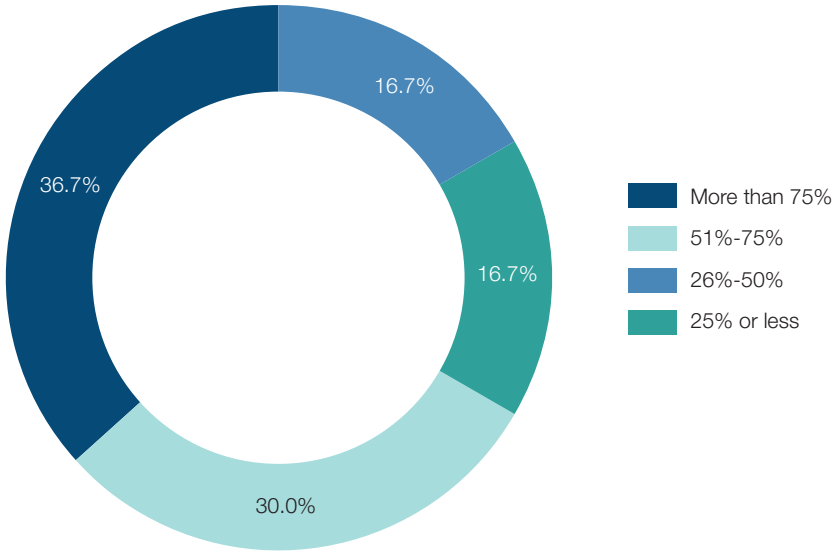
- 27 countries provided some data on admissions, only 18 on admissions to psychiatric units in general hospitals and 8 countries on admissions to mental health community residential facilities.
- The number of admissions to psychiatric wards in general hospitals did not differ from that in 2014; only in the EU (pre-2004) was a substantial change found (a decrease of 36%).
- The median reported proportion of people who stayed more than 1 year in a facility was 15%, which constitutes a modest improvement over 19% in 2014. In view of the small number of responding countries (n=22), however, these values are only indicative.

Involuntary admissions

European Mental Health Action Plan objective 2: Promotion of voluntary admission and strong safeguards in case of involuntary admissions.

- 9.4% of all countries in the European Region provided full information on involuntary admissions to mental hospitals, psychiatric wards in general hospitals and mental health community residential facilities.
- The median proportion of involuntary admissions among total admissions was 3% to mental hospitals and 1% to psychiatric wards in general hospitals.
- Country groups varied most widely in the proportions of involuntary admissions to psychiatric wards in general hospitals, from none reported to > 20%. Different definitions or interpretations of what constitutes involuntary admission complicate comparisons of data on this item.

Fig. 11. Proportions of countries that reported the percentage of people with mental disorders discharged from hospital who were followed-up within 1 month in 2016 (n=30)



Continuity of care:

- The highest rate of continuity of care is found in EU (post-2004) countries, 80%, and ≥ 50% of discharged inpatients are followed-up within 1 month. 37.5% of SEE countries reported follow-up in < 25% of cases, and 50% of responding NIS countries reported follow-up in ≥ 75% of cases.

3.4.3 Outpatient care

- Mental health outpatient services are more accessible in community-based settings, as indicated by a smaller population per facility (207 478 per hospital-based mental health outpatient facility; 78 773 per community-based or non-hospital mental health outpatient facility).
- The largest population per hospital-based or community-based mental health outpatient facility is found in SEE countries, while the population per other outpatient facility is particularly high in NIS countries (2 382 771). This indicates reduced availability and thereby more limited access to outpatient treatment.
- Community-based or non-hospital outpatient facilities recorded at least twice as many visits as hospital-based mental health outpatient facilities. In EU (pre-2004) countries, the trend is reversed: 10 288 visits were registered to hospital-based mental health outpatient facilities, which is seven times the number of visits to community-based outpatient facilities.

3.4.4 Social support

- 96% of people with severe mental disorders receive monetary or non-monetary welfare benefits from public funds.
- Welfare benefits are designed to compensate for disability, to enable service users to participate fully in society. Most countries provide income support (88%) and social care support (90%).

Fig. 12. Median population per facility in outpatient care, by country grouping

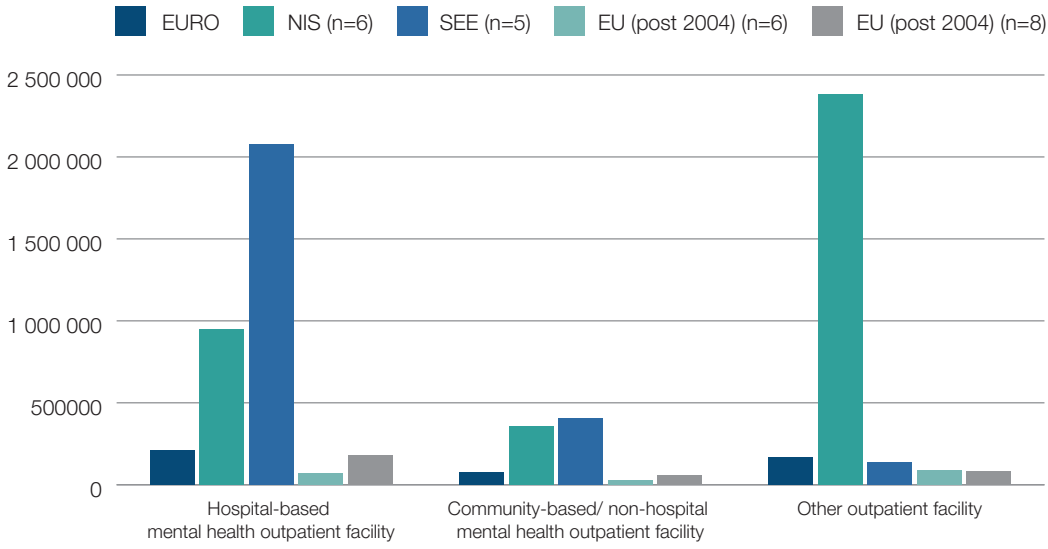


Fig. 13. Median number of visits in outpatient care in 2016 per 100 000 population, by country grouping

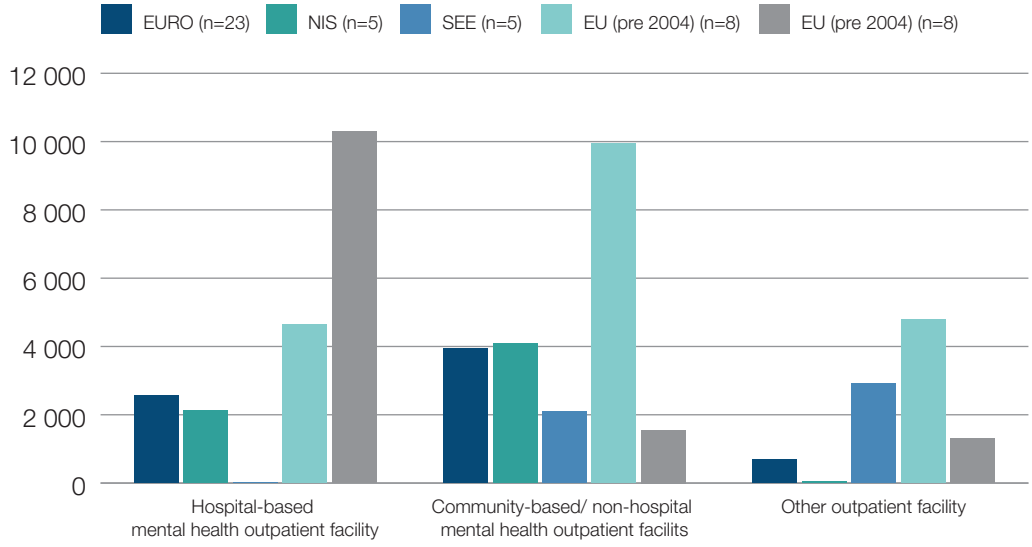
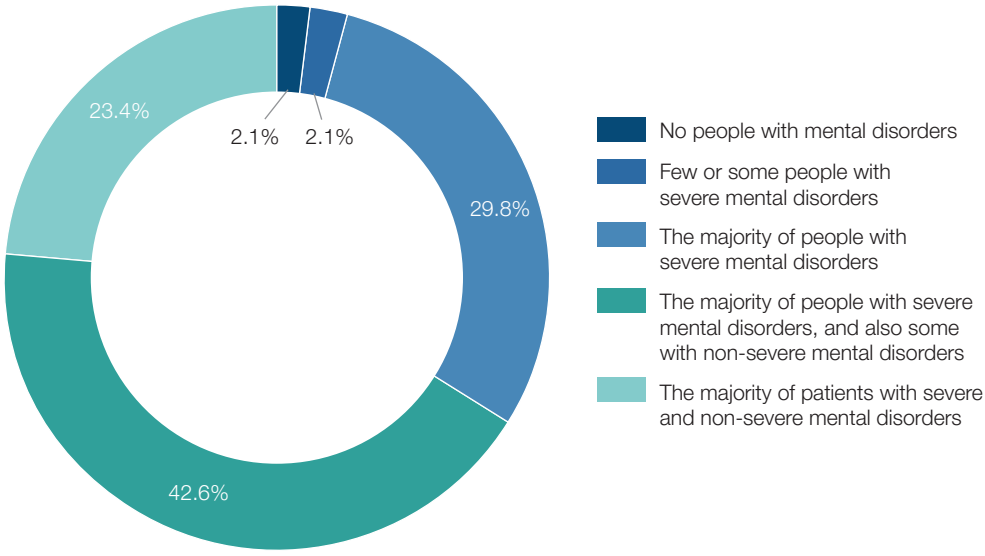


Fig. 14. Availability of government social support for people with severe mental disorders (n=46)



Spotlight on child and adolescent mental health:

- The median number of psychiatrists working in government child and adolescent mental health services is less than 2 psychiatrists or child psychiatrists per 100,000 children and adolescents (0-19 years).
- The absolute number of non-medical professionals working in government child and adolescent mental health services varies enormously e.g. ranging from 4.2 speech therapists per 100,000 children and adolescents in EU (post-2004) countries to 0.1 in NIS countries.
- In terms of outpatient care, one mental health outpatient service specifically for children and adolescents provides for 33 743 children and adolescents in EU (post-2004) countries and 757,680 children and adolescents in NIS countries (European Region median: 94 882).
- In terms of inpatient care, one mental health inpatient service specifically for children and adolescents is available per 975 574 children and adolescents in NIS countries, compared to 200 788 children and adolescents in EU (post-2004) countries (European Region median: 301,712). Six beds per 100,000 children and adolescents are available.
- On average, 18 countries provided data on mental health workforce and 50% of countries on available facilities. Because of the low response rate, these numbers have merely indicative value. However, they underpin the necessity of adequate resources and reporting to face the challenge of child and adolescent mental health.

3.4.5 Promotion and prevention programmes

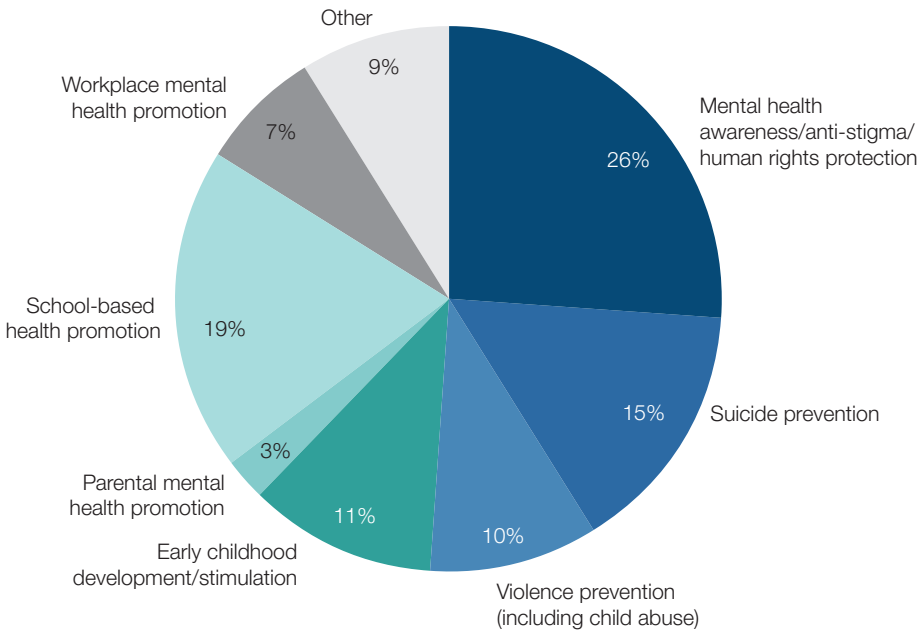
Comprehensive Mental Health Action Plan global target 3.1:

80% of countries will have at least two functioning national, multisectoral promotion and prevention programmes in mental health.

2014: **51%** 2017: **78%**

- All responding EU-post-2004 countries have at least two functioning promotion and prevention programmes.
- Countries reported on up to five programmes. Of the 114 reported programmes, 32 are on mental health awareness, anti-stigma or human rights and 17 on suicide prevention, in line with objective 1 of the Plan.
- The availability of certain types of programmes varied by country grouping. 7 programmes of NIS countries address mental health awareness, anti-stigma or human rights; however, no NIS country reported a programme for school-based health promotion, whereas these programmes are frequently (n=11) found in EU (pre-2004) countries.

Fig. 15. Distribution of functioning promotion and prevention programmes (n=114)



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Annex 1. Country groupings

WHO Member State	Country grouping
Albania	SEE
Armenia	NIS
Austria	EU (pre-2004)
Azerbaijan	NIS
Belarus	NIS
Belgium	EU (pre-2004)
Bosnia and Herzegovina	SEE
Bulgaria	SEE
Croatia	SEE
Cyprus	EU (post-2004)
Czechia	EU (post-2004)
Denmark	EU (pre-2004)
Estonia	EU (post-2004)
Finland	EU (pre-2004)
France	EU (pre-2004)
Georgia	NIS
Germany	EU (pre-2004)
Greece	EU (pre-2004)
Hungary	EU (post-2004)
Iceland	EU (pre-2004)
Ireland	EU (pre-2004)
Israel	SEE
Italy	EU (pre-2004)
Kyrgyzstan	NIS
Latvia	EU (post-2004)
Lithuania	EU (post-2004)
Luxembourg	EU (pre-2004)
Monaco	EU (pre-2004)
Montenegro	SEE
Netherlands	EU (pre-2004)
Norway	EU (pre-2004)
Poland	EU (post-2004)
Portugal	EU (pre-2004)
Republic of Moldova	SEE
Romania	SEE
Russian Federation	NIS
Serbia	SEE
Slovak Republic	EU (post-2004)
Slovenia	EU (post-2004)
Spain	EU (pre-2004)
Sweden	EU (pre-2004)
Switzerland	EU (pre-2004)
Tajikistan	NIS
The former Yugoslav Republic of Macedonia	SEE
Turkey	SEE
Ukraine	NIS
United Kingdom of Great Britain and Northern Ireland	EU (pre-2004)
Uzbekistan	NIS

NIS, Commonwealth of Independent States, including Georgia as a former member and Ukraine as an associate state; SEE, South-eastern Europe Health Network, including Turkey for this report; EU (post-2004), countries that joined the European Union after 2004 and are not a part of the NIS or SEE; EU (pre-2004), countries that were members of the European Union before 2004 are not a part of the NIS or SEE, plus Iceland, Monaco, Norway and Switzerland.

Annex 2. Country data

	Governance		Resources		
WHO Member States	**Mental health policy or strategy available (integrated into those for general health or diasbility or stand-alone)**	**Mental health legislation available (Stand-alone or integrated into general health or disability law)**	**The govern-ment's total expenditure on mental health as % of total government health expenditure**	**Total mental health workforce per 100 000 population**	**Total number of child psychia-trist (gov. and non-gov.) per 100 000**
Albania	integrated	integrated	-	-	-
Andorra					
Armenia	integrated	integrated	19.5%	27.4	0.3
Austria	stand-alone	stand-alone	-	-	-
Azerbaijan	integrated	integrated	3.5%	20.6	0.3
Belarus	integrated	integrated	2.1%	22.4	-
Belgium	integrated	integrated	-	173.7	-
Bosnia and Herzegovina	integrated	integrated	-	34.3	-
Bulgaria	stand-alone	stand-alone	2.7%	40.7	0.3
Croatia	integrated	integrated	4.3%	-	0.8
Cyprus	integrated	integrated	-	-	-
Czechia	integrated	stand-alone	4.0%	52.2	0.9
Denmark	integrated	integrated	-	-	-
Estonia	integrated	integrated	2.9%	71.7	-
Finland	not available	integrated	5.6%	250.6	0.4
France	integrated	not available	15.0%	173.6	2.8
Georgia	integrated	integrated	1.9%	9.3	0.3
Germany	integrated	integrated	11.3%	144.9	2.8
Greece	integrated	integrated	-	72.8	1.4
Hungary	stand-alone	stand-alone	-	47.8	0.5
Iceland	integrated	stand-alone	5.7%	-	-
Ireland	integrated	integrated	6.0%	-	-
Israel	integrated	integrated	3.4%	177.2	2.2
Italy	integrated	integrated	3.5%	55.7	-
Kazakhstan					
Kyrgyzstan	integrated	integrated	0.1%	11.0	0.2
Latvia	stand-alone	stand-alone	5.3%	80.3	0.7
Lithuania	integrated	integrated	-	87.3	3.2

	Governance			Resources	
WHO Member States	**Mental health policy or strategy available (integrated into those for general health or diasbility or stand-alone)**	**Mental health legislation available (Stand-alone or integrated into general health or disability law)**	**The govern-ment's total expenditure on mental health as % of total government health expenditure**	**Total mental health workforce per 100 000 population**	**Total number of child psychia-trist (gov. and non-gov.) per 100 000**
Luxembourg	in Excel: no / in internet: yes	integrated	-	21.0	3.2
Malta					
MKD[a]	integrated	integrated	-	19.7	0.5
Monaco	integrated	integrated	-	405.4	10.4
Montenegro	integrated	integrated	-	27.5	0.2
Netherlands	integrated	integrated	7.1%	156.1	-
Norway	integrated	integrated	-	576.0	-
Poland	integrated	integrated	2.6%	93.6	1.6
Portugal	integrated	integrated	-	-	-
Republic of Moldova	integrated	integrated	2.2%	23.1	0.4
Romania	integrated	integrated	-	26.9	0.6
Russian Federation	integrated	integrated	-	20.3	1.0
San Marino					
Serbia	integrated	integrated	6.6%	29.9	0.2
Slovakia	integrated	integrated	-	-	-
Slovenia	stand-alone	integrated	5.8%	75.9	0.7
Spain	integrated	stand-alone	-	15.4	-
Sweden	integrated	stand-alone	-	69.7	-
Switzerland	integrated	stand-alone	5.1%	234.7	7.9
Tajikistan	not available	integrated	2.0%	3.2	0.1
Turkey	integrated	stand-alone	-	205.4	0.3
Turkmenistan					
Ukraine	stand-alone	integrated	-	9.0	0.8
United Kingdom	integrated	integrated	9.7%	-	-
Uzbekistan	integrated	integrated	2.7%	23.6	0.6

[a]The former Yugoslav Republic of Macedonia

	Services			Data availability
WHO Member States	**Mental hospital beds per 100 000 population**	**Community residential facility beds per 100 000 population**	**Annual visits per 100 000 population to hospital / community-based mental health outpatient facilities**	**Mental health data availability and reporting**
Albania	16.8	4.6	n.a. / 1,993	no data compiled
Andorra				
Armenia	-	1.7	n.a.	for general health statistics
Austria	26.1	19.5	n.a.	for general health statistics
Azerbaijan	38.3	0.4	1,262 / 78	report on public data
Belarus	57.4	3.2	18,228 / n.a.	report on public data
Belgium	98.9	22.7	n.a.	report on public and private data
Bosnia and Herzegovina	13.7	23.4	2 / 3,606	report on public data
Bulgaria	33.2	13.8	52 / 2,097	report on public data
Croatia	75.4	16.5	n.a.	report on public and private data
Cyprus	11.4	3.5	n.a. / 7,008	-
Czechia	80.9	12.3	n.a. / 27,623	report on public and private data
Denmark	51.6	-	19,703 / n.a.	-
Estonia	8.7	58.4	1,429 / n.a.	report on public and private data
Finland	-	47.7	269. / 1,244	for general health statistics
France	7.0	22.3	25,356 / n.a.	for general health statistics
Georgia	36.7	2.5	2,571 / 4,079	report on public and private data
Germany	55.7	80.6	n.a. / 996	for general health statistics
Greece	10.7	5.7	1,891 / 1,863	for general health statistics
Hungary	-	85.7	7,637/ 3,952	for general health statistics
Iceland	18.2	32.7	10,289/ n.a.	report on public data
Ireland	21.7	21.7	n.a. / 624	report on public data
Israel	35.2	4.2	8,492 / 9,355	report on public data
Italy	-	9.0	218 / 17,141	report on public and private data
Kazakhstan				
Kyrgyzstan	27.7	1.6	6,138 / 347,424	report on public data
Latvia	102.5	-	10,097 / 6,670	report on public data
Lithuania	40.2	49.6	n.a. / n.a.	report on public and private data
Luxembourg	39.7	32.3	n.a. / n.a.	no data compiled

	Services			Data availability
WHO Member States	**Mental hospital beds per 100 000 population**	**Community residential facility beds per 100 000 population**	**Annual visits per 100 000 population to hospital / community-based mental health outpatient facilities**	**Mental health data availability and reporting**
Malta				
MKD[a]	48.1	9.6	n.a. / n.a.	no data compiled
Monaco	-	148.8	28,175 / n.a.	for general health statistics
Montenegro	46.5	4.3	n.a. / n.a.	no data compiled
Netherlands	-	-	n.a. / n.a.	report on public and private data
Norway	74.3	-	35,606/ n.a.	report on public and private data
Poland	30.5	15.6	3,522 / 11,918	report on public data
Portugal	5.7	11.8	1,064 / 4,782	report on public data
Republic of Moldova	35.5	0.9	16 / 3,075	report on public data
Romania	82.5	55.0	n.a. / 1,071	for general health statistics
Russian Federation	93.0	-	25,924 / n.a.	report on public and private data
San Marino				
Serbia	41.4	18.3	n.a. / n.a.	for general health statistics
Slovakia	-	-	n.a. / n.a.	report on public data
Slovenia	57.1	9.5	4,649 / 9,940	for general health statistics
Spain	28.2	14.3	1,552 / 49	report on public data
Sweden	31.1	-	41,464 / n.a.	for general health statistics
Switzerland	75.6	13.8	n.a. / n.a.	report on public and private data
Tajikistan	10.3	6.6	1,701 / n.a.	for general health statistics
Turkey	5.2	4.7	n.a. / n.a.	for general health statistics
Turkmenistan				
Ukraine	65.5	1.9	n.a. / n.a.	report on public data
United Kingdom	23.9	-	n.a. / 18,588	-
Uzbekistan	24.6	0.4	463 / n.a.	report on public data

[a] Republic of North Macedonia

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Estonia
Finland
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Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
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Mental Health Atlas 2017

Monitoring mental health systems and services in the who european region

A stated objective of the European Mental Health Action Plan 2013-2020 concerns better information and knowledge for service planning, development, monitoring and evaluation, including a specific proposed action for Member States to complete and return the indicators of the Comprehensive Mental Health Action Plan 2013-2020.

Monitoring of progress being made towards internationally agreed mental health objectives and targets is being facilitated through the periodic administration of WHO's Mental Health Atlas.

This booklet provides a snapshot of where countries of the WHO Regional Office for Europe lie in relation to a number of core mental health targets and indicators, based on results of the WHO Mental Health Atlas carried out in 2017.

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