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IS AN EU-WIDE APPROACH TO THE MENTAL HEALTH CRISIS NECESSARY?

Dr Gerry Mitchell, Dr Emily Murphy, Dr Sara Bojarczuk and Dr Shana Cohen

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FEPS
FOUNDATION FOR EUROPEAN
PROGRESSIVE STUDIES

Avenue des Arts 46, B-1000 Brussels, Belgium +32 2 234 69 00
info@feps-europe.eu
www.feps-europe.eu
@FEPS_Europe

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28 Merrion Square North, Dublin 2, Ireland. D02 AW80
https://www.tasc.ie/
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EXECUTIVE SUMMARY

Executive summary

Demand for an EU mental health strategy existed before the pandemic but has intensified since. This policy study explores the need for that strategy, given the increased prevalence of mental health conditions, and the corresponding demand for services and cross-national concerns about mental health in Europe. Building on previous FEPS/TASC studies of health inequalities,[1,2] it examines mental health systems in France, Ireland and Poland; the scale of mental health issues that have arisen during the pandemic and the extent to which marginalised and at-risk groups receive targeted support. In the context of these findings, it considers the need for an EU-wide strategy for mental health systems to meet these challenges and build resilience in EU communities.

The research itself involved 33 interviews with representatives from the mental health sector: doctors and psychiatrists; or those working in advocacy and third-sector organisations. Respondents were asked not only about key features and relative capacities of mental health provision in the countries they worked in, but also their views on what role the EU should have in building mental health policy across the union. The policy study examines what policy work has already been conducted in Europe, by the Commission and other organisations. It also considers the potential consequences of not developing a strategy for mental health at the EU level.

Respondents were clear that **the multiple crises facing Europe have intensified a "hidden pandemic" in mental health**, which mental health sectors in all three countries were struggling to respond to, themselves characterised by ongoing crises for many years, due to long-term low status and underinvestment, together with a policy failure to respond to the negative and interacting impacts of the social determinants of mental health and related inequalities on mental health incidence and outcomes.

In **France**, the incidence of depression doubled during the pandemic, with those in financial difficulty experiencing double or even triple the rate experienced by the rest of the population.[3] Rates of attempted suicide are among the highest in Europe.[4] Despite relatively high investment compared to the other two case studies, the dominance of hospital provision and the lack of community care leads to patients with low-level mental health conditions being admitted to acute psychiatric care unnecessarily.

Ireland is the most affluent country in the study and has the highest self-perceived health status.[5] However, in 2022, 42% of the population met diagnostic requirements for at least one mental health disorder and more than one in ten adults had attempted suicide.[6],[7] Spending on mental health is relatively low and charities and local civil society organisations have traditionally plugged the gap. As with France, services are hospital-centric and there is a lack of primary mental health services.

Mental health care in **Poland** is described as being in a permanent state of crisis.[8] It has very low numbers of practising doctors, psychiatrists and nurses. There is a particularly acute shortage of child psychiatrists. As a share of GDP and in per capita terms, health spending in Poland has remained consistently below the EU average. Rates of anxiety and depression are higher among young people and increase with decreases in income.[9] Suicide remains much higher in Polish men compared to the EU average,[10] and mental and behavioural disorders account for the largest share (over 17%) of the benefits paid out by social insurance to those with short- and long-term incapacity to work.

The policy study reviews EU policy, to date, on developing a mental health strategy for the union and, for each case study country, outlines mental health provision and the policy context to inform the findings from interviews with representatives of its mental health sector.

The policy study found the following characterised mental health provision across the three countries:

1) Underinvestment in the workforce (poor pay and conditions)

2) Lack of locally provided primary care and services for common mental health conditions

3) Lack of public education campaigns raising mental health awareness, reducing stigma and developing mental health literacy

4) Lack of data coordination and sharing of patient information

5) Lack of support for (yet also over reliance on) civil society's provision of mental health services

6) Increased demand, long waiting lists and people left untreated

7) Inadequate response to the COVID-19 public mental health emergency

8) Barriers to accessing care due to stigma and geographical inequalities of access including lack of digital literacy, lack of private spaces, language barriers, digital exclusion (rural areas), stigma and lack of support in schools and other institutions

9) Hospital-centric and over-medicalised provision

10) Systematic failure to address the social determinants of mental health, to incorporate/integrate them into other related areas of policy

11) Lack of identification of the policy provision required at different points in the mental health pathway (such as that outlined in the EU's Beating Cancer Plan[11]), including a failure to distinguish between treatment for chronic life-long patients, support for episodic mental ill-health and a well-being approach integral to health and other sectors

12) Lack of additional targeted and appropriate provision/support for vulnerable or at-risk groups during crisis, particularly children and young people and migrants, refugees and asylum seekers

Below is a summary of the report's key recommendations:

1) **Actively address misconceptions, discrimination and stigma related to mental health in member states. This includes**
   - destigmatising the language on mental health, moving away from the language of "problems" because that suggests deficiency;
   - training in mental health literacy;
   - raising awareness of mental health conditions;
   - promoting public campaigns on mental health well-being throughout the life cycle.

2) **Be clear that good mental health has intrinsic value and access to a high standard of healthcare is a human right. It is also a valuable resource to the EU and strongly impacts on the cohesion and resilience of society.**

3) **Be clear that incidence and outcomes of mental health conditions cannot be improved without addressing the social determinants and inequalities of mental health.**

4) **Be clear about the cost for member states of current underinvestment in mental health provision, unaddressed mental ill-health and mental health inequalities.**

5) **Target mental health services to vulnerable groups and groups with specific needs.**

6) Determine the budget, framework and benchmarks for better tools to understand and improve the mental health system performance and monitoring of implementation.

7) Further invest in the mental health workforce by improving working rights and conditions; provide protective psychological support for medical and frontline social care workers who dealt with patients during the pandemic.[12]

8) Demonstrate the strategic centrality of mental health in policymaking across EU policies and adopt a "mental health in all policy" approach.

9) Use a multi-stakeholder, multi-sectoral approach to developing mental health policy; involve a wide range of stakeholders in the decision-making process to build awareness and gain public trust.[13]

10) Actively address misconceptions, discrimination and stigma related to mental health in member states.

11) Develop clear mental health pathways in mental health policy.

12) Develop coordination among different parts of the mental health system.

13) Build capacity in primary health services and in local government to deliver community mental health services.

14) Promote the importance of investing in activities that expand social contact.

15) Advise member states to conduct audits of current mental health provision before developing further strategy.

16) Convene member states to fix goals; set clear deadlines, commitments and necessary funding; and connect the main actors through effective partnerships, sharing data and digitalisation.[14]

17) Share information, research and best practice on the mental health system as a whole between member states.

18) Develop methodologies for and then promote more extensive use of mental health policy evaluation.

19) Consult people with lived experience and their representative organisations from design, implementation, monitoring to evaluation of mental health strategy.

20) Build digital capacity between member states so that the digital innovation seen during the pandemic can continue to facilitate the development of mental health provision.

1 INTRODUCTION

1 INTRODUCTION

This policy study analyses the policies to address mental health in France, Ireland and Poland. It explores the impact of the pandemic and economic fallout on social determinants of health and mental health provision in each country, if they have exacerbated existing inequalities in access to services, and the response of each country to the mental health crisis within their populations.

More specifically, the policy study identifies the potential for a coordinated EU strategy to address the current mental health crisis. The findings encompass views on progress with mental health policy reform; public awareness and attitudes to mental health knowledge; gaps in provision; and the need for coordination between state, voluntary sectors and EU national governance structures.

The choice of these three countries allowed for a comparison of the influence of factors such as economic performance, levels of public investment in mental health provision and delivery models (to what extent services exist at the local level, for example) on the capacity and resilience of mental health systems to meet the intensified demand for their services, particularly by marginalised and at-risk groups. Notwithstanding, it is important to note that some caution is needed when comparing data on the prevalence of mental health conditions.

The specific objectives of the policy study are to investigate the following in France, Ireland and Poland:

- How have their health systems and public provision responded to the reported rise in mental health issues provoked by the COVID-19 pandemic and public health emergency?
- How well do they integrate/embed mental health policy into other policy areas, for example, migration?
- What policy responses/targeted interventions were there to support mental health and well-being during the crisis, in particular, those that target particularly at-risk and marginalised populations?
- Have local mental health services benefited from any innovations in digital care provisions over the last two years?
- Have they become more proactive in tackling mental health issues since the pandemic? What barriers do they still face?
- What kind of support could the EU provide to tackle mental health challenges in the case study countries?
- Do we need an EU mental health strategy? What would be its added value?
- What policy recommendations and actions are needed at the EU level to better inform a coordinated approach to mental health outcomes in Europe?

In answering these questions and reviewing qualitative and quantitative source material, our major research objectives are to:

1) Examine how well the health systems, public support and charities in these three European countries responded in the context of a public health emergency; and
2) Draw out policy recommendations for generating an informed and accountable action plan to tackle mental health within the EU.

In the following sections, we briefly discuss the development of mental health policy in the EU, the prevalence of mental health conditions pre- and post-COVID-19, their relationship to inequalities, and the social determinants of health and the significant role of stigma.

Policy context

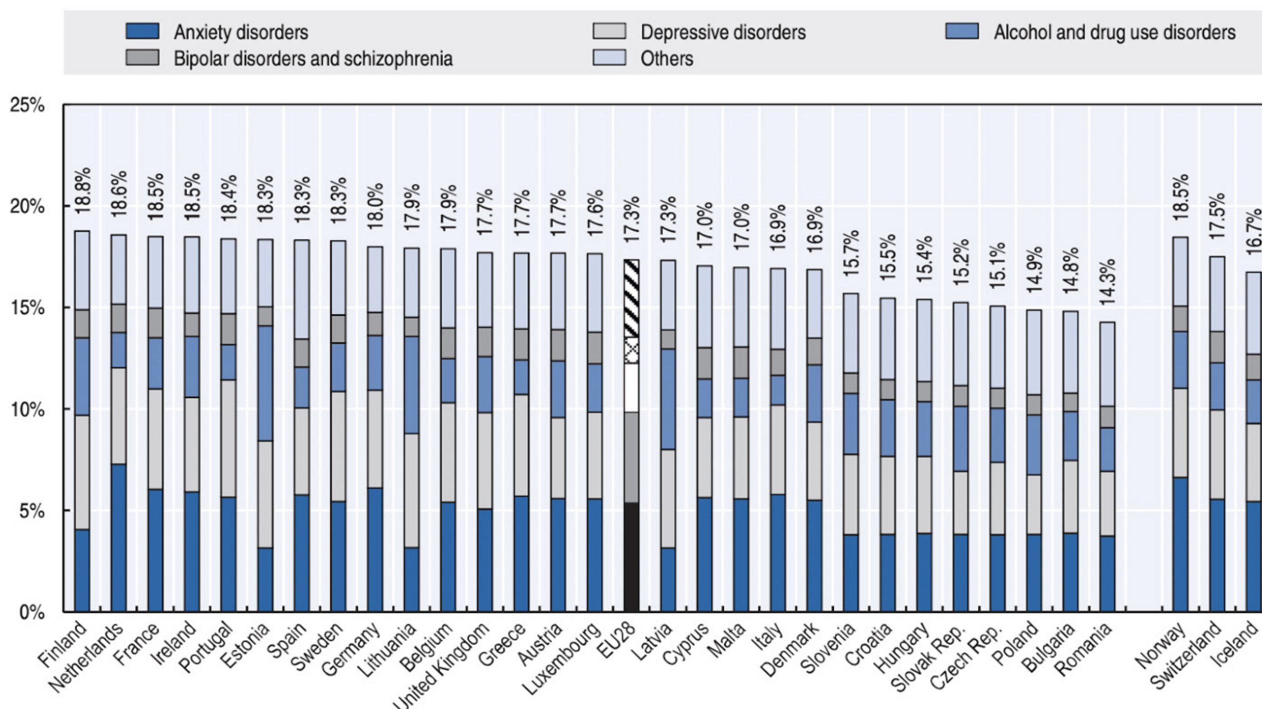
The EU and mental health

Mental health issues are common in Europe. In 2016, it was estimated that one in six people living in the EU – approximately 84 million people – had a mental health condition (see Figure 1). Globally, the World Health Organization (WHO) estimates that depression is the third leading cause of disease burden and that it will be the leading cause by 2030.[15] In 2021, GAMIAN-Europe (Global Alliance of Mental Illness Advocacy Networks) reported that, while depression was the most prevalent health problem in many EU states, only 50% of those affected received treatment. At least 30% of people with severe mental health conditions do not have access to mental health care. Nor have they benefited from prevention and promotion interventions. This is in the context of knowing that, in many or most cases, mental ill health can be prevented, cured, treated and managed. A fact that, as GAMIAN notes, if more widely understood would help combat the stigma around mental health.[16]

The economic argument for member states to address mental ill-health is incontrovertible. The cost of mental ill-health in Europe stood at more than €600 billion or more than 4% of GDP across the 28 EU countries in 2015.[17] The OECD estimated that a large part of these costs were due to lower employment rates and lower productivity of people with mental health issues, greater spending on social security and direct spending on healthcare.[18]

Despite this, mental health has long been neglected in our societies and by policymakers, partly because of widespread stigma and preconceptions.19

Figure 1. Estimated prevalence of a wide range of mental health disorders in Europe (2016).



Source: Institute for Health Metrics and Evaluation (IHME) estimates (referring to 2016) of the prevalence of a wide range of mental health disorders across all age groups based on a wide variety of data sources and a set of assumptions.

However, without better convergence of member states' welfare systems, the economic convergence that the EU has witnessed in recent years will not be maintained. [20 21]

The documented shortcomings of European mental healthcare systems include the risk of increased medicalisation of mental health problems, neglect of the social determinants of mental health, and the need for sharing best practice between member states and using information collectively.[22] The EU has also been alerted to the scale of mental health problems faced particularly by adolescents. Cross-sectoral European action is needed to ensure that the current public health crisis does not become a long-term social crisis and that we do not replicate ineffective patterns in our mental health and social systems.[23]

The need for a comprehensive European strategic approach was first raised several decades ago. Previous priority areas, joint actions and pacts for targeted policy responses have focused variously on "mental health promotion";[24] tackling stigma, discrimination and social exclusion; prevention;[25] human rights; needs-based and community-centred approaches; and promoting the integration of mental health in all policies.[26] However, pre-pandemic initiatives relied on member states to voluntarily take action, and only a few EU countries had fully implemented previous recommendations. This led to growing calls from within the EU Parliament for the EU to use its policy, legislative and governance frameworks to develop a comprehensive mental health strategy to implement, monitor, and support member states in advancing their own mental health policy.[27]

During the pandemic, the EU's Third Health Programme funded joint action on best practices in mental health.[28] In June 2020, having sought a commitment to introduce an EU Mental Health Strategy, the European Parliament proposed a resolution for an EU-wide action plan on mental health, which would focus on both the biomedical and psychosocial factors affecting mental health.[29] Coalitions such as the MEP Alliance and the Mental Health Coalition called for the EU to learn from the pandemic and ask policymakers to use the opportunities provided by the various existing international policy frameworks delivered on mental health to develop a collective human-rights-based mental health policy.[30] However, following a scoping review of developments between 2017 and 2019, Mental Health Europe concluded:

> *Despite visible progress and meaningful actions taken up by many member states, a stronger commitment is necessary to better align developments and create synergies. Stronger coordination and increased exchanges of good practices can enhance adequate developments across the European Union and beyond.*[31]

The WHO has called for mental health to be placed at the heart of the post-pandemic recovery process. Its European Framework for Action on Mental Health 2021-2025 highlighted routine collection data on the mental health of population groups and the performance of mental health systems to foster mental health and well-being resilience amongst children and young adults and investment in mental health support for older people as priorities.[32] It updated its Comprehensive Mental Health Action Plan 2013-2030 to include an indicator on preparedness for mental health and psychosocial support in public health emergencies.[33] In August 2022, the European division of the WHO set up a Pan-European Mental Health Coalition, a flagship initiative of the European Programme of Work 2020-2025 focusing on the alignment of mental health strategy across the region,[34] with objectives that included countering the stigma and discrimination associated with mental health conditions and advocating for and promoting investment in accessible quality mental health services.

In November 2020, the European Commission put forward a package to build a strong "European Health Union" to prepare and give a unified response to the current health crisis and prepare for future public health emergencies. The final pieces of regulation to complete this were adopted by the European Council in November 2022.[35] In December 2020, the EU adopted Next-Generation EU, its €800 billion+ recovery plan.[36] Member states then submitted their recovery and resilience plans, describing the reforms and public investment projects that they plan to implement with the support of the plan's central instrument: the Recovery and Resilience Facility (RRF).[37 38]

Within the RRF, the Horizon programme, for example, has been used to develop mental well-being among adolescents, training programmes in personal and community resilience for schools, teaching mental health skills, reducing the impact of mental health problems in the workplace, and promoting the mental health and well-being of health professionals to enhance their productivity. In March 2021, EU4health was launched, with a €5.3 billion budget during the 2021-2027 period and, with the objective of reserving medical supplies for future crises, increasing surveillance of health threats, developing the digital transformation of health systems and giving access to healthcare for vulnerable groups.

By 2021, the OECD concluded that European countries were still "[struggling] to identify whether their mental health system is delivering effective results"[39] that, "[d]espite the widespread rhetoric and intention for a more integrated mental health, skills and work policy in national mental health plans, successful implementation of such integration remains the exception, not the norm" and that "too often, interventions come too late".[40]

In February 2022, calls for project grants from the EU4 Health Programme included support for stakeholders in implementing best practices promoting children's and adolescent mental health and well-being, with a focus on vulnerable groups, such as children living in deprived areas[41] and mental health and psychosocial support to displaced people from Ukraine, exchanging best practices, and increasing awareness and knowledge sharing in support of health professionals.[42] Also in February, the European Parliament's regional development committee put forward a motion for a resolution on cohesion policy to reduce healthcare disparities and enhance cross-border health cooperation,[43] essentially calling for a new European action plan for mental health based on the model of Europe's Beating Cancer plan.[44]

The plan uses a whole-of-government approach, "strengthening cooperation and opportunities for EU added value" and "mobilising the collective power of the EU to drive change to the benefit of our citizens". The motion acknowledges that, while there is economic convergence of many developing countries, their welfare systems have not similarly converged and that "promoting accessibility to mental health services could also help to increase employment and eliminate poverty in less developed regions".[45] The motion further recommends that cohesion policy funds[46] are used to contribute to upgrading the digital capabilities of healthcare systems and interoperability of IT systems, facilitating cross-border provision of e-health services and especially of telemedicine services.[47]

In June 2022, the Commission launched the Healthier Together: EU Non-Communicable Diseases (NCDs) Initiative aimed at supporting member states to reduce the burden of major NCDs and improve mental health and well-being. The initiative highlighted the importance of promotion and prevention of good health:

> *Considering that improved health promotion and disease prevention can reduce the prevalence of NCDs by as much as 70%, implementing such integrated strategies on a large scale within the OECD/EU can be cost-effective and generate substantial health and well-being gains. Particular attention must be paid to social determinants, as these are responsible for large inequalities in the prevalence and mortality of NCDs.*[48]

It also acknowledged the importance of recognising the vulnerability of some groups (children and youth) but not others, for example, people experiencing homelessness and Roma, and to tailor support for them so that they experience equality of access to services. The initiative reaffirmed previous calls from various organisations to adopt a *mental health in all policies* whole-of-government approach because "it is insufficient to view mental health as a public health challenge alone; rather it needs to be considered as everyone's business and a priority for public policy more broadly".[49]

EU initiatives have been criticised for not presenting good mental health as, above all else, a human-rights imperative. The right to good health includes

the right to mental health, as recognised variously by the 2017 European Social Pillar, the European Disability Strategy, the UN Convention on the Rights of Persons with Disabilities by the European Union (UN CRPD)[50] and the WHO 2030 Agenda (the 2030 Agenda for Sustainable Development). They have also been criticised for not sufficiently integrating the need for mental health services into existing universal health coverage, for not recognising the relationship between mental ill-health and NCDs (between depression and cancer, for example), not sufficiently moving the focus towards primary and community-based care (which would also help to destigmatise mental health conditions), and not encouraging countries to move more quickly away from an overly medicalised and hospital focus.

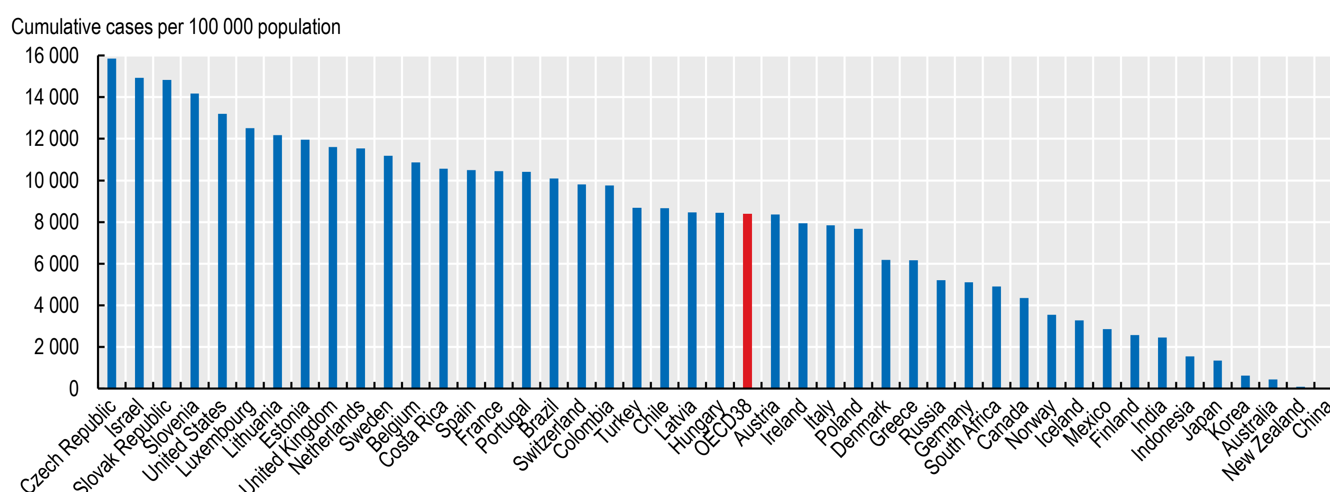
Yet, despite post-pandemic recovery funding and a recognition that it is in the EU's strategic interest to reach out and coordinate on health[51] to build a strong European Health union, there is still no EU-led mental health strategy. "We have to make sure with proposals on mental health that we really improve in this subject. It is, for some of our fellow Europeans, life-saving", Commission President Ursula von der Leyen said in her 2022 State of the Union address, and the corresponding letter of intent announced that a new mental health initiative would be presented in 2023.[52] [53] In October 2022, the Commission confirmed that a non-legislative report on a comprehensive approach to mental health will be published in spring 2023, with discussions on a strategy expected to commence in July 2023.[54] In November 2022, experts and politicians signed a joint memorandum further calling on EU institutions to form an EU-wide action plan, which was presented at "Resilient Mental Health in the EU" an international conference, held under the Czech Presidency of the EU, Czech Deputy Health Minister, Jakub Dvořáček.[55]

COVID-19, inequalities and the social determinants of mental health

The cost of not addressing, treating and preventing mental ill-health has been starkly illustrated by the COVID-19 crisis. Much of the economic burden of mental illness is not the cost of care, but the loss of income due to, for example, unemployment or a range of indirect costs due to a chronic disability that begins early in life. However, funding allocated to tackling mental health as part of total governmental budgets remains insufficient to this day. Despite differences in relative investment across member states, the lack of financial investment is a recurring theme. In Ireland, and similarly in Poland, mental health has received, on average, over the last few years, around 6-7% of the public health budget. [56] [57] By contrast, mental health expenditure in France accounts for approximately 14% of the French National Health Insurance Fund.[58]

Multiple waves of COVID-19, and government measures necessitated by these waves, had marked effects on mental health trends globally. The expanded numbers of those reporting depressive, anxiety and stress responses related to COVID-19 was a worldwide phenomenon.[59] Common trauma happened suddenly but simultaneously affected every aspect of people's lives: their family; work; and social relationships. OECD data for March and April 2020 confirm that almost all countries recorded higher levels of anxiety and depression in the general population than pre-pandemic. France recorded the highest levels of anxiety and depression, followed by Ireland then Poland. In France, the United Kingdom and the USA, the prevalence of symptoms of anxiety and depression increased during periods when there were peaks in COVID-19 infections and deaths,[60] and when there were increased containment measures in place.[61] [62] [63] Figure 2 gives an indication of the numbers of COVID-19 cases across the three case studies between 2020 and 2021.

Figure 2. Cumulative number of reported COVID-19 cases per 100,000 population, January 2020 to early October 2021.



Source: ECDC (2021) "COVID-19 datasets": ECDC data use national data sources for non-European countries.[64]

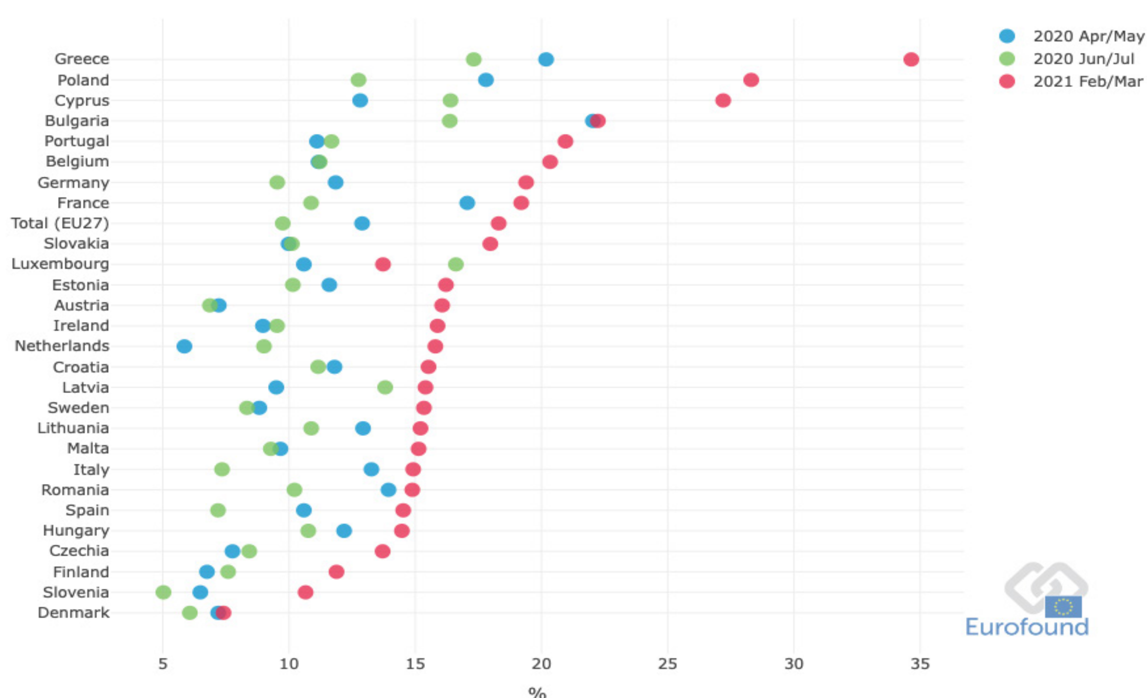
Research conducted by Eurofound on the impact of COVID-19 on mental health in four European countries (Denmark, France, the Netherlands and the United Kingdom) found that in February-March 2021, mental well-being was lowest amongst all age groups since the emergence of COVID-19. The groups most severely affected were those who had lost their jobs and younger age cohorts. The research, which focused on loneliness, worry and anxiety, also found that respondents with previously diagnosed mental illness had poorer self-reported mental health during the early phase of the pandemic.[65]

Figure 3 shows survey responses collected at three points between 2020 and 2021, asking people whether they had a low mood or had felt depressed either "all" or "most" of the time. There was an increase in people indicating a feeling of low mood in all three case study countries. The largest increase is seen in Poland; here the percentage rose from approximately 18% in April-May 2020 to approximately 28% in February-March 2021. France ranks below this, but still with a large proportion of the overall population reporting low mood – at just under 20% by 2021, with Ireland at around 16% by 2021.

The mental health effects of the pandemic have been particularly pronounced amongst young people, people with pre-existing mental health issues, women and older people.[67] In May 2022, a series of surveys were carried out by FEPS in six European countries to explore the impact of COVID-19 on mental health and suicide. The studies highlighted the disproportionate effect on the mental health of those who were socio-economically disadvantaged during the pandemic – on younger people and younger women, in particular.[68]

Depression and anxiety have been shown to be associated with individuals' worsening financial circumstances during the pandemic across several European countries.[69] They often lead to a variety of negative outcomes, including poor education and labour market outcomes, a high dependence on social benefits, exacerbated physical health problems and a decline in well-being, which even further undermine social cohesion.[70] Research from the early stages of the pandemic highlighted that mental distress was and continues to be exacerbated by systemic level failures to address the fundamental social determinants of health that existed before it.[71]

Figure 3. Percentage of respondents reporting low mood/felt depressed "all" or "most" of the time (2020-2021).



Source: Eurofound (2020) "Living, working and COVID-19 dataset". http://eurofound.link/COVID19data[66]

COVID-19 shone a light on the crucial role of social determinants of health in the incidence and outcome of mental health. They are estimated to account for between 30 and 55% of all health outcomes, and the contribution of sectors outside health exceeds the contribution from within the sector itself.[72] Factors include neighbourhood deprivation, food insecurity, poverty, unemployment or low pay, and poor working conditions and precarious housing.[73]

Stigma is also a significant contributory factor. Despite the fact that social awareness of mental health and mental well-being have increased as a result of the pandemic, many people suffering from episodic or chronic mental health problems still experience stigma, including labelling, stereotyping, status loss and discrimination.[74] Any European strategy that aims to reduce or curtail the stigmatisation of mental health disorders must thus be strategic in its aims to enhance the social inclusion and socio-economic status of those suffering from mental health conditions – which then has the potential to target both the cause and effect of them. The language used to communicate mental health policy is key.

The relationship between health inequalities, the social determinants of health, and mental health have become more prominent in the discourse around mental health. In parallel with the development of modern mental health services, there has also been a significant and positive shift in public perception, knowledge and awareness around many aspects of mental ill-health.[75]

Respondents spoke about a wide range of clients from those with pre-existing mental health conditions prior to the pandemic to those who accessed mental health services for the first time in response to it. Population groups they described as more vulnerable to worse mental health outcomes included survivors of domestic abuse, youth, lower socio-economic

groups, migrants, refugees, prisoners and those with physical and intellectual disabilities.[76] [77] They spoke about the impact of multiple crises: the pandemic; the economic crisis; and the Ukrainian war. During the pandemic, widespread feelings of social isolation induced by lockdowns or fear of social engagement due to infection risks became a determining factor in relapse and onset of depressive episodes.[78]

COVID-19 has also raised concerns about the impacts of teleworking on mental health, as compared to in-person work, with longer and more irregular working hours in some countries, as well as the mental health challenges of remote learning and the associated blurring of boundaries between education, work and home.[79] There remains scope for further analysis of the impact on mental health and related policy from broader digital transformation, including increased teleworking and the changing organisation of work and study in schools, universities and other educational institutions.[80] This may include, for example, changes in the nature of risks associated with mental health, such as a rise in cyberbullying. Digital transformation will not benefit or affect everyone equally. A majority of jobs still "cannot, or can hardly be performed from home", and only around one third of jobs can be done from home under normal conditions with significant differences between industries.[81] Moreover, data from the OECD Survey of Adult Skills (PIAAC) shows that, on average, in 28 countries, more than 50% of the adult population can only carry out basic ICT tasks or have no ICT skills at all.[82]

Research methodology

This policy study is based on research conducted between April and August 2022:

- Analysis of mental health services in 2020-21 in Ireland, Poland and France, including:
    - a review of relevant national and European surveys on mental health, (with an emphasis on anxiety, depression and isolation/loneliness) during the pandemic and their particular impact on economic and social outcomes;
    - the impact of the pandemic on the delivery of services (for example, using online resources); and
    - what additional supports are needed in the future.
- Thirty-three qualitative interviews across the three countries with medical and mental health organisations, experts, health officials and charity representatives[83] to acquire a better understanding of the scale of the crisis and the interventions/actions/ response from each country.[84]

The interviews were semi-structured and lasted approximately 30 minutes to one hour. In-depth qualitative data were analysed using thematic analysis to furnish our policy recommendations. All respondents were anonymised.

Any European strategy that aims to reduce or curtail the stigmatisation of mental health disorders must thus be strategic in its aims to enhance the social inclusion and socio-economic status of those suffering from mental health conditions

A note on policy definitions of mental health

Mental health is a complex construct, and hence, its definition encompasses a wide range of interrelated issues. In its broadest sense, the European Commission states being mentally healthy as "being capable of self-realisation, being at ease when forming relationships with others, to contribute to community life and being productive at work".[85] The WHO describes mental health as "a state of a person's mental well-being, when the person can show their potential, handle stress and challenges well without breaking down"[86] and as "an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in".[87] It refers to mental wellness, not mental conditions. They note three types of well-being – emotional, behavioural and cognitive – that correspond with thinking, feeling and behaviour patterns.

Using appropriate language in the field of mental health is critical.[88] Mental health conditions vary in terms of length, severity and the policy responses required. They range from temporary feelings of mental distress, which may not necessarily be clinically significant mental health conditions, through to severe depression and conditions such as schizophrenia. This policy study predominantly uses the terms "mental health condition" and "mental health issue" as being understood to encompass conditions at all levels of severity, from those that have a significant and long-term impact on a person's life and day-to-day functioning, through to those that are highly prevalent in the population but do not necessarily need specialist mental health care. As one respondent said:

> *It is always a challenge to try and put parameters around what we mean when we're talking about mental health. Because, you know, if you take that kind of the spectrum idea, you know, it ranges from everything from say, things like, you know, psychosis, schizophrenia, bipolar disorder, down to, you know, you know, anxiety, and so on, each of which has their own level of severity and degree. [Interview IE5]*

As language evolves, policy terms that may have been acceptable a few years ago may not be now. Opinions will differ, according to who is using the language (the person with the mental health condition or the psychiatrist treating them, for example), and in what context (how does the language of mental health policy differ between countries and across sectors, for example) and individual preference, to some extent. While the objectives of this study did not specifically include research on the attitudes to the language used in mental health provision, it is nevertheless mindful of the responsibility of policymakers to be aware of the impact of language and the taboos and stigma still very much associated with mental health conditions.

Mental health policy will encompass primary-level services designed for common mental health conditions, hospital-based services for more serious mental health conditions, related support services (such as financial and housing support), targeted support for specific vulnerable groups or post-treatment rehabilitation services (such as employment support), policies for public health promotion of mental health and well-being, prevention, awareness raising and reduction of stigma. There is a wide range of individuals and organisations involved in each type of the services listed above, including peer advocacy groups, charities, pressure groups, psychological, psychiatric, counselling and non-medical support services. The policy study interviewed professionals (from psychiatrists to nongovernmental organisation (NGO) staff) in a range of organisations (whether in terms of sector or the services they provided, for example, from clinical services to advocacy). They will all operate with different priorities, budgets, timeframes, relationships and levels of partnership and coordination both within and between nation states. The emphasis put on certain areas of provision over others, by, for example, national governments or European and supranational policy frameworks, will have differential impacts on the ground, and may, for example, create perverse funding consequences.

2 MENTAL HEALTH PROVISION IN FRANCE

2 MENTAL HEALTH PROVISION IN FRANCE

Policy context

The economy and labour market

After Germany, France contributes the most to EU GDP, 17.2% in 2020.[89] In contrast, Ireland contributes 2.8% and Poland contributes 4.0%. GDP per capita in France, as measured by purchasing power parity (PPP) (EU = 100), was slightly above the EU average in 2021 and well below that of Ireland's, which has a PPP of more than twice the EU's.[90] France has relatively high productivity, but it is less than the other two countries.[91] Services constitute about 80% of total employment in France and industry 10% (compared to 60 and 20% for Poland).[92] In 2021, its unemployment rate was equivalent to the EU average, or 7.31%.[93] The percentage of young people (15-24) categorised as not in education, employment or training (NEET) is just below the EU average of 10.8%.[94] The pay gap between men and women in France is significantly higher than the EU average of 13% (women < men), at 15.8%.[95] At 4.8%, France has one of the highest levels of precarious employment in Europe, with Poland not far behind at 4.5%.[96] 18% of French people are at risk of poverty or social exclusion.[97] About 30% of the French population cannot meet unexpected financial expenses.[98] France spends the most on social protection benefits of the three case study countries: 33% of GDP in 2021 (compared to under 25% for Poland, and lowest for Ireland of all EU countries, at 13%).[99]

Population health

France has one of the largest populations in Europe, 67.7 million in 2021, and second to Germany, at 83.2 million;[100] one of the highest birth rates and the second-highest number of asylum applications. Within the population, 20% is aged 65 and over 38% live with at least one chronic condition. 24% smoke (compared to 16% in OECD countries), and this may be a contributing factor.

At the same time, France is one of the highest spenders on health, at 10% of GDP (with Germany highest at 11.2%), while Poland has the lowest (4.8%) – and was the only country to record a decrease in expenditure between 2019 and 2020.[101][102] However, healthcare spending reached record lows during the pandemic, with France spending barely more than in 2019, despite or because of the pandemic. Social protection as a system has enabled French people to live longer and healthier lives, but there are tensions around raising the retirement age and changing amounts allocated due to its financial difficulties.

COVID-19: key impacts

As of 17 October 2022, France had a COVID-19 death rate of 233.95 per 100,000, placing it above Ireland (160.9), but below Poland (310.52).[103] As of mid-November 2020, it had one of the highest rates of prevalence in Europe.[104] [105] During the pandemic, France had strict national lockdowns, similar to Italy. The government imposed a restrictive lockdown in March, including the closure of all schools and other public places, except essential shops. Only people providing essential services were allowed to go to work. Written justification was required for going out, other than to buy food, for medical reasons or for one hour of recreation. The response to the first wave, "revealed the low level of preparedness for pandemics and the overly hospital-centred provision of health care in France".[106] The conditions of the lockdown became progressively stricter, with the closure of outdoor areas, such as open food markets, parks, forests and beaches, and an intensification of police controls to enforce the stay-at-home policy.[107] There were 30,000 deaths and more than 30,000 patients were hospitalised (at its peak) in the first wave.[108] As with Poland and Ireland, those most at risk of contracting the virus were older. From March 2020 to June 2022, 73% of those who died were aged 75 and over.[109]

Among more than 300 indicators, income was the most associated with hospitalisation during COVID in France. Those in unskilled occupations living in deprived areas were at high risk during the pandemic, but not for severe COVID-19. They were likely to remain active, but with a high rate of infection. As in other countries, lower-paid workers, particularly in the service sector (e.g., food, cleaning or delivery services) were more likely to be key

workers and required to go to work and rely on public transport to do so. All these factors increased their exposure to the virus and to virus transmission in their neighbourhood, and thus, indirectly contributed to an increased hospitalisation rate. Occupational status, immigration status, unemployment status and living in public low-rent housing were strongly associated with the hospitalisation rate.[110]

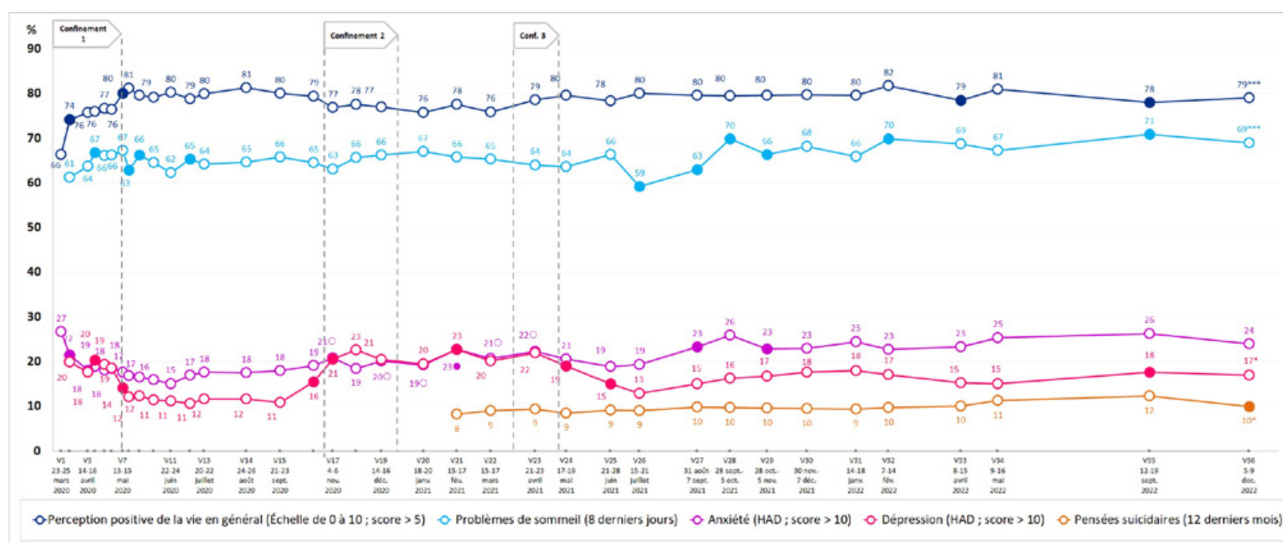
During the pandemic, health insurance benefits were automatically extended for vulnerable groups, and COVID-19 was recognised as an occupational disease for medical staff.[111] Two thirds of salaried workers benefited from employment protection programmes.[112] However, the impact of COVID was felt the most for those in precarious employment. 9% of 15-24 year olds lost their jobs during the March-May lockdown in 2020 versus 2% of those aged 40-65. There was a loss of 715,000 jobs during the first half of 2020.[113] In May 2020, 23% of households thought their financial situation had deteriorated, especially those whose working hours had been reduced.[114]

COVID-19 and mental health

COVID-19's impact on mental health in France was significant.[115] CoviPrev survey data (see Figure 4) showed that one third of the French population reported symptoms of anxiety or depression during the pandemic.[116] In a May 2022 Ifop survey, 40% of French respondents reported having felt more depressed since the start of the pandemic. The French were found to be the most likely to act on suicidal thoughts among the six European countries. One in five had contemplated suicide and nearly one third had attempted suicide in the same period.[117] This is reflected in the comments of a head of a psychiatry department in a regional hospital interviewed for the study, who described "a wave of demand […] with an increase in suicide ideas and suicide attempts". [Interview FR7]

Young people, those living alone, single parents, low-income families and women were all groups found to be suffering more from a range of mental health conditions.[118] Those in financial difficulty experienced double, even triple, the rate of depression and anxiety compared to those in a

Figure 4. Prevalence of sleeping problems, anxiety, depression and suicidal thoughts experienced in the French population during the pandemic.



Source: Coviprev Survey 2020.

Key: dark blue – current life satisfaction; light blue – problems with sleeping in the last eight days; purple – anxiety; pink – depression; yellow – suicidal thoughts

good financial position. An astonishing 41% of those in a difficult financial position expressed anxiety in October 2022.[119]

In May 2022, 12% of respondents categorised as "getting by" declared that they were having suicidal thoughts, a jump of almost 4% from April. In general, over the past two years, this percentage has remained between 8 and 12%. Those in a very difficult position are almost double those of the other categories, ranging from 13.5% at the lowest point, in November 2021, to 22.6% in September 2022. Most of the time, the percentage has ranged from 16 to 18%. The recent FEPS study quoted above reported that 30% of the French population had been hospitalised for suicide attempts during the pandemic, with 9% having undergone multiple attempts.[120]

People do not want to hear about mental health

While the pandemic had helped raise awareness of mental health in France, as one respondent put it: "so now people are concerned about well-being", all respondents emphasised the need to promote mental health literacy and reduce stigma. "In France, people do not want to hear about mental health. It is completely taboo." [Interview FR6]

A clinical psychologist linked a relatively high national uptake of prescribed medication with the difficulty that French people have about talking about mental illness: "In France, mental disorders remain taboo, even though we are, I believe, the country that consumes the most antidepressants. But there is really a difficulty in being able to talk about depression, anxiety." [Interview FR9]

Stigma was attributed to low levels of mental health literacy: "A very poor knowledge and the impossibility of experiencing, and therefore, understanding psychological disabilities and cognitive disorders lead to a great stigmatisation." [Interview FR1]

A lack of knowledge extended to those working with people with mental health conditions and its impact on their care:

> *A young man with a disorder that, among other things, causes him difficulty in understanding a schedule, does not warn the home care staff when he is absent and misses his appointment. The worker wants to punish him by not assigning him the missed hours of care. However, to do this effectively amounts to penalising him because he has a disability that is apparent. [Interview FR1]*

Stigma leads to isolation and negatively impacts on the ability to access housing and employment. Inequalities in housing and employment, in turn, are linked to mental ill-health:

> *We must work on the stigma suffered by the people concerned, thus allowing better access to housing and better access to employment. Better support for families who suffer enormously and who are often the first to be laid off. [Interview FR2]*

Respondents commented that people need to be comfortable with the word psychiatry – as it has long had negative connotations. Currently, stigma acts as a barrier to early intervention:

> *We need a television campaign, communication through the media. We need a way to reach the entire population if we want social representations to change and access to care to be earlier, and there is less trauma and less hospitalisation. So, it's a global problem, and we can't limit ourselves to psychiatry. You must take mental health into account, in general, if you want it to work. [Interview FR6]*

A very poor knowledge and the impossibility of experiencing, and therefore, understanding psychological disabilities and cognitive disorders lead to a great stigmatisation. [Interview FR1]

Lack of investment

French politicians recognise there is a crisis in the mental health care sector.[121] Even before the rise in mental health issues associated with the pandemic, demand for mental health provision was high in France. Yet, throughout the interviews, the mental health system was referred to as the one that was given lowest priority by government funding:

> *The post-pandemic mental health system is an exhausted system that is also finding its wear and tear from problems that dated back to before the pandemic […]. This is because in France, the psychiatric sector has always been very neglected. [Interview FR9]*

Respondents described the lack of investment, poor working conditions, low pay, and the resultant staff turnover and shortages in the sector:

> *We are really paid very little in the hospital, so it's hard to envision a career. I love the hospital; I really enjoy working in the public sector. But, at the same time, I am paid €900. It is unbearable in the long term. That is, at some point, I will have to leave. [Interview FR9]*

> *And how these had been exacerbated by the pandemic: "Today, there are not enough psychiatrists, resources, that are invested in psychiatry in France. Following the health crisis, there was a shortage of professionals: nurses and nursing assistants left their jobs." [Interview IR2]*

There is little investment in innovation and medical research:

> *Psychiatry is a discipline of which we still know nothing. Neuroscience must continue to work to try to understand, for example, what is happening in the brain of a depressed person. I believe that the resources allocated to mental health research must be multiplied by ten. Currently, we have the lowest budget for research in France. If it is at one in France, it is at ten in the USA. [Interview FR7]*

There is also little data on socio-economic inequalities. As Michael Marmot has discussed in the *Lancet Voice*, little is known about the extent to which people from minority ethnic groups have been affected by the pandemic, with an outdated restriction on ethnic data collection, a barrier to mapping systemic inequalities and informing policies.[122]

Hospital-centric

Mental health services in France are largely hospital-centric. Hospitals are the primary providers of clinical treatment, focusing on the treatment of mental disorders, with a particular emphasis on supplementing capacity for psychiatry and the psychiatric wards across hospitals.[123] As an indication of this, a person's referrals to psychiatrists and related hospitalisations are covered by health insurance, whereas visits to a psychologist have only been included fairly recently in that coverage.[124] At present, French general practitioners (GPs) have little contact with mental health care teams and report communication with psychiatrists to be particularly difficult. However, when GPs do have access to collaborative care with psychiatric services, they report greater knowledge, better skills and more comfort in managing psychiatric disorders.

The initial response to COVID-19 was based in hospitals. What was illustrated during the pandemic was the need for continuity in mental health care, not just a change from hospitalisation to GP but to local community provision.[125] Respondents felt that the crisis should be a lever for both transforming health care provision and improving the governance of public health.[126] One respondent described the need

Today, there are not enough psychiatrists, resources, that are invested in psychiatry in France. Following the health crisis, there was a shortage of professionals: nurses and nursing assistants left their jobs. [Interview IR2]

in the sector "to diversify the care offer by creating services, mobile teams, home hospitalisations, day hospitals". [Interview FR8] One consequences of the continuing emphasis on hospital-provided psychiatric services is that people who could be treated locally for common mental health disorders often end up in acute care, as described by this respondent:

> *Care pathways need to be gradual. For example, when you have an anxiety attack, you must go see your general practitioner. If it lasts a long time, you can receive extra help, etc. Things must be gradual but, in France, we are not good at this. We will use second-level resources for patients who do not even require any first-level resources. Therefore, we overload the second level, which is going to be unable to manage what there is to really do for more serious, more severe patients. [Interview FR7]*

While there has been a long-standing and strict dichotomy between hospital and community care, the pandemic forced the health system to introduce a more flexible structure of care that progresses it towards providing home aftercare, social services in the community and rehabilitation services that are not singularly confined to clinical or hospital settings. There has been some reform that has "promoted and developed cooperation and multi-professional practice, in particular, in health centres and clinics, and more recently, territorial coordination".[127] However, there is a continued lack of investment in primary health care services and public health; lack of coordination between primary, social and hospital care providers; and a failure to adapt measures to local needs: "[We need to] increase the number of caregivers to meet current needs. Here, 'caregivers' refers not only to doctors but also to speech therapists, psychologists, and paramedics." [Interview FR11]

All outpatient care activities continue to be managed by multidisciplinary teams connected to a hospital and, while these represent an attempt to shift towards more community-based mental health care, studies of the beliefs and attitudes of GPs show that structural change will be required to move towards collaborative practice in delivering mental health services.[128] The overfocus on hospital provision also means that people are seen primarily as patients and are not given support in other areas of their lives. This failure to address the person's needs holistically was identified by the Director of an NGO:

> *The solution is to do cross-training between the health, social and medico-social sectors. The main priority for people with mental health problems is to promote accompanied housing. One cannot be cured without housing. That's why we have to work on the social and health sectors at the same time […]. To limit the management of psychiatry and mental health to the health sector is to confine people to the status of patients. But they should always be treated as citizens. [Interview FR1]*

The interviewee went on to recommend the establishment of an interdepartmental forum to be set up for mental health and psychiatry, in collaboration with all ministries, in particular, the Ministries of Housing and Employment.

Lack of promotion/prevention policy

Another consequence of the focus on acute treatment is a relative neglect of preventative services:

> *We should create many more resources, jobs and infrastructure at the level of prevention. Because, for example, we are always busy in our territory managing people who need urgent attention. So, how do you want us to take care of people who are doing well today so that they don't have to fall sick in the future? [Interview FR7]*

A psychiatrist specialising in adolescent mental health described how they are always responding to emergencies and have very few opportunities to practise the preventative side of mental health provision:

> *Ever since I came here, the only thing I've done is emergency medicine. If I were to do prevention, I clearly don't know where I'd put it in my schedule. I don't know if it's just because we're badly trained, we don't have enough time, or it's just not in our culture. [Interview FR11]*

Respondents in all countries stressed the need to improve access to mental health services. In France, a psychologist in a rehabilitation centre remarked:

"At the moment, at the French level, we must create structures everywhere to promote access to care." [Interview FR6]

More specifically, there is a need to provide access to services for common mental health disorders.

> *To avoid complete collapse, we must not create specialised structures for people who already have a diagnosis. We need to create very liberal access to mental health to attract people and to be able to direct people to very general care and prevention. [Interview FR6]*

Promotion and prevention were central to the mental health roadmap of 2018,[129] published after analysis of national health needs by the *Haut Conseil de la Santé Publique* (High Council of Public Health). They included promoting well-being, preventing and detecting mental disorders early, and preventing suicide to guarantee coordinated chains of healthcare, backed by accessible, diversified and high-quality psychiatric services and improving living conditions, social inclusion and citizenship of those with mental health conditions.

Telemedicine is not a panacea

Telemedicine on its own was not seen as sufficient:

> *The use of telemedicine is a double-edged sword. It can be beneficial and really allow people who live far away to access care despite everything. Together, in-person and online healthcare go well hand in hand, but online healthcare alone is poor. [Interview FR11]*

A clinical psychologist pointed out that: "To use telemedicine, you have to be mindful of your framework, your ethics. You must know how you use it and why you use it." [Interview FR9]

It was also not appropriate for some people:

> *It was still quite a difficult transition because this system was new. For example, there are some young people who told me that it was not easy to talk on their phone or on video. They weren't always comfortable. Not everyone, including caregivers, was comfortable. [Interview FR10]*

Another spoke of challenges building trust between professionals and patients in online consultations:

> *Telemedicine has not been easy during the pandemic. Everyone had the right equipment, but on the patients' side, there was a sort of discomfort. In these virtual interactions, there is a lack of intimacy. It's not easy to go and talk to your therapist when you are in a collective accommodation. [Interview FR3]*

Respondents described the way in which telemedicine could be used to reduce inequalities in mental health care: "Virtual care does not create inequalities, it solves inequalities: interviews become possible in remote territories." [Interview FR6]

At the same time, inequalities are a barrier for vulnerable groups to make use of mental health services online, and there is a lack of funding to enable people to access the internet:

> *I know there are people who don't have access to the internet; I'm not going to offer them telemedicine. They just come to the hospital. However, are there any funds allocated for people to have more access to screens? No, not at all. [Interview FR9]*

While most respondents were quite positive about France's progress with digital innovation, it is nevertheless weak relative to other countries. Only 23% of adults who needed to see a doctor during the pandemic could do so remotely, compared to an OECD average of 45%.[130]

3 MENTAL HEALTH PROVISION IN IRELAND

3 MENTAL HEALTH PROVISION IN IRELAND

Policy context

The economy and labour market

Ireland is considered to have one of the most affluent economies in the EU. However, multinational corporation investment in Ireland serves to artificially inflate GDP.[131] [132] The European Union Statistics on Income and Living Conditions (EU-SILC) survey found an increase in household income and wealth between 2020 and 2021 and decreased income inequality.[133] Approximately 20% of people in Ireland were at risk of poverty or social exclusion, slightly lower than the EU average of 21.7%.[134] The Government of Ireland's roadmap for social inclusion sets out a goal to reduce the numbers of people living in consistent poverty to 2% or less by 2025.[135] SILC data have recently indicated that progress is being made towards this target, with consistent decreases in the numbers in consistent poverty.[136]

Ireland has amongst the highest levels of productivity internationally.[137] Precarious employment, including temporary and permanent part-time work, underemployment, marginal part-time work, and involuntary temporary work, is increasing in Ireland, with an estimated 31-51% of employees at medium to high risk of precarious employment.[138]

In 2019, 13.6% of GDP was spent on social protection in Ireland, representing the second-lowest level of spend as a proportion of GDP in the EU.[139] However, as mentioned earlier, the distorting effect of multinational corporation investment on the GDP rate must be considered when interpreting these figures. When the global hunger index (GHI) was used as a comparator with GDP from other OECD countries, Ireland ranked third in its health expenditure as a percentage of GDP/gross national income (GNI) behind Switzerland and the USA.[140]

Population health

Ireland has a relatively young population, with a median age of 38.5, compared to the EU average of 44.1 in 2021.[141] It has one of the highest fertility rates in Europe, behind only France and Sweden in 2017.[142] Over the period 2008-2018, life expectancy increased by two years for women and three years for men, with women now expected to live to 84 years and men expected to live to 80 years.[143] The dependency ratio is expected to rise by 1.7% between 2019 and 2039.[144]

In 2018, the leading cause of death in Ireland was cancer-related diseases, followed by diseases of the circulatory and respiratory systems. Research indicates that across all causes, mortality rates have declined by 10.5% over the period 2008-2018. There has been a significant fall of 38% in suicide rates over the period 2009-2018. The suicide rate of 7.6 per 100,000 population is below the EU average.[145][146]

Ireland has the highest self-perceived health status in the EU, with 82.9% of people rating their health as good or very good. Higher income earners were more likely to report good or very good health.[147] In 2017, 28% of males and 27% of females reported a long-standing illness or health problem, considerably lower than the EU average.[148] 13.5% of the Irish population had a disability, with slightly more women than men reporting one.[149] In 2016, 18.5% of the Irish population had a mental health disorder, such as anxiety, bipolar, depression or drug or alcohol use.[150] It was one of the highest rates of mental illness in Europe, with the EU average at 17.3%.[151] However, in 2022, 42% met diagnostic requirements for at least one mental health disorder, and more than one in ten adults had attempted suicide.[152]

There is a strong association between area-level deprivation and suicidal behaviours in Ireland. Suicide rates are two to three times higher in the most deprived neighbourhoods compared to the most affluent.[153] Those who have experienced a traumatic life event, are employed in jobs requiring shift work and are younger in age are more susceptible to mental illness.[154] Research also indicates that unemployed people are more likely to self-report depression than people in employment.[155]

COVID-19: key impacts

As at 15 October 2022, a total of 7,970 deaths related to COVID-19 were recorded in Ireland. Men accounted for slightly over half of deaths at 53.5%. Just over three quarters (76.3%) of all deaths had a known underlying health condition. The median age of death was 82 years, with 40.5% of all deaths in the 85+ age group and a further 32.5% of deaths in the 75-84 years age group.[156]

Those in disadvantaged socio-economic groups accounted for higher proportions of deaths in the 65+ age group, relative to their share of the population. While limited data were available, evidence also indicated that those with Black or Asian ethnicity and eastern European nationals accounted for slightly higher proportions of deaths relative to their share of the population.[157] Many of the most at risk occupational groups were in the low-paid sector, including care workers, processing plant workers, elementary cleaners and transport drivers. The combined effect of their underlying characteristics (such as socio-economic background, chronic disease and age profile) and working in essential services on the frontline during the pandemic put these groups at the highest risk of severe COVID-19-related outcomes.[158]

The impact of the COVID-19 pandemic on the employment rate was significant in Ireland, with the second-largest decrease in the employment rate across EU member states between 2019 and 2020, at almost 3% among people aged 20-64.[159] Almost half of all workers (47%) had their employment affected by COVID-19, with 14% of this group stating they had lost their job and 33% stating they were temporarily laid off. Younger age cohorts experienced the highest rates of job loss and temporary layoff, with 46% of 15-24 year olds being temporarily laid off and 22% experiencing loss of employment.[160]

Evidence suggests that the labour market recovered somewhat in 2022, with the employment rate standing at 4.4% in October, below the value of 5.3% recorded in 2021. The youth unemployment rate (jobseekers aged 15-24) remained high (although declining) at 12%.[161] The long-term unemployment rate has fallen over the past year, and currently stands at 1.2%, down from 1.7% in the first quarter of 2022.[162]

Despite significant effects on employment, household savings increased in most member states over the course of the pandemic, largely driven by decreases in consumption. Ireland had the second-highest level of increase in savings at 12.8 percentage points.[163] COVID-19 supports, such as the pandemic unemployment payment and wage income support scheme, cushioned against the potential severe impact on income and household debts, both at the EU and national levels.[164][165][166][167] It has been estimated that, without them, median gross household income would have fallen significantly.[168]

COVID-19 and mental health in Ireland

Studies conducted shortly after the onset of the pandemic found high levels of loneliness, depression, anxiety and post-traumatic stress amongst respondents[169][170][171][172] Crowley and Hughes[173] found a significant increase in demand for online and telephone-based mental health services/supports during the pandemic, with a 490% increase in traffic to the Health Service Executive (HSE) website yourmentalhealth.ie, and a 137% increase in MyMind online counselling service usage. The Healthy Ireland Survey 2021 found that 30% of respondents felt that their mental health had worsened since March 2020.[174]

Specific groups identified as being at increased risk of mental health problems directly or indirectly associated with the pandemic include those bereaved due to the pandemic, healthcare workers,[175][176] those who lost their jobs as a result of the pandemic, low-wage workers and those in precarious jobs/no job security, people at risk of domestic violence, youth, older people and single parents, women, and those who live alone.[177][178] Similar findings were reported by FEPS, with young people, women, those who experienced unemployment and sexual harassment or bullying at work, and people who had previously been exposed to suicide at high risk of mental health conditions and suicide.[179]

Studies continue to be conducted with a view to learning more about the immediate, lasting and heterogeneous effects of the pandemic on mental health.[180] So, for example, at the onset of the pandemic, it was expected that, while levels of depression, loneliness, isolation and anxiety would be heightened for the population as a whole, they

would revert to normal over time for some sections of the population, while other groups may be at increased risk of ongoing mental health issues. Groups particularly susceptible to longer-term negative mental health outcomes associated with the pandemic include those with a history of mental illness, experience of loneliness, death anxiety, intolerance of uncertainty, and those with lower levels of resilience most likely to experience depression, anxiety or COVID-19-related post-traumatic stress disorder (PTSD).[181]

A similar crisis of underinvestment

As with the other case studies, mental health provision had been pushed up the agenda in Ireland during the pandemic:

> *I suppose that a positive has been that mental health was mentioned in nearly all of the government addresses talking about COVID-19, you know, during lockdown and looking after people's mental health and you know, that it's at the forefront of people's minds, you know, we're into looking after each other's mental health. [Interview IE4]*

However, spending on mental health as part of the wider health budget remains comparatively low, with a figure of around 6%.[182] Historically, there has been such a lack of public sector funding for mental health services that charities and local community or civil society organisations have played an important role in providing mental health services and raising public awareness around mental health issues. They also often receive ad hoc or partial state funding. Consequently, the model of mental health provision has evolved differently to that of France or Poland.

Respondents all spoke of the increases in mental ill-health during the pandemic and the corresponding increase in demand for services, which highlighted the underfunding and under-resourcing of the healthcare system, particularly ongoing staffing issues within the public sector. One mental health charity talked about the 35% increase in numbers calling their helpline during the pandemic, but also an increase in numbers wanting to volunteer with the charity.

In the public sector, staff turnover remains high:

> *Like in the olden days, when people like new came to a job, he stayed in it, if you like, to the way everybody is moving and changing, like I, I just don't go to any more parties on our team, because somebody comes there for a year and they're gone again, you know, you're exhausted, number one getting them used to it. [Interview IE1]*

Understaffing and turnover led to a tick-box approach, in which staff did not know case histories and did not build longer-term relationships with patients:

> *[P]eople are busy, so they don't have time to read the files, you know, the way but I do think, you know, in the olden days assessment was look at the old file, you know, the way to get a sense of what's going on here, you know, the way the people that were there for the previous 20 years worked and competence. Yeah, read the file, you know, the story. And yes, a fresh pair of eyes may bring something new, but don't discard the history there, you know, that sort of [thing]. [Interview IE1]*

This was made worse by COVID-19, with staff going back to their home countries with the effect that "often people didn't know who was knocking on the door that morning to help them with care packages". [Interview IE1] As one respondent pointed out, this is in the context of Ireland's overall crisis in health provision, not only mental health:

> *Okay, you know, notwithstanding the lengthy waiting lists, or the inaccessibility, or the chasm between public and private health care, and so it's bigger than mental health, you know, so the ethos in our like, so you'd hear the national conversation talking about the health crisis now. So, what does that mean? The length of the waiting list for someone to have a hip replaced, or to have a kidney transplant or whatever it might be? The conversation doesn't necessarily pertain to the length, you know, and anecdotally speaking about it, how many psychiatric beds are there in the country for people experiencing acute crisis? [Interview IE3]*

The long waiting lists for access to services in some parts of the country are also well documented.[183]

There was also discussion across the interviews of the knock-on effects of mental health on physical

health. Those with mental health conditions, especially during the pandemic, delayed going to their doctors about physical symptoms. While they may have seen this in all groups, the impact would have been felt more in vulnerable groups: "People may have delayed getting help, or any kind of healthcare over the last while or across the board." [Interview IE2]

Hospital-centric

As in France, there is a lack of local primary support for common mental health disorders, and so, people find themselves in the acute sector:

> *If people are having a reaction to a crisis, most of them aren't going to need specialist-level help; they might need support at a primary care level. And that's really important. And we should be certainly increasing the level of support available at that level. Okay, no, and not all the time funnelling people up to the most specialist type of service, right, we should be responding to people at the most appropriate level in the system for their needs, you know? So, it's kind of a crude analogy, but you know, if I sprained my ankle, I wouldn't go to see an orthopaedic surgeon. No, you know, if I'm having, you know, some sort of reactive anxiety to something that's happening in my life, I don't necessarily need to see a consultant psychiatrist. [Interview IE5]*

The Irish government has been criticised for not implementing enough of a move away from institutionalised and hospital-based services and towards community-based services, early intervention and preventative measures to avoid and alleviate mental health problems. The national strategy to reduce suicide has focused on strengthening pathways to services for people vulnerable to suicidal behaviour and improving the capacity of community-based organisations to provide appropriate information around suicide and recognising risks.[184]

While Ireland has significantly reduced the number of psychiatric hospital beds (70% reduction in the past 20 years compared to 10% in Poland),[185] poor delivery structures, workforce planning issues, increased demand and underfunding have resulted in long waiting lists in some geographical areas and a lack of access to services, such as help for those experiencing a mental health crisis or emergency.[186] [187]

The interviews confirmed the multidisciplinary approach now taken:

> *When I came here, there was the nurse, social worker, the doctors, you know, it was quite a small team. And now we have dieticians on the team, you have employment specialists, you have occupational psychology [...] our team always has full capacity. [Interview IE1]*

However, despite the benefit of these teams, she described the short termism (rather than longer-term support) provided by current delivery:

> *They do it in very short-term inputs, you know, the way and then they all come to the meeting and say everybody's kind of cured and doing very well, you know, but unfortunately, within a couple of months, most of those cases do come back to the social worker, the community nurse and the doctor. [Interview IE1]*

While charities and those on the ground in the public sector had a good understanding of the complexity of the issues and need for integrated responses, they were concerned that there was no integration of government policy:

> *So, there's kind of no strategic focus on the issue of disadvantage, and how that links with children's well-being, so we would have had better outcomes, brighter futures, which was the national strategy for children and young people, which would have tried to integrate those different strands. [...] But in the interim, there's nothing there. And we just hope that it's very, very ambitious for children and young people, and that there's buy in from all government departments that it's not just either the Department of Social Protection tasked with addressing the poverty piece was the Department of Children addressing child and family services where it's really, you know, health, education, housing, all those departments need to come together to work. [Interview IE2]*

Respondents saw the need for local government to provide mental health services:

In other countries, obviously, there are local authorities or their local governments are much stronger than what we have here in Ireland, which is always a limitation, but something that we would like to see is that there's kind of social-inclusion funding provided to local authorities, where they have to make social-inclusion plans for the delivery of services in the community that involves people in the community. [Interview IE2]

One respondent, head of policy and advocacy for an Irish mental health charity, felt that innovations in mental health provision currently come from the bottom up in the voluntary sector, including empowering volunteers within the community:

[It] would be interesting to see from a bottom-up approach around this kind of innovation, particularly in the community and voluntary sector, who do work directly with people who are maybe marginalised and how that intersects with mental health difficulties as well. But also, you know, around mental health, well-being and connection, well-being around volunteering and working in your local community as well, and how you can ensure that the communities that people are supporting are represented in the volunteering profile as well. [Interview IE2]

Recognising the socio-economic context of people's lives

The consistent message in the Irish interviews was that both policy and services need to address the socio-economic context of people with mental health issues. A policy and advocacy coordinator working in a men's health charity, and part of a national mental health coalition, talked about the effect of the pandemic:

[T]he cohorts of society who lost their jobs and the pandemic as well tended to be young women, migrant workers who might have been working in the low-paid hospitality and tourism industry. So, there's, there's that kind of socio-economic piece that's interwoven [in]to all of this as well. [Interview IE4]

Another head of policy and advocacy working for one of the largest charities tackling poverty in Ireland also spoke about how mental health issues are exacerbated by low socio-economic status: "Mental health issues would be prevalent in our work anyway. Okay, whether it's a cause or consequence of poverty or low income, or other factors of deprivation or disadvantage, it can exacerbate that situation for people." [Interview IE2]

They spoke of the importance of delivering services that gave both financial and emotional support to vulnerable groups:

[A]nd having a chat with someone, you understand exactly what's going on, why or why someone may need help with food that week – could be for a myriad of reasons. So, they had to pay for schoolbooks, or they had a rent increase or, you know, understand exactly what's going on. And then, because support and friendship are so important, it's not just about financial assistance, it's about being able to make that kind of connection with people as well. It's way more difficult. [Interview IE2]

Prevention and early intervention

The Irish government has committed to developing a mental health system that "delivers a range of integrated activities to promote positive mental health in the community; it should intervene early when problems develop; and it should enhance the inclusion and recovery of people who have complex mental health difficulties."[188] Stated policy priorities are both prevention and promotion oriented around well-being, ways to support positive mental health in community terms, and early intervention. Looking at co-operation on mental health from a wider public health perspective would offer space to explore this focus, as well as the structural and

both policy and services need to address the socio-economic context of people with mental health issues

social determinants of mental ill-health. Several respondents spoke of the role that employers and industry have in establishing workplace culture that promotes mental health:

> *[We need to] sharpen the conversation and broaden it, in respect of, you know, well-being: emotional well-being – psychological well-being, not just in the workplace, because we kind of divide ourselves into, you know, a professional self and a personal self; we are just one person. [Interview IE3]*

Notwithstanding, the literature has identified a need for clarification on the difference between raising mental health awareness of the "softer" or "milder" presentations of mental health issues, and an associated discourse that all mental health issues can be prevented, and that self-care – exercise, for example – can help in all cases. This may lead to a disproportionate focus on prevention and early intervention, at the expense of specialist services for those with more complex or severe needs.[189 190]

The need for digital mental health policy

One positive development in mental health provision, as a result of the pandemic, that was described by respondents and has been widely examined in policy literature was further use of digital services (as recommended in the government's 2020 Sharing the Vision recommendations):[191]

> *I mean, from the digital perspective, basically, they are moving on in terms of the policy, for example, there is now a specialist group on digital mental health that mental health reform also sits on. And there is an improvement. I mean, it is, you know, we got that specialist group recently set up. So at least now there is definitely an acknowledged need for digital mental health policy. And that's, I think, connected with the dramatic shifts during the pandemic we talked about. Before the pandemic, it wasn't, well, maybe not taken, it wasn't taken seriously. But the urgency wasn't there. [Interview IE4]*

During the pandemic, the government expanded self-help services to promote physical and mental health. Specialist mental health services continued to operate at 85-90% of pre-pandemic capacity, in both community and acute settings.[192] These included the Keep Well campaign; [193] the expansion of telephone and text support; and digital mental health initiatives, including video consultations and online counselling. One respondent spoke about increased government interest in innovation in developing digital services and strategic opportunities for the private, public and voluntary sector to work together on digital innovation projects. The Irish-developed Silvercloud is one example of a CBT delivery platform, marketed to mental health service providers and third-level institutions (such as student counselling and staff counselling):[194]

> *We've been working for the last five years on this with our international partners, some of them were trying to bring them to Ireland. And now I think, again, as a result of the pandemic, the HSE got interested in some of these as well, that they weren't maybe interested before. So definitely, the shift is happening and the increase in interest, there's more support to do that. [Interview IE4]*

The provision of online services was felt to reduce both geographical barriers to access and stigma. A director of services for a mental health charity described the impact of online services in Ireland:

> *But also, I suppose, the fact that we were able to, and one of our core objectives is to reduce the stigma around mental health. So, a lot of people from maybe more rural settings around the country felt more comfortable coming forward to our virtual offerings, because they were, or virtual programmes or virtual support group offerings, because they were not confronted with the idea that they would meet someone they knew; their anonymity was protected by the very nature of that it was nationwide. So that was a boon to a lot of people subjectively on the ground around what they were able to provide for people. [Interview IE3]*

And where demand might not have been there in one local area for an in-person service, they were still able to run services to those areas online. Online group calls might cover several geographical areas, which also led to people with mental health difficulties living in different places being able to connect with each other.

Other innovations that were variously introduced in the case study countries included prescribing online, telehubs for CAMHS (child and adolescent mental health services) and out-of-hours services.

E-mental health has many potential benefits, including wider reach of and access to mental health services, cost-efficiencies in delivering high-volume services, treatment innovation and enhancement, more user involvement and empowerment, and expansion of self-help and access to peer support.[195] However, respondents made it clear that digital innovation was not a panacea for mental health services. It was not only a question of whether the provision was there: "[B]ut it's now how to use it and how to use it safely and appropriately and for whom and how; that's why the choice element here is going to be the most important." [Interview IE4]

It also has different purposes, including to increase reach and access to therapy, enabling innovation in existing treatment approaches, supporting people to manage their mental health issues, or a variety of other purposes.

Regional inequalities in internet connectivity are an issue:

> *In one way, you know, it improved access, especially for people living in remote areas, and different groups that maybe wouldn't access the services previously. So, they were able to access it now. But, on the other hand, the ones who were digitally excluded weren't able. So that was the big change that happened. [Interview IE4]*

And there are inequalities in digital literacy:

> *[T]he COVID-19 pandemic has reduced some of them in relation to people from more remote or isolated settings being able to access support, obviously, if people are digitally literate. I think it's dependent on localised funding, you know, regarding the provision of statutory support. [Interview IE3]*

One member of a mental health national coalition organisation felt that:

> *[T]he government has become more and more aware of the digital divide. You know, so traveller-specific mental health services, having services available in different languages, we've seen, so we also developed a cultural competency toolkit for mental health services. So, like that, if in your community, you might have some Ukrainian refugees arriving, and you want to adapt your mental health services. So, there's a toolkit available on our website, and we did the ethnic minority guidelines with the Mental Health Commission as well. [Interview IE4]*

Not having a private space at home to have the consultations online was another barrier to access:

> *For some, it was great to have the first conversation online, because young people felt, if they don't like the psychotherapist, they can always drop or whatever, like they have, it was very secure to have it. But for others, for example, because of housing issues, they don't live on their own or they share apartments. So, it's not appropriate to have therapy sessions. So, there's a lot of difference. [Interview IE4]*

A director of policy and research for one mental health NGO pointed out that services now needed to look at the infrastructure needed to roll out digital services more extensively:

> *But I suppose putting the infrastructure in place that supports that. So, I mean, that's, that's the obvious things like broadband, and so on, but there's this, there's a potential for a possible intermediary level of, of support. So, it doesn't have to, you know, you're not necessarily accessing this in your own home, particularly, maybe, maybe if you don't have, you know, a laptop or so on. Yeah. But there would be mental health hubs. So, for example, a primary care centre might have a room that could actually be a room that you could go and have your consultation in. [Interview IE5]*

Data collection, and attendant accountability in relation to that, is also an area that respondents pointed out needed to be improved across mental health services in Ireland. This has been recognised by the government in its commitments on data policy outlined in Sharing the Vision.[196] One issue is that a large proportion of services are provided by the community and voluntary sector, and these are not always captured along with the statistics for state providers.

4 MENTAL HEALTH PROVISION IN POLAND

4 MENTAL HEALTH PROVISION IN POLAND

Policy context

The economy and labour market

Poland is not as affluent as the other two case studies. In 2021, GDP per capita was €13,760, compared to €70,530 in Ireland and €32,530 in France.[197] However, the country has been relatively resistant to an economic crisis during the pandemic.[198] This is due to a combination of factors, including its economy performing very well before the pandemic, a relatively lax approach to economic lockdown and luck.[199] It has faced a sharp decrease in direct trade, as a result of sanctions with Russia and Belarus; weaker domestic demand; decreased demand from trade partners and the impact of its precarious labour market.

Productivity in Poland in the first quarter of 2022 was behind Ireland but ahead of France.[200] [201] In 2019, 29% of the population were economically inactive. Labour market participation was also highly uneven across populations with different skills levels, and women were also less likely to be economically active.[202]

Unemployment rates in Poland have steadily improved over recent years and in 2021, at 3.4%, were the lowest in the EU, according to the latest Eurostat figures.[203] The employment rate is similar to that of Ireland at approximately 73% and slightly lower than France. Around 1.3 million Ukrainian refugees (equivalent to 3.5% of the Polish population) are currently hosted in Poland. Most have been able to find work, but many are working in elementary jobs. This has temporarily alleviated labour shortages in parts of the economy.

Poland has a lower percentage of those at risk of poverty or social exclusion (16.8%) than France (19.3%) or Ireland (20%).[204] 40% of the population live in rural areas, and they are 11% more at risk of poverty than those in cities.[205]

Government expenditure on social protection in Poland is approximately 17% of GDP (2020), compared to 27% for France and 11% for Ireland. Most of that, as with France, is spent on older people, much less on unemployment.[206] Spending on health in Poland as a share of GDP, at 4.8%, is the lowest of the three case study countries and has remained consistently below the EU average. It was the only country to record a decrease in expenditure between 2019 and 2020.[207] [208] 72% of Poland's spending is from public sources, but out-of-pocket spending is high, accounting for just over 20% of current health expenditure.[209] Compulsory health insurance covers 91% of the population.

Population health

Poland has an older population than Ireland at a median age of 42 (the same as France). The Polish population over 65 years old increased more than the other two countries between 2011 and 2021,[210] and in 2019, its dependency ratio was 77% compared to 37.6% for France and 45.2% for Ireland.[211] In 2019, life expectancy at birth reached 78 years in Poland, but fell dramatically in 2020 to 76.6 due to the very high level of excess deaths. This was one of the largest reductions recorded within the EU, increasing the gap in the average life expectancy between the EU and Poland to four years. Inequalities in life expectancy by education level are particularly large. A 30-year-old man with a low level of education can expect to live at least ten years less than a man with a higher level of education.[212]

Between 12.2 and 21.5% of the Polish population is estimated to be disabled and half of those people are of working age.[213] At 10.71%, its mortality rate in 2022 is still higher than most EU countries (compared to 6.73% for Ireland and 9.54% for France.)[214] Mortality rates from cancer are among the highest in the EU, with rates more than 20% higher than the EU average.[215] Preventable mortality due to alcohol-related diseases is about 50% higher in Poland.[216] All three case study countries have coronary/circulatory/cardiovascular disease as their leading cause of death, followed by lung cancer in Poland and Alzheimer's and dementia in France.

There are no systematic epidemiological studies of mental disorders in the general population in Poland. One representative survey conducted in 2012 found that approximately 23% of the Polish population aged 18-64 suffered from mental disorders. Of these, the most common were alcohol abuse (11.90%), specific phobias (4.3%) and depression (3.0%). The number of patients diagnosed with these disorders and receiving treatment increased steadily between 2014 and 2016. Suicide remains much higher in Polish men compared to the EU average.[217] Mental and behavioural disorders account for the largest share (over 17%) of the benefits paid out by social insurance to those with short- and long-term incapacity to work.

Polish healthcare spending has been relatively low over the past decades and remains below the EU average. (Its public health expenditure per capita is one of the lowest in the EU. 3.7% – less than 3.5 billion złoty – of its total budget is allocated to its National Health Service) It spends four times less on its mental health care than Germany.[218] As part of the Next-Generation EU (NGEU) National Recovery and Resilience Plan, 12% of €35 billion will be invested in Polish healthcare between 2021 and 2026. The loans and grants are to improve the efficiency of the health system, particularly the hospital sector; the accessibility and quality of health services; to develop capacity in digital services, medical universities and healthcare providers by training medical staff; and to support scientific research and the pharmaceutical sector, to strengthen the resilience of the Polish health system.[219]

COVID-19: key impacts

As of 8 November 2022, there had been 118,178 coronavirus-related deaths recorded in Poland.[220] The country's geographical structure meant that the natural speed of transmission in Poland was slower than in more densely populated western European countries. The proportion of its population living in low-density rural areas greatly limited the number of daily contacts.[221]

During the first spring 2020 wave of the pandemic, there was no statistically significant increase in the number of excess deaths (above the five-year average) in Poland and the economy was doing well. However, in the second wave, the government implemented a wait-and-see approach, introducing belated measures that ultimately proved less adequate. While teleworking was used to avoid layoffs, this was not amenable to the higher share of industrial jobs not able to be performed online in over half of the country's regions.[222]

The poverty rate and income inequalities increased as COVID-19 reduced the employability of those with the lowest level of qualifications. With less than a third of the population having any savings and 25% working in precarious employment, and therefore, not receiving coverage from unemployment insurance, many were dependent on government provision. In a recent survey, nearly half of respondents stated that the pandemic had worsened their financial situation, with those in the 40-45-year age range expressing the most concern and people working in hotel, catering and recreational industries hit the hardest.[223]

The Polish government was quick to close borders and enforce strict quarantine measures. In April 2020, they introduced a programme that included more flexible employment, subsidised salaries of employees, gave loans to microentrepreneurs and gave sickness benefits to those required to quarantine.

COVID-19 and mental health

COVID-19 worsened an already severely overstretched Polish public healthcare system, as described by a respondent:

> *COVID-19 hasn't changed the system […]. I would love to say that it hasn't got worse, but the less staff we have, the worse it will be in the healthcare system. And this is the direction we are heading anyway; in general, we can see that the care is getting worse. [Interview PL3]*

Mental health provision is based in large hospitals, which were closed during the pandemic. Therapy could not always take place by phone, as there was no system in place to access records, for example. As a result, many patients lost their psychological support. One consequence of being afraid of going to hospital during COVID-19, combined with the availability and low cost of medicine, is that people

increasingly took prescription medicine, as opposed to having therapy combined with medication.

The situation was complicated in hospitals. Wards were treating patients with a range of mental health conditions, but also managing COVID-19 and health and safety restrictions. Patients who were treated in mental health wards could not be admitted to COVID-19 hospital wards due to their psychiatric needs. The only way in which psychiatric hospitals could continue treating their patients was by setting up COVID-19 wards within their psychiatric units. Those who were already being cared for in care homes or psychiatric hospitals experienced isolation and large-scale COVID-19 infection.[224]

While Poland's COVID-19 response was relatively early, allowing the first wave of infection to be contained effectively, the system quickly came under pressure when infection rates increased in the second wave. The shortage of health workers prevented any upscaling of care, even when infrastructure, such as additional beds, was mobilised. The hospital-centric model of COVID-19 response was replaced with one centred on primary health care, which became the first line of response. While telemedicine innovations allowed primary care to continue, provision of inpatient care suffered, with resources being reallocated to COVID-19 patients.

During the pandemic, younger people were more likely to suffer from loneliness, as well as the symptoms of anxiety, depression or stress, the severity of which was also higher in younger respondents and increased with decreases in income.[225] The challenges of working from home, especially for women, have also been associated with increases in these conditions.[226] Greater depression and anxiety symptoms were noted in those of all ages with lower income and whose income was negatively impacted by social restrictions and restriction on earning opportunities.[227]

The pandemic demonstrated that the planning process in Poland had not addressed many areas of crisis management.[228] Shortly before the first outbreak of COVID-19 in March 2020, and again after the milder first wave of infections between June and August 2020, there was a shortage of personal protective equipment and reserve beds in hospitals. Interventions to help the economy were concentrated on companies and employers, rather than on employees. Health workers received some support, but less than originally planned.

Mental health remains taboo

While respondents across the countries felt that the pandemic had moved mental health up the political agenda and into the public conversation, mental health in Poland remains a taboo, a source of stigma. Formal recognition of mental health policies only took place as recently as 1994, with the introduction of the first Mental Health Act. Until then, there had been no definitive legal and social protection of the rights of those with mental health conditions. Training and development of healthcare staff in communicating with patients with mental health issues was an issue identified in Poland. One respondent talked about the tone and body language used by staff. This psychiatrist was involved in projects funded by NGOs, setting up and running cultural projects designed to address perceptions of mental illness and to promote patient self-esteem:

> *The projects showed us that patients are smart and intelligent people, and that if we involve them to participate and talk about issues that are relevant to them, but not in a therapy setting, it strengthens those people, and many of them came out and became guides through the exhibition and openly talked about their crisis. [Interview PL2]*

A respondent described the fear of being identified at work as someone who suffers from mental health difficulties and being stigmatised:

While respondents across the countries felt that the pandemic had moved mental health up the political agenda and into the public conversation, mental health in Poland remains a taboo, a source of stigma

With depression, it is not the sadness that bothers patients. It is the inability to perform at work and focus, and to make decisions – that's what drives people to seek medication. They don't want their boss to find out there is something wrong with them. [Interview PL7]

Mental health in the workplace, such as repetitive instances of burnout, has increased by remote working, which, for many, was the only means of continuing in employment throughout the pandemic. Those with a medical history of mental illness face worse employment opportunities or total exclusion from the labour market. That, in turn, forces them to rely financially on social welfare and makes it more difficult to lead an independent life. The cycle of worsening mental health perpetuates, pushing individuals into further mental health crises. Respondents also spoke of the effect of stigma on vulnerable groups, including migrants and their children, and this is further discussed in chapter 5.

The care is getting worse: a permanent state of crisis

Public mental health care is "in a permanent state of crisis",[229] severely underfunded and overstretched in every way: from physical capacity to accommodate patients; through to financial capability to fund new programmes; to the end point of being short-staffed at every stage of service provision.[230 231]

The majority of service providers (about two thirds) are contracted to provide only one form of care (i.e. outpatient, community, day or emergency (hospital) care), which, combined with poor cooperation among the various providers, means that most patients do not have access to comprehensive and coordinated psychiatric care. Poland has the lowest number of practising doctors and nurses per 1000 population in the EU, particularly in rural areas. There are nine psychiatrists per 100,000 Poles, whereas the figure in France is almost 23 and in Germany is more than 27.[232] There is an acute shortage of child psychiatrists; the distribution of these specialists across the country is unequal. As a result, those diagnosed with mental health conditions, but who do not receive specialist care,[233] face limited availability of publicly funded psychologists and psychiatrists and long waiting times to access support. Another consequence is that high numbers of people self-treat using non-prescribed medicines.[234 235] When people have to pay for health care, the amount can be so high in relation to income that it results in "financial catastrophe" for the individual or the household. Such high expenditure can mean that people have to cut down on necessities such as food and clothing.[236] In 2014, 8.6% of households in Poland had catastrophic spending on health,[237] compared to 2.1% for France and 1.2% for Ireland, with those households in the bottom consumption quintile most likely to experience it.[238]

Frustration in the sector

The interviews in Poland conveyed the frustration of practitioners in the sector. When asked where they saw the greatest opportunities for innovation in mental health services, at the community, national or EU levels, one respondent commented: "If it remains in the hands of the government – nothing will change". Respondents also had a low level of trust in the government: "If you ask if going to the government is a good solution – then I say no, they are corrupted and focused on the opinion polls". [Interview PL2] "No political will to help. The health minister does not consult the representatives of medical care about anything." [Interview PL3]

Respondents described hospitals focused on daily procedures, but with little capacity to develop staffs' skills, renovate hospital buildings or improve the quality of facilities:

If you ask if going to the government is a good solution – then I say no, they are corrupted and focused on the opinion polls". [Interview PL2] "No political will to help. The health minister does not consult the representatives of medical care about anything. [Interview PL3]

Our directors are not keen on taking up the collaboration and new development project. They say we do not have people to work, and we have no energy […] but surely, when you have €600,000-700,000 you can hire someone to do the admin job, but they still said no. [Interview PL2]

Another respondent talked about the connection between the need to destigmatise mental health and raising the status of the mental health sector as a workplace: "the most urgent thing to do is to communicate; it's to destigmatise; it's to improve attractiveness, and to avoid the flight of staff". [Interview FR6]

Charities and private sector plug the gap

Due to the lack of statutory community provision, civil society organisations play an important role, despite little support from the government – sometimes co-funding hospital wards, for example. The number of NGOs, and consequently, the scope and area of voluntary sector provision of mental health, has been growing continuously in Poland since the 1990s. In March 2021, there were over 300 charities listed as operational in different parts of Poland. The humanitarian and refugee crisis has also led to bottom-up self-organised initiatives, where private practitioners have offered therapy to those fleeing the Ukrainian war.

One hospital employee described how reform, such as national roll-out of newly formed mental health centres, is hampered by lack of investment, departmental changes at a governmental level, and low wages and poor working conditions (terms and conditions of contract, the actual conditions of the building and staff shortages):

They came up with the reform, to move treatments away from the hospitals to outpatient clinics and homes, but there are many obstacles […]. First of all, the number of psychiatrists and specialists. Psychiatry is severely underfunded […]; moreover, [there is] resistance from traditionally oriented psychiatrists. Luckily, some doctors, the younger ones, understand that psychiatry needs to be brought out of its four walls. [Interview PL2]

To make ends meet, public sector staff combine shifts in public and private practices, managing two or three workplaces, or they move to the private sector, as described by this psychiatrist working in the private sector:

I would have loved to work in public services […] but when I see the money they offer, then even if I really wanted to work there – I can't. I can't work in public practice because I cannot afford it. My qualifications and training cost me more and my hourly rate is way higher than in public service. The money offered is ridiculous […]. People give up public practices, and go private […] or combine, but they go private because they need to earn something. The money they offer is ridiculous […] the government promised a 1000 zloty increase, but they are still waiting […]. For many, private practice is the base from which to earn enough to survive. [Interview PL1]

Some medical staff would rather migrate than work in the public sector because of the poor conditions: "Often with bad working conditions, no gratitude and low pay, medical staff would rather migrate than keep working in public hospitals." [Interview PL1]

Due to limited capacity and bottlenecks in the public system arising from workforce shortages, waiting times and other symptoms of underinvestment, there was increased demand for private services, despite the costs:

the most urgent thing to do is to communicate; it's to destigmatise; it's to improve attractiveness, and to avoid the flight of staff. [Interview FR6]

If the NFZ[239] system worked, the patients would be looked after [...] but they are not, because I still have queues to my practice [...]. As professionals we work together – you cannot leave anyone without help – so we recommend each other [...] our diaries are full [...] people queue to start psychotherapy, but it is still shorter than for publicly provided consultation. [Interview PL1]

Lack of coordination between sectors

Private and public systems operate separately, and there are few joint initiatives. Rather than any central planning, it is down to the local community to either collaborate with public institutions or organise support independently. Private support and therapy groups do exist in higher-income areas. Art and mindfulness projects are popular; these are organised by groups of volunteers and NGOs. Inevitably, many of these stopped during COVID-19, due to related restrictions.

One consequence of the lack of coordination between sectors is that patient data is not shared between GPs, psychiatrists and other specialists. For instance, medical practitioners looking after a patient with long-term chronic illness do not have access to any shared information on their previous treatment. The most common care route identified by respondents was direct contact with psychologists or psychiatrists for initial contact and then follow up with GPs for maintenance prescriptions.[240] Individuals also use GP services to receive immediate help while waiting for specialist consultation. However, as patient records are not available or shared between professionals, doctors rely on whatever information is provided by the patient at each consultation: "In most cases, we help a patient while he is waiting for psychiatric consultation [...] we give him drugs but then he is gone, and we don't know what is happening with him later." [Interview PL3]

Failure to develop community-based care

There have long been proposals to move towards more community-based mental health care in Poland.[241 242] However, by 2016, only 1.9% of patients used community mental health care and only 1.6% used hospital day services. Only a third of counties in Poland have a community treatment team or access to a day ward.[243] Mental care services receive just over 3% of the National Health Fund expenditure (one of the lowest shares in Europe. Of which, about 70% of these funds are allocated to residential care, mostly to dedicated psychiatric hospitals.[244] This is partly because of the perverse consequences of the funding system in Poland. Hospitals receive funding for occupied beds, and thus, it is in their interests to fill available beds. A report from 2012 shows that close to 15,000 first-time psychiatric consultations resulted in a diagnosis of schizophrenia.[245]

One strategy suggested was to provide daily care wards in general hospitals, allowing the number of beds in the larger psychiatric hospitals to be reduced. Daily care is seen as an opportunity to increase the availability and access to mental health services. However, mental healthcare is still severely underfunded. Unequal distribution of resources affects the quality of service available for patients. New patients are allotted 30 minutes for their first consultation, while returning patients only see the doctor for half that time.

Acknowledging the failure to develop community mental health centre provision, the second National Mental Health Protection Programme (2017-2022) is a renewed attempt to reform the psychiatric services provision and move patients out of hospitals, establishing 41 mental health centres, piloted until the end of 2022. These provide:

In most cases, we help a patient while he is waiting for psychiatric consultation [...] we give him drugs but then he is gone, and we don't know what is happening with him later. [Interview PL3]

comprehensive psychiatric care through diverse types of services that are coordinated and adapted to the local needs. They deliver short- and long-term outpatient care, counselling, liaise with social welfare institutions and – to some extent – hospital care for immediate assistance in urgent cases.[246]

Mental health centres offer more personalised treatment and a place to create local community groups, which, in turn, could provide a safety net for those who suffer from milder conditions (such as isolation, depression and loneliness) and those who require support to return to society after hospitalisation. The more flexible organisational structures of the centres allow them to employ mental health care professionals other than psychiatrists, and this may, to some extent, help mitigate the problem of staff shortages. New recovery assistant and mental health care coordinator roles are also being piloted to provide post-recovery support. The pilots have so far shown positive results.[247]

Lack of support

Respondents spoke about the dearth of any support for patients after treatment. While the biomedical approach to treat mental health focuses on institutionalised care in hospitals, the system lacks services that support a transition towards community-based mental health care for patients. Those who have experienced a severe crisis, and who have needed hospital treatment, have to either rely on their social circle (usually friends or family) or informal support groups, if available locally. Such support does not exist in current inpatient provision, raising concerns about the quality of care and treatment programmes: "When I was doing a medical internship in the psychiatric hospital, I felt I was the only entertainment there." [Interview PL1]

A private psychiatrist spoke of the initiatives that he had helped set up to support patients in rebuilding their confidence, overcoming fear and stigma. He felt they should be more common, with the aim of returning into society structured from the early stages of treatment, to allow those individuals to recover and become independent:

We wanted to organise an exhibition and create a series of podcasts to involve those who had experienced crises. It will relate to the barriers faced when returning to society: leaving the hospital; challenging stigma; but also enhancing patient's agency; positive self-esteem; support in job search. It will be done in the help centres (part of the hospital) and support groups. When they leave, they are left alone, and those people need a supporting hand. [Interview PL2]

As in the other case study countries, there has been a push toward the promotion of well-being and positive mental health, increased awareness of mental health and prevention of mental health conditions in Poland. There have also been calls for the integration of services under one roof to better address the complex needs of economically inactive people.[248]

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5 TARGETED PROVISION FOR VULNERABLE GROUPS IN FRANCE, IRELAND AND POLAND

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Introduction

A strong socio-economic gradient is evident in mental health.[249] People with lower socio-economic status have a higher likelihood of developing and experiencing mental health issues, and the pandemic has compounded those inequalities. This means not only paying attention to the health system, but also to social, labour market and educational outcomes. The importance of accounting for the unequal burden of the crisis is already evident from the particularly high prevalence of mental health issues among certain groups, such as, but not limited to, young people, low-income households and individuals with prior experience of mental health conditions.[250]

Those calling for an EU mental health strategy point to widening inequalities, and the need to focus policy attention on supporting the mental health of disadvantaged groups and those disproportionately affected by the crisis. Respondents from all three countries felt that their mental health systems do not sufficiently acknowledge either how socio-economic factors impacted their patients or the impact that mental health crises leave on their lives.

There are inequalities at all stages of the mental health pathway, starting with inequalities of access. In large cities, the availability of mental health services is high (which is met by high demand among patients), but in some rural areas mental health services are almost non-existent.[251] Therefore, the efficiency and effectiveness of the healthcare organisation is largely dependent on its location.[252]

Respondents were very aware of the need to see a person with a mental health condition in the context of their whole lives: "Other aspects that influence mental health are poverty and inflation; fear of how you will manage to pay off the mortgage that rises dramatically every month". [Interview PL1]

> *All respondents spoke about vulnerable groups who, pre-pandemic, were already experiencing social exclusion, including mental health issues, and had then become even more isolated:*

People with severe and enduring mental health difficulties have been excluded from those conversations, you know, people involuntarily detained, you know, when there was so much during COVID-19, around being able to visit loved ones, you know, if you had a loved one in an inpatient unit for mental health care, they also weren't receiving any visitors or someone to come in and bring their laundry in and out. [Interview IE4]

The lack of early intervention and support for individuals who suffer from milder conditions contributes to an overreliance on the biomedical approach and on the private sector:

> *Patients in need, they either try to manage themselves, or if they don't manage or know that they have a problem, they go private because it is more accessible. It is expensive, so this is a barrier, but it works. The public system is rather for those who have been prescribed more advanced treatment. [Interview PL3]*

Respondents from all three countries felt that their mental health systems do not sufficiently acknowledge either how socio-economic factors impacted their patients or the impact that mental health crises leave on their lives.

Nearly all respondents spoke about the significance of stigma to a range of outcomes, not only acting as a barrier to accessing mental health services:

> *We must work on the stigma suffered by the people concerned, thus allowing better access to housing and better access to employment. Better support for families who suffer enormously and who are often the first to be laid off. [Interview FR2]*

One respondent, also in France, spoke about the impact of stigma on children. They see this when parents first receive their child's diagnosis: "Some things are still stigmatised, and I think this is a mistake. Unfortunately, I see this in the reactions of parents when they learn of their children's diagnosis." [Interview FR10]

They continued to talk about the importance of developing inclusive practice, so that providers are more confident working with people with mental health conditions:

> *Inclusivity in schools is a first step for children to learn that one can function with a psychiatric pathology. What works is meeting people and really being in contact with patients who suffer from psychiatric disorders. It allows you to be less afraid. [Interview FR8]*

There was concern among charities and advocacy organisations that, while there had been progress in support for some groups, other vulnerable ones were still overlooked. Those whose circumstances are precarious, whether through experiencing homelessness, domestic violence or being institutionalised, such as prisoners or refugees:

> *But for those who were most vulnerable and marginalised, you know, there wasn't huge strides forward, and, you know, the conversations around mindfulness and, you know, mental health haven't extended to, well, let's make sure prisoners have access to, you know, their, their visits. [Interview IE4]*

Women

Mental health conditions are not evenly distributed between men and women, and subsequently, mental health policy responses will have to take a gender lens.[253] The COVID-19 crisis has been a timely reminder of the need to focus on the gender dimensions of integrated mental health policy. Women in Europe self-rate their mental health lower than men (62 points to 66).[254] As well as showing lower levels of mental well-being, they are significantly more likely to report feeling unhappy, depressed, unable to overcome problems and a loss of self-confidence.[255] Gender-specific mental health disorders have different impacts on health status. Across the EU, women have consistently higher rates of internalising disorders, for example, depression, anxiety, phobias, and suicidal thoughts and attempts.[256] The prevalence of depression in the EU is 1.7 times higher in women than in men, and the prevalence of anxiety is twice as high. Gender differences in eating disorders are even higher, with almost three times more adult women than men suffering from this illness. The gender gap is reversed in cases of substance use disorders (SUDs), with internalising mental health disorders more common in women and SUDS more common in men. SUDs are twice as prevalent among men. SUDs account for only 13% of all healthy years of life lost among EU women overall. This share differs across EU countries. It ranges from 24 to 25% in Estonia and Poland, to less than 10% in southern European countries and the Netherlands.

Even before the crisis, working-age women were 45% more likely than men to report mental health conditions. Initial evidence after one year into the crisis suggests that there may be disparities in how the mental health of men and women has been affected, with corresponding long-term consequences. COVID-19 has increased gender inequality in the EU, as women have been disproportionately affected by the pandemic and the related economic downturn.[257] Gender inequalities in society impact on individual women's mental health. Lower levels of women's political participation, economic independence, employment, and sexual and reproductive health and rights to assess levels of gender equality are associated with higher levels of depressive symptoms. On the other hand, macro-level gender equality supports good mental health for women and men.

Caregiving is an important factor influencing the physical and mental health of those providing care. 92% of regular carers (several days a week) are women, who experience accumulated chronic stressors and often neglect their own health.[258]

Women report self-assessed lower levels of mental well-being, regardless of family composition, age, income level, country of birth or disability. Further assessment of levels and gender gaps indicates that social determinants of mental health are at play.[259]

Income inequalities impact on mental health, with women and men with a higher income having better well-being than those with a lower income. Data show that income increases affect the mental well-being of women slightly more than they do men. Generally, research evidence confirms that social exclusion and material deprivation are the strongest social determinants of poor mental health.[260]

During the pandemic, the fatality rate for men was twice that of women.[261] However, the mental health of women as frontline workers and at home was more affected than men's. In spring 2021, the WHO reported that the lowest level of reported mental well-being in spring 2021 was among women aged 18-24 (together with women aged 35-44).[262] This was due to, among other factors, specific psychological and psychiatric risks faced by women as patients, carers and workers in the health sector; the increased risk of violence against women at home and in the workplace; and, finally, the risk faced by children within their families. However, there is still relatively little research on mental health issues during the COVID-19 pandemic, especially in women.[263]

In 2016, the WHO published its strategy on women's health and well-being in the European region,[264] noting that rates of mental ill-health were increasing throughout the region across all ages. They cited the high levels of depression and anxiety among adolescent girls as of particular concern and gender-based violence as a serious public health problem. The strategy was underpinned by the values of the European policy framework for health and well-being, Health 2020, which acknowledged that gender was a determinant of health, alongside social and environmental determinants, and which identified gender mainstreaming as a mechanism to achieve gender equity. Global efforts to advance women's health have been endorsed by member states through the adoption of the 2030 Agenda for Sustainable Development and its accompanying sustainable development goals (SDGs), in particular, SDG3, SDG5 and SDG10,[265] on health and well-being, achieving gender equality, and reducing inequalities.

Women's mental health was raised as a particular area of need throughout the interviews in Ireland:

> *In some of the studies and the surveys that were done across the country, there tended to be a higher percentage of women taking part in the surveys, and so on, also, then reporting higher levels of concern around their mental health, and the impacts of COVID-19 on their mental health. [Interview IE4]*

The Polish government was also criticised for not providing enough support for women during the crisis.[266] The SHARE research project, conducted in 12 European countries, assessed the level of loneliness in the population aged over 65.[267] Chronic loneliness, as research shows, leads to many mental disorders, such as self-destructive behaviour. The association between loneliness and various socio-economic factors and subjective health status was significantly higher in women. In a survey of just under 500 Polish women in October 2020, Dziedzic et al. found that those with the most affected mental health were women who lived alone, had poorer self-rating of their financial situation, lower subjective health rating and certain chronic diseases. Two in three women experienced loneliness.[268]

Lone parents are another group identified by respondents in this study as needing targeted support with mental health conditions. France has the most single-parent families (24%), followed by Ireland (20%) then Poland (10%). A survey conducted in France by COFACE – a network that represents millions of families, volunteers and professionals across Europe – found that only a quarter of single parents said they were in good health, citing sole responsibility for their children, isolation, loneliness and lack of time to care for themselves.[269] A respondent working in a centre for women's rights in Poland spoke of the need for mental health support for single parents:

> *People who are single parents, mostly single mothers. People who started asking for help in our centre were those who were raising the children alone, but also with worse moods among children because they have no contact with their peers; they stay at home. Mothers said that kids don't want to go out; they just want to stay at home all day, in front of the computer. So, also addictions, from playing computers. [Interview PL6]*

The risk of poverty for women in Poland is higher than men, and due to COVID-19, the rate of women who had to stop working was almost twice the rate of men.[270] The majority of healthcare workers at the frontline of the pandemic were also women. However, women hybrid working during the crisis in Poland were found to have the highest levels of anxiety, depression and irritability.

Support for those suffering from domestic violence was another issue discussed by respondents. While there had been "awareness-raising, especially about the violence the pandemic could have on women and on children", few countries, including France, had detailed guidance on emergency action.[271] A deputy director of a mental health NGO described the lack of GPs trained in how to work with patients experiencing domestic violence:

> *Domestic violence can be one of the causes that accentuate vulnerability and lead a person to develop mental disorders. Support for victims must be provided at first by general practitioners, who must seek to identify domestic violence and then refer the person to the appropriate services. In order for general practitioners to take on this role, there is a very important training effort to be made. [Interview FR1]*

In Poland, respondents spoke about the safe spaces provided by community workshops for Ukrainian refugees, 90% of which are estimated to be women and children:[272]

> *During those handicraft workshops, women were exchanging the information; they were talking about life in Poland. What surprised them, but they also exchanged information on how to sign up a child to creche, where it is full and where there are still some spaces. Very pragmatic information, how to function in Poland. It relieved a lot of stress from those women. I also feel that the majority of Ukrainian women need psychological help, but they feel that when they go – there will be too many things that will be set up in motion and they are scared. And in those workshops – they can talk in that safe space, between women. They don't need to go to a psychologist, but they can talk about the general things […] that they worry about their close ones, husbands who are left in Ukraine […] they just feel safer. [Interview PL6]*

Asylum seekers, migrants and refugees

Intensifying climate change and geopolitical crises are two of the drivers that have led to severe impacts on mental health in the EU, and all respondents spoke about the vulnerability of migrant workers, refugees and asylum seekers. While the prevalence of mental disorders in refugees and migrants shows considerable variation, by specific migrant group and by methodology, the prevalence of depression and anxiety tends to be higher in this group than in host populations. Poor socio-economic conditions, such as unemployment, are associated with increased rates of depression following resettlement. PTSD is also higher than host populations in those refugees exposed to threatening and extremely stressful experiences. Similarly, children and unaccompanied minors also experience higher rates of depression and PTSD symptoms than other refugee and migrant groups.[273]

Respondents also observed that they tended to put their mental health low down their list of needs, and therefore, did not attempt to access help: "Refugees will never seek mental health care when they have other problems such as housing, food, etc." [Interview FR2]

Trauma made it difficult to recount experiences, a necessary part of the process of applying for asylum:

> *Acknowledging the mental health problem amongst asylum seekers: the narratives will not necessarily be coherent; but today, incoherent narrative leads to the rejection of the asylum application. It must be recognized that applicants are often traumatised and need support towards integration and asylum application. [Interview FR2]*

The inclusion of migrants into the health system of destination countries is an essential component of their integration. Yet, there is little investment in targeted support to ease the process. Looking at our case study countries' performances in the migrant integration policy index (MIPEX),[274] Ireland's overall approach to integration has improved, with a MIPEX score of 64. The implementation of the 2017-2020 Migrant Integration Strategy created what MIPEX categorises as "a slightly favourable comprehensive approach to integration" that guarantees equal

rights, opportunities and security for immigrants. This launched Ireland into the international "top ten" countries of the MIPEX in 2020. It also scores highest for health-system responsiveness, with a score of 84. France, with a score of 56, is in a group of countries ranked as providing "temporary integration – halfway favourable", which is described as "providing immigrants with basic rights and equal opportunities, but not a secure future in the country". Further that "policies in these countries encourage the public to see immigrants as their equals and neighbours, but also as foreigners rather than as potential citizens". Nevertheless, MIPEX comments that France's health system is inclusive and that "most immigrant patients can access healthcare entitlements, information and orientation to the appropriate health services, enjoying the same legal rights as residents and citizens in France". Its health score is 67.[275] Poland has the lowest MIPEX score (40) of the case studies. Its integration is defined as "equality on paper" – slightly unfavourable in that immigrants do not enjoy equal opportunities. It also scores lower on its health-system responsiveness at 27.

In terms of healthcare coverage and ability to access services, MIPEX notes that a country's wealth, as measured by GDP per capita, strongly influences scores on the health strand. Countries that have difficulty providing adequate health services to national citizens are reluctant to adapt service delivery to the needs of migrants. It also points out that tax-based health systems are no more inclusive for migrants than insurance-based ones but are more likely to adapt service delivery to migrants' needs. While good entitlements usually go hand in hand with responsive services, there are exceptions. MIPEX cites France as an example of a wealthy country prioritising entitlements over responsiveness, and Ireland as an example of the opposite being true. Ireland is also given as a country in which immigrants are, to some extent, more actively involved in designing and providing health information and services.

The 2018 Global Compact on Migration is a UN-brokered, non-legally binding agreement expressing a collective commitment to improving cooperation on international migration based on the understanding that no one state can address migration on its own due to the inherently transnational nature of the phenomenon. The Compact sets out EU members' commitments to:

> *[i]ncorporate the health needs of migrants in national and local health care policies and plans, such as by strengthening capacities for service provision, facilitating affordable and non-discriminatory access, reducing communication barriers, and training health care providers on culturally sensitive service delivery, in order to promote physical and mental health of migrants and communities overall.*[276]

While the right to health and, therefore, the right to health services should be universal in the EU, in reality, refugee and migrant populations often find that that right is restricted based on their legal status and there are large variations across the region.[277] For example, the social and labour protections provided to migrants from the EU/European Economic Area are more extensive than those afforded to those who are third-country nationals.[278] Migrants with irregular status, in particular, are not routinely allowed to work in EU countries and are not entitled to most social benefits. Host-country-specific restrictions also apply to asylum seekers. The new EU Action Plan on Integration and Inclusion (2021-2027)[279] promotes better access to health services, and refers to, in particular, non-discrimination and segregation.

In France, for example, there is a major barrier to accessing services, as asylum seekers are not eligible for full health coverage for their first three months in the country: "The system of access to care is discriminatory: it is designed in such a way that access to care is based on visas (there are waiting lists up to three months)." [Interview FR3]

Despite the increased need for psychological support for those who are or have experienced war, gender-based violence, sexual exploitation and human trafficking, as Mental Health Europe notes: "Migrants' mental health, although affected by the entire migration experience, often remains an afterthought. In many places, the capacities for providing tailored services are stretched or non-existent, while financial and human resources are scarce."[280]

In France, for example, mental health services tend not to be included in healthcare for refugees: "The care of refugees is difficult: the system of equitable access to care is somatic rather than psychological." [Interview FR2] And while psycho-trauma centres had been set up, they were not designed to treat refugees: "But these centres are often focused on issues regarding attacks or accidents, but not on the trauma faced by asylum seekers." [Interview FR3]

Respondents commented that more therapeutic services were needed that could work with people who had experienced, for example, the violence associated with the refugee journey to France, including the role of criminal gangs or those who had been tortured. Mental Health Europe has already made recommendations on the mental health provision to Ukrainian refugees, noting that "trauma-informed and recovery-based approaches to mental and emotional health should be central to humanitarian aid and support" and that it should be "incorporated into the needs assessment for refugees and helplines."[281]

Respondents noted that existing services at the national level should also be adapted to migrants on the move: "There are people for whom it is difficult to have continuity of care when they are sent from one place to another, including on the national territory". [Interview FR3]. This is even harder to achieve when evacuees are sent to remote areas and find it even more difficult to access services, and remote support by phone or video is rare. The COVID-19 crisis had made that even more difficult:

> *[It] has weakened the continuity of care. Some patients have gone off the radar, while others have preferred to pause their consultations. COVID-19 has caused a general saturation in healthcare facilities. And for the exiled, it was even more difficult for many reasons, including language. [Interview FR3]*

Several respondents noted that it was often the voluntary sector who provided care for vulnerable groups where there were gaps in public sector provision: "Today, most actions taken for the mental health of exiled people rely on non-profit organisations." [Interview FR4]

Those working in charities who provide mental health services to refugees and asylum seekers felt that awareness raising was necessary at the EU level for the need to provide language interpretation services and access to care at the point of reception. The lack of interpreters was cited as a major barrier in French provision: "There are huge problems with interpreting: it is largely expensive. And one needs training to become an interpreter. So, during psychological consultations, you must be financially prepared to call on an interpreter."

Respondents in France spoke about care for refugees only improving if health professionals were trained to work with them:

> *If we do not sensitise health professionals to political asylum, and then to specific care, there will always be problems when it comes to treating people who have been in a system of control, such as torture, for example. It is therefore necessary to know how to manage all this and offer a real possibility of care. [Interview FR5]*

UNICEF has called for the EU to invest adequate resources in targeted actions to train health and social workers in promoting mental health and psychosocial well-being under the EU4Health Programme and under the Asylum, Migration and Integration Fund to support services for children on the move.[282] Mental Health Europe also points to the need for training on mental health beyond the healthcare sector, so that professionals are able to identify and support refugees that have mental health needs – to signpost them, for example.

They note that mental health training would help key workers manage their own stressful working conditions and mental health. As integration takes place in receiving countries, the wider population will have to have an increased understanding of mental health (through public campaigns and guidance resources).[283] That includes addressing the barriers to access created by stigma: "The care of refugees is extremely stigmatised: when we propose to go see a psychologist, it is attributed to madness." [Interview FR2]

They spoke about how long the process can be and its impact on people going through it:

There are administrative procedures that are extremely painful and long, which end up affecting their physical health. The problems of access to care greatly alter the mental state of people in a position of waiting, forced inactivity and uncertainty. [Interview FR3]

This was also discussed by respondents in Poland. They talked about migrant mothers' fears of having their children diagnosed with Autism, Asperger's syndrome, ADHD and other developmental disorders, as they felt it would harm their children's education prospects and leave a mark on their public health record:

We see many children and young people who struggle [...] we encourage them to get diagnosed but the mothers know – once they have the paper, children's opportunities are becoming limited. Not every school will accept a child with ADHD. They prefer children that are easier to deal with. [Interview PL5]

Leaving a child without adequate diagnosis, however, puts them at risk of not fitting in the school setting and not being able to cope with the environment without appropriate tools and help. Developing awareness within vulnerable groups about the stigma associated with mental health issues is another area of policy that needs to be considered by any future strategy.

Finally, respondents also noted that support for staff working with vulnerable groups was also necessary. For example, a doctor working in a psychiatric hospital in Poland spoke about the need to roll out psychological training for those working in support centres on the front line, supporting traumatised women through long-term therapy.

Young people

The COVID-19 pandemic has had a huge impact on young people's lives, particularly the most vulnerable ones. They have been separated from their peers, prevented from participating in social life, confined to their homes for prolonged periods of time during lockdowns and many have suffered from loneliness and isolation.[284] Their mental health has been disproportionately affected in comparison with other age groups,[285] with sharp increases in the rates of depression, tension and anxiety among young people during the COVID-19 crisis.

The prevalence of mental disorders for boys and girls in Europe aged 10-19 is 16.3%, while the global figure for the same age group is 13.2%. Nine million adolescents aged 10-19 in Europe live with a mental disorder.[286] The figure for France is 18.3%, Ireland 19.4 and 10.8% for Poland. In 2019, anxiety and depression accounted for 55% of mental disorders, with suicide as the second leading cause of death among young people in Europe. Around half of all mental health conditions are established by age 14, and three in four by age 24.[287]

This means that, in many cases, the symptoms and signs of mental health issues are apparent from a young age, making mental health interventions and support in childhood, adolescence and youth particularly important for timely identification of mental health issues.[288] Many children's mental health needs go undiagnosed.[289]

Mental health issues can affect children's and young people's education and future labour market outcomes. Students indicating mental distress are 35% more likely to have repeated a grade at school.[290] Individuals with mental health issues are 20% less likely to be in employment, and they impact on performance at work for adults. In some cases, poor mental health can result in prolonged sick leave, unemployment and labour market exit. Individuals with a mental health condition are also around 50% more likely to be receiving benefits.

Respondents in all three countries felt that the most vulnerable group since the pandemic has been children and young people: "The adult will manage, will find a way around the issue [...] or functioning only in four walls, even with alcohol [...] but children can't." [Interview PL2] "They are fragile emotionally and in a natural environment they are quite social, and COVID-19 took it away from them." [Interview PL4]

The health crisis has highlighted that some groups are more vulnerable than others, particularly children, adolescents and young adults. Being isolated, not understanding what is going on and receiving anxious messages contributed to creating anxiety for children, adolescents and young adults. [Interview FR1]

French respondents were clear that the system had broken down for the provision of children: "[It is] very ineffective for children. There is trouble finding

beds; there are delays that are extremely long to get a diagnosis." [Interview FR11]

> *The post-pandemic mental health system is an exhausted system that is also finding its wear and tear from problems that dated back to before the pandemic. This is because, in France, the psychiatric sector has always been very neglected. [To give you] an example: Right now, hospitalising a teenager for suicidal thoughts is extremely complicated. We don't have enough places, and it's getting worse and worse. [Interview FR9]*

While there had been some programmes set up during the pandemic, such as Macron's set of ten free counselling sessions for children,[291] such one-off initiatives were not sufficient to address the rising demand. A head of psychiatry at a French university hospital reported that the hospital admissions for teenagers had increased by 40% and that the demand for unscheduled emergency care had been in suicidal crisis and eating disorders, in particular: "For children and adolescents, there has been a considerable demand for care, especially unscheduled, or even an emergency, in the field of suicidal crisis and eating disorders." [Interview FR7]

In 2021, the rate of suicide attempts among children in Poland increased by 77% compared to the previous year. At the same time, only around 500 child psychiatrists worked in the country.[292] There are access issues for children who live in rural areas, in particular, and whose family cannot get them to specialist help further away: "Quite bad [...] so when it comes to psychiatric help for young people it is terrible. When it comes to people suffering from depression or schizophrenia – the waiting times are huge." [Interview PL5]

Similarly, professionals in Ireland described a "tsunami" of adolescents in mental distress during the pandemic and a severe lack of provision for children and adolescents. In 2021, the Irish Hospitals Consultants Association stated that "It is not possible to provide appropriate urgent inpatient care to children and adolescents due to a severe lack of beds for this group of patients."[293] There is a particular concern at the level of mental conditions among adolescent girls. 72% of child and adolescent psychiatric admissions are female. 30% of which are admissions for depressive disorders.[294]

The Irish interviews described the vulnerability of families with young children. The isolation and added pressure on lone parents to manage during the pandemic:

> *The group that we will assess most would be the isolat[ed]; the extra pressures that were placed on lone parents, in particular, during that time because they weren't able to rely on their wider networks of support, whether that's extended family, or if their childcare closed down. So [with] that very level of isolation, greater financial distress certainly came to the fore. [Interview IE2]*

And the need for practical and financial support:

> *And then there were other issues, you know, not being able to get access to shops, because you couldn't bring children with you. What if you had no other option? How are you going to get food? And yeah, and then I think just the added financial pressure during COVID-19. If people had lost income, then all sorts of expenditures on essentials would increase. [Interview IE2]*

Respondents in Poland spoke about the need for parents to be provided with information: "Most of the time, families do not know that there can be guidance, so they understand what is going on with their children." [Interview IE10]

They were concerned at the effects of the pandemic on disadvantaged children:

> *But really, there were a whole myriad of different issues that emerged that weren't really highlighted or addressed sufficiently by the government, and particularly around them, the children from disadvantaged backgrounds, or children who were living in very cramped conditions, whether that was in direct provision, or homeless accommodation. And during that time, where they had to stay, in very, very poor conditions, didn't have access to learning, didn't have access to their friends. [Interview IE2]*

They also all spoke of the urgent need for more funding for young people's provision. Pre-pandemic, the countries faced similar problems, including a

lack of coordination of stakeholders, with a marked separation between the social and health care sectors, widening territorial and social inequalities; difficulties in accessing specialists, owing to there being too few or the uneven distribution thereof; and overly long waiting times to access specialised treatment services.[295]

Respondents in all three case study countries spoke about the long-term effects of the pandemic on children's mental health:

> *So we're worried about, obviously, at the time, the impact of that at the time, but we think there's going to be longer term consequences on children's mental health and well-being resulting from that. And I think that would be very, I think, the pandemic affected all children and young people, but particularly [for] those very marginalised children [it] would have been greater. [Interview IE2]*

A respondent working in a mental health charity reflected on the importance of recognising the social determinants of mental health and the impacts of adverse childhood events for mental health in adulthood:

> *If you think about the structural inequalities within society […] to think that adverse childhood events or episodes contribute to depression in later life […] so it's, again, back to the analysis of what depression is, [is] it an organic disease, you know, that's obviously a loaded word, organic condition, or is it something that's society war? And so, we are aware, you know, specific to some of our research goals, to think about the social causes of depression and mental health conditions. [Interview IE3]*

They spoke of the need to plan provision with young people in mind and the lack of trained professionals to work with them:

> *At the time of the pandemic – I had plenty of consultations with young people; they had fears, difficulties to manage stress […]. There is a huge need for psychotherapy for kids and teenagers – a difficult issue. For instance, a 13 year old – biologically is a woman, but she needs a child psychotherapist or psychologist. There aren't many of those specialists around. [Interview PL1]*

> *"There is a very long waiting time; psychiatry – a few months […] and how many psychiatrists deal with children's psychiatry? Like one every few hundred […] we have a lot to catch up with here." [Interview PL5]*

Online provision was felt to work for young people and young men in particular: "And so, for some groups, and particularly, and I think it's some young men, and maybe young people more generally, you know, it was, it was a very appealing way for them to get in support." [Interview IE5]

Research indicates that online mental health support for young people may well be more likely to be perceived as a non-threatening, confidential route of help-seeking for anxiety or low mood. In one study conducted in 2019 before the COVID-19 mental health crisis hit, amongst 1,308 young people in Ireland aged 18-25, 82% of respondents reported the use of web searches and 57% the use of health websites.[296]

A CEO of a charity working with young people with mental health conditions noted that delivery planning needed to take into account the dangers of young people being left waiting alone in a mental health crisis:

> *We started the texting service because we felt that emergency departments are just not appropriate places for people to be presenting in a mental health crisis. And we wanted to try to support young people to stay safe at home, which is a less invasive environment for want of a better word than or less kind of, what's the word, distressing environment, I guess, because if you're already in a mental health crisis, and you go into an emergency department, you know, it's not a good environment for somebody with poor mental health. [Interview IE10]*

It included providing spaces where young people could talk privately with mental health professionals: "More resources must be allocated to build places where teenagers can come without always talking to their parents first." [Interview FR9]

It also included developing policy in schools. At the moment, half of Poland's schools employ a psychologist. The respondents spoke of the need to train teachers to then train children in how to manage

their mental health, provide support groups, promote mental health awareness and reduce stigma:

> *Actions at schools – how to deal with fear and stress. Teaching people what the stigma is should be done in primary school, and kids should be also taught the tools and mechanisms, how to deal with stress and fear […] but nothing like that exists; even in private schools it doesn't exist. Mindfulness at schools. Small support groups for teenagers at schools. Media/internet addiction awareness – parents would come for the training, but teachers didn't. [Interview PL1]*

UNICEF is calling for the EU to adopt an integrated and coordinated approach to mainstreaming children's well-being and promoting children's mental health in EU policies through adopting a comprehensive EU strategy on mental health by 2025 as a key building block for a reinforced EU Health Union.[297] The European commission is supporting interventions (via, for example, the EU4Health's Horizon Europe programme) to facilitate vulnerable groups' access to mental health and psychosocial support services, promoting mental health, as well as those aiming to prevent, diagnose and treat mental illnesses; improve regional infrastructures; and strengthen young people's engagement, participation and inclusion in society.[298] Digital and online innovation is also developing to reduce gaps in access to mental health support and reach populations who may traditionally lack access to these services.

There is an emphasis on the importance of early intervention, whether in school or the workplace before people drop out of either, as this will have a more lasting impact. Several respondents, including this professor of psychiatry at a university hospital, felt that the policy focus should now be on improving the mental literacy of young people at school:

> *Inclusivity in schools is a first step for children to learn that one can function with a psychiatric pathology. What works is meeting people and really being in contact with patients who suffer from psychiatric disorders. It allows you to be less afraid. [Interview FR8]*

Schools are ideal vehicles through which to facilitate access to mental health and psychosocial support, whether through creating safe spaces for children to discuss and share their concerns; programmes to build awareness and strengthen emotional coping skills for adolescents, for example; and training teachers and staff in strengthening the well-being of students.[299]

This has been happening via the EU's Horizon 2020 funding: the UPRIGHT programme has been working on promoting mental well-being among adolescents. It has designed a training programme in personal and community resilience for 17 schools from five countries, teaching mental health skills across four categories: coping; efficacy; social and emotional learning; and mindfulness. In June, the WHO in partnership with the Greek government launched a new programme to support and promote the quality of mental health care of children and adolescents in all 53 countries of the WHO European Region to ensure they have access to quality mental health services, which, as WHO Regional Director for Europe, Hans Kluge, said, is as important as childhood vaccinations.[300] Support includes developing national strategies and frameworks and sharing lessons learned, a common platform to share knowledge and expertise, expertise in translating findings and lessons learned into practical tools, and policies that support children's and young people's mental health needs.

Strengthening mental health services in both schools and higher education institutions (including the transition from school to university) has been seen as a key area for improvement in mental health policy in Ireland. An example of a promotion approach to mental health in schools is Ireland's Well-Being Policy Statement and Framework for Practice for 2018-2023. It not only sets out the government's

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vision for well-being in schools, but also stipulates that every school in Ireland must implement a school self-evaluation process that follows the framework and looks at well-being in four key areas: culture and environment; curriculum; policy and planning; and relationships and partnerships.[301] However, Ireland has also been slow to implement recommendations for children and adolescent care.[302] Mental health services for youth, in particular, remain ill-equipped, with investigations finding unreliable diagnoses, inappropriate prescriptions, poor monitoring of treatment and need for greater accountability oversight for clinical care practices. Use of digital platforms and technology is also limited.

In Poland, respondents envisioned the development of such policy as not coming from government, but something that could be brought about through the EU's role in building partnerships with NGOs and sharing good practice: "The platform to share the information about the initiatives and cooperation; where we could share the knowledge and cooperate; practice sharing platform." [Interview PL1]

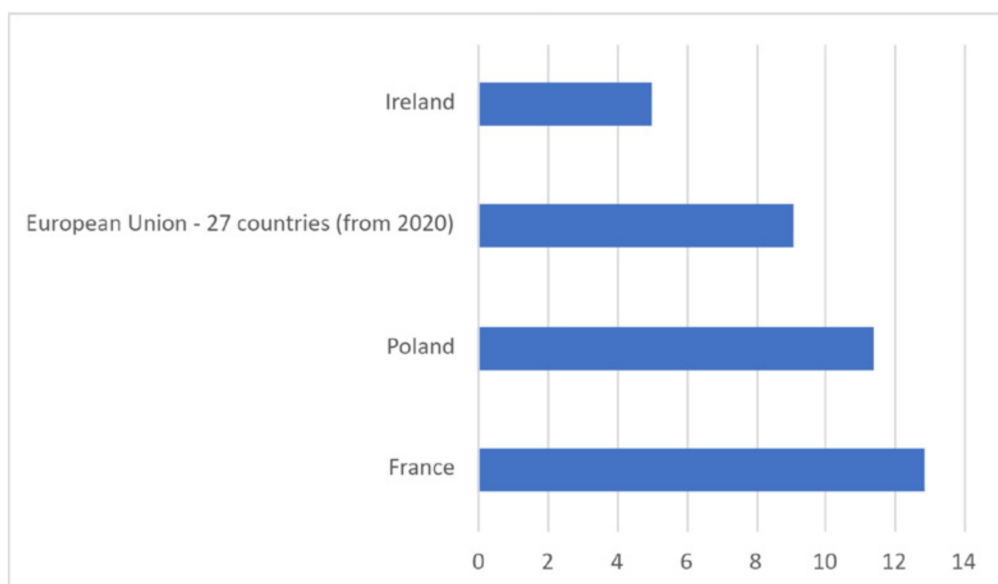
Providing a choice of good-quality services is key, particularly in web resources now targeted towards young people seeking help with mental health issues:

> *I think lots of people sometimes criticise duplication, whereas actually, particularly for young people, they're looking for choice; they're looking for the service that kind of blends in with what they want. So that's good. Primary care is almost kind of, from our perspective, non-existent, particularly for [...] the demographics that we would serve. And, you know, kind of that 16 to 34 age group, and the primary care is well developed in certain parts of the country and underdeveloped and just not developed at all, in many parts of the country. [Interview IE10]*

Older people

In 2016, the share of the population in France over the age of 65 was 18.8%, in Poland it was 16% and Ireland 13.2%.[303] By 2050, those aged 65 and over are expected to make up one quarter of the population in the region, a rise of over 70% over 20 years – a dramatic shift in the demographic profile of countries in Europe.[304] The old-age dependency ratio by 2030 is projected to be 27% in Ireland, 35.6% in Poland

Figure 5. Percentage of those aged 65 and over with depressive symptoms in Ireland, France and Poland (2019).



Source: Eurostat (2021) "Current depressive symptoms by sex, age and income quintile".

and 40% in France. In 2015, women in France could expect to live another 23.5 years and men another 19.4. In Poland, those figures were 20.1 and 15.7, while in Ireland they were 21.0 and 18.4, respectively. 37.5% of elderly people live alone in France, 28.2% in Poland and 29.1% in Ireland. Almost half of those aged 65 or older are perceived as having a disability or "self-perceived long-standing severe limitation in usual activities due to health problems".[305]

While it is positive that life expectancy continues to rise in Europe and that each person has a good chance of living longer, it is important to also recognise that additional years of life may be characterised by a range of medical problems, disability or mental illness.[306] At age 65, women in France can expect to live another 10.7 healthy years (men 9.8), in Poland those figures are 8.4 and 7.6 and in Ireland 12 and 11.4 years. It is important to remember that older people were more vulnerable to the Coronavirus. According to Eurostat, between March to June 2020, those aged 70 and over in Europe accounted for 161,000 or 96% of the 168,000 additional deaths recorded when compared to the average rate registered for the same period between 2016 and 2019.[307]

According to Eurostat's last report on mental health statistics in older people, in 2014, 7.1% of people aged 55-64, 6.5% aged 65-74 and 13.1% aged 75 or older had depressive symptoms in the 12 months preceding the survey. This pattern was repeated in all but two of the 25 EU member states for which data were available. Older women aged 75 or older were more prone (than older men) to experience depressive symptoms. In 2014, 15.8% of women in this age group reported depressive symptoms, compared with a 9.2% share among men of the same age. Older women are more likely to be living alone than older men. 2019 data on the prevalence of depressive symptoms in those aged 65 and over are given in Figure 5. The suicide rate of people aged 85 and older is reported at 22 per 100,000 people, on average, against 13 per 100,000, on average, for all age groups.[308]

Recent work by EuroHealthNet focuses on the projected increase in older workers in the labour market (55% of the workforce by 2030) and the need to address their psychosocial risks:

> *As our workforce turns older and our working lives become longer, healthy workplace environments will increasingly become a political priority for EU institutions and member states. Addressing psychosocial risks for older workers will help mitigate further social and economic challenges and eventually contribute to achieving an economy of well-being.*[309]

This along with many other aspects of ageing were laid out in the 2021 Green Paper on Ageing, one of many policies on older people in the EU, including the Horizon Europe Work programme 2023-2024, the EU Long-term care report, the "Healthier Together" – EU NCD initiative and the new care strategy. The Green Paper includes reference to how the silver economy, a developed market of products and services for healthy and active ageing, could improve the efficiency of health and social care systems. The paper also detailed the disproportionate negative impacts on older people's health from loneliness and social isolation and the effects of climate change, natural disasters and environmental degradation.[310]

The impact of demographic change in the EU is of concern. Ageing regions, in particular when rural, remote or mountainous, will have to better address older people's needs in the future. The report highlights the shortage of GPs in rural areas, as well as the lack of long-term care available for older adults. In addition, since social protection for long-term care does not exist in all member states, contrary to healthcare protection, the report stresses the risk of further socio-economic exclusion of older generations in the future.[311] Other contributions to the recent green paper on ageing have reminded the EU of the discrimination in healthcare for older people and the issues of elderly abuse, social isolation and loneliness as predictive factors for mental health conditions.[312]

The EU has already committed to addressing demographic change and enabling better health and care for Europe's growing ageing societies.[313] However, this will not happen without a comprehensive policy response, as laid out in the Green Paper on ageing, which includes investing in quality services and infrastructure, including healthcare research and innovation, offering attractive work conditions to address

staff shortages, and using innovative technology to improve efficiency and provide services and therapies in new ways, not just in hospitals.

Green provision of ambulatory and community care infrastructure is prioritised, not only to provide better care but to allow older people to take part in social and well-being activities. It goes on to point out that cross-border mobility of staff would play a role. Integrating health and long-term care needs into existing migration policy will improve the use of skills of migrants in the EU, who make up a significant part of the health and long-term care workforce.[314]

Lack of investment

The ageing of the population puts the Irish long-term care system under considerable demographic pressure, in terms of greater demand and, at the same time, fewer resources to secure future supply. While Ireland has been relatively protected from rapid ageing, it will face serious ageing-related challenges in the next 20 years. The population aged 65 and over has grown by 35.2% since 2009 (compared to an EU27 average increase of 16.5%).[315]

Susan Finnerty paints a stark picture of mental health provision for older people in Ireland in the introduction to Mental Health Services for Older People written for the Mental Health Commission in 2020.[316] 15% of adults aged 60 and over suffer from a mental illness, and physical illness is more common. Depression is the most common mental health problem in this age group. It is estimated that it affects 22% of men and 28% of women aged 65 or over and 40% of older people in care homes. The prevalence of anxiety disorder in the community ranges from 1.2% to 15%, and in clinical settings from 1% to 28%. The prevalence of anxiety symptoms is much higher, ranging from 15% to 52.3% in community samples. Loneliness, bereavement, financial difficulties and lack of appropriate accommodation are other factors in their mental health.

Staff shortages lead care workers to provide services under pressure, undermining quality of care and their relationships with the people being cared for, as described by a psychiatric social worker in Ireland:

> *They've ticked a box, we still have the same issue where you have maybe an elderly lady who needs a bath, but she's kind of saying she may not know. She may think Mary's turning up on Monday, Mary gets sick, and they just send a man. [Interview IE1]*

Lack of community support

Irish respondents spoke of the progress made, but there was still some way to go, to intervening earlier at the community level with support for older people: "When they end up in hospital, 70% of them are unknown to the community services, an awful lot of struggles that go on behind the door. Okay. And so, in some ways we get to people too late." [Interview IE11]

The healthcare system failed to address the needs of older patients. Their mental health conditions were usually interlinked with other issues: "Those solutions didn't address the needs […] in terms of elderly people, I think they didn't really notice that their situations were quite bad […] elderly people don't use the internet; they are more prone to isolation." [Interview PL6]

Irish respondents spoke of the importance of developing social prescribing, which they described as:

> *investing in quality services and infrastructure, including healthcare research and innovation, offering attractive work conditions to address staff shortages, and using innovative technology to improve efficiency and provide services and therapies in new ways, not just in hospitals*

about and located very much in primary care, and they're often called a link worker, or somebody who meets with the individual and, you know, establishes what their own wishes and interests and so on are, and what the gaps might be in their life, and then helps them to link into already existing stuff in the community. [Interview IE5]

And particularly for combating isolation and loneliness:

And it's this idea of, actually, even before the primary care level, yeah, although it is activated at primary care level, it's this idea that people need all sorts of support to maintain good mental health and mental well-being. Yes. So that can be, it might be somebody who was trained in counselling, but it might be having something meaningful to do, or a leisure or activity that you enjoy doing. And we know that having that social contact is really important. And because loneliness is a huge issue, and very detrimental to your mental health. [Interview IE5]

However, there is still a lack of community support (such as home care packages and respite care) with only 1.2 dedicated acute mental health beds for older people per 100,000 (compared with six for England and nine for Northern Ireland). There are also hardly any liaison teams working in general hospitals to address the mental health needs of people being treated primarily for physical health needs. Finnerty writes that "apart from two areas of Dublin, there are no liaison teams and the needs of this population are met by already stretched community teams".[317]

Digital exclusion

Both Polish and Irish respondents spoke about the digital exclusion of older people: "With elderly people as well [...] they didn't have a phone and they struggled to contact us as well." [Interview PL6]

Elderly patients became even more isolated during the pandemic, as their capacity to deal with online solutions is limited:

The main problem was that people were used to just coming to see us in person and meet us. It was difficult to understand that we work remotely. The older a person, the more difficult it was to accept. How come we can't see you? I have a paper here and I need to see you. Younger people had less problems with it. [Interview PL6]

There were also problems accessing online services: "My experience with telemedicine is not good either. Many patients, our clients, could not get through to get support." [Interview PL5]

A psychiatrist described the advantages of e-consultations:

[They] perfectly fit the rural areas [...] many patients come from small towns. They can't travel to bigger cities, but they can meet us online. Allow to reach people in smaller towns who because of stigma don't go to the local practice, because they all know each other. People from Krakow would look for someone from Gdansk [...] they look for privacy and anonymity; people feel safer. Online consultations will stay with us for longer; they are very beneficial: patients from small towns, with children, those who are very busy, work remotely [...] we moved our work to home [...]. [Interview PL1]

Digitalisation also has the potential to improve services in Ireland. The pandemic jump started the use of telemedicine and the growth of digital mental health supports.[318] The *#NieDamySię* campaign, supported by the government, was organised by a group of independent specialists. *Psychologist for society* was a common initiative, undertaken by a joint action of psychologists and psychotherapists through which those specialists could offer support (free of charge) during the pandemic. This national-level initiative was among the first ones to make use of e-consultations and gathered approximately 200 specialists.[319]

Lack of mental health literacy

A Polish respondent commented that elderly people were not used to talking about their mental health: "They're 60-70 and they become aware that they should also look after their head. They become aware that they had depression and so on, and they say they regret they didn't look for help before." [Interview PL6]

A CEO of a charity working with older people made the same point:

> *[T]he thing about that low level of mental health challenge around loneliness is that the age group we work with may not have the language around it. Okay. So, if you take, you know, mental health, and, you know, even if you take teenagers, just a stereotype for a second, people in schools have developed a language in the mental health area, you know, the type of it's alright, not to be okay. It's not a language that maybe is there for over 60s. […] So naming these things and realising that's what's going on is difficult. So, people may not be able to distinguish that alone. [Interview IE11]*

6 DEVELOPING AN EU STRATEGY FOR MENTAL HEALTH

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Several respondents felt that mental health was integral to any discussion of security within the EU, particularly the experience of entering countries: "Facilitating access to care, security, and social stability." [Interview FR3]

> *I think that if there are things that can change at the European level, it will always be better if we actually act on entry into territory and if we manage to ensure that there is a little less violence. Even if it's indirect, it has an impact on mental health. [Interview FR5]*

They felt that there should be "a European approach about the strategies of reception and care of refugees, especially their mental health". [Interview IE 3]

French respondents pointed out that developing an EU-wide strategy would be aided by the shared impact of the crisis in mental health services across countries:

> *There are some caregivers who already come from other EU countries to help us. But these countries also need their caregivers (in a health crisis). Our neighbouring countries are probably as much impacted by the crisis as we are too. We find ourselves in somewhat similar situations, with difficulties in each country. [Interview FR10]*

Some respondents, having seen the way in which EU governments had worked together during the pandemic, were optimistic that they could do the same on an EU-wide mental health strategy, such as this deputy director of a mental health charity: "If we look at the effectiveness of the EU's anti-COVID strategy, which has allowed health ministries from different countries to work together, we can see that the EU could indeed work on strategies and preventive measures." [Interview FR1]

Others were unsure whether mental health policy and asylum seekers were discussed at a European level:

> *Are the policies for the care of people in exile played out at European level? I don't know. I can't really say. But I think it would be interesting to be able to raise awareness at a higher level and harmonise practices. [Interview FR5]*

Several respondents felt that the EU had a role to play awareness raising for mental health and in reducing stigma: "The EU can be at the origin of a reflection on mental health and mental illness that urgently needs to take place at the societal level. The EU can help the process of de-stigmatisation of mental illnesses." [Interview FR1]

Others felt that the main role of the EU was to provide funding:

> *The support we would like to receive from the European Union: financial means. We are really paid very little in the hospital, so it's hard to envisage a career. I love the hospital; I really enjoy working in the public sector. But at the same time, I am paid €900, which is unbearable in the long term. That is, at some point, I will have to leave. [Interview FR9]*

It was also seen as a regulator:

> *In France, there are areas where international recommendations are applied in terms of patient care. There are other places where the guidelines are not respected. If Europe could, somehow, impose the fact that medical care must comply with the guidelines, it would help a little. [Interview FR11]*

Respondents talked about the need for a platform that would enable them to cooperate, share and coordinate knowledge and practice: "If Europe can contribute only one thing and push us to go in the right direction and bring tools, that would be good." [Interview FR6]

The EU is an obvious strategic leader in building member states' data platforms such that user

groups and the social functioning or responsiveness of mental health services across Europe can be better guided by evidence and best-practice tracking. On one hand, the roll-out of telemedicine holds the potential to compensate for certain inequalities in access to mental healthcare services (as in-person services are often expensive, as well as hard to access on public waiting lists). The rise in the number of startups and online services provide tentative evidence for the potential seen in apps, websites and other numerical tools to help those suffering from periodic bouts of mental ill-health.[320] And there is a role for the EU in advancing standardisation of those services. However, on the other hand, during the pandemic, digital inequalities between socio-economic groups and technology gaps resulted in those with access to phone and ICT technologies being more supported.[321]

> *The EU is an obvious strategic leader in building member states' data platforms such that user groups and the social functioning or responsiveness of mental health services across Europe can be better guided by evidence and best-practice tracking.*

7 CONCLUSIONS FROM THE CASE STUDIES

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The policy study has shown that mental health provision in France, Ireland and Poland is characterised by underinvestment, lack of infrastructure, poor working rights and conditions, staff shortages and high turnover, leading to resultant gaps in provision and inequalities of access. The Polish government is criticised for its failure to adequately respond to the level of need for mental health services. Whereas, in France, despite greater investment relative to the other case study countries, there is a lack of national planned response and targeted provision for young people and migrant groups. In Ireland, the focus is less on lack of provision and more on a critique of government procedures and its reliance on voluntary-sector organisations to fill gaps in public mental health services.

There was consensus that early intervention was critical, that it needed to be provided locally, through primary care and a wide range of community services. Mental health systems are still hospital-centric, despite calls across Europe to move beyond a traditional reliance on the medical, biometric approach to mental illness and instead support an integrated approach to the planning and delivery of mental health services that takes the wide varieties of social determinants of mental health into account. Mental health provision in all three countries is still associated with low status, stigma and taboo. It is still a Cinderella service.

The pandemic exacerbated what was already a long-term crisis in the mental health sector across Europe. During the exceptional circumstances of the pandemic, "common trauma" arose, specifically the rise in persons experiencing depression, anxiety and loneliness/isolation[322] – many of whom still require support. While those who had chronic long-term conditions predating COVID-19 may have experienced worsening mental health, which, due to the pressure on services, was left untreated. This crisis reflects the imbalance of the EU as a health union. While there has been increasing economic convergence of developing countries, there has not been an accompanying convergence of their health systems. The capacities of individual member states' health systems reflect these imbalances. Some are work-related and need to be considered as an integral part of future EU regulation of employment.

While not all adversity may be prevented or mitigated, an increase in mental health conditions post-pandemic should have been anticipated and the institutional framework for responding to them could have been better prepared. The pandemic highlighted the need for countries and their populations to develop psychological resilience, enabling them to thrive despite adversity.[323] However, in 2020, the WHO estimated that only 31% of its member states globally had a mental health policy to implement.[324] In Europe, few countries have a comprehensive mental health system that addresses both promotion, treatment and prevention across the sector.[325]

There were some positive outcomes, particularly in the form of digital innovation and that is not to discount the differential impact of that innovation. For example, while young people may have found it particularly beneficial for accessing services, others may have faced multiple barriers to accessing and using them digitally. However, mental health reform was paused during COVID-19, and respondents in this study observe that, in many cases, it hasn't been returned to. The policy study has very clearly shown that there is a crisis within a crisis. The pandemic exposed many long-term issues with the structure and capacity of the mental health sector within each member state, including a workforce shortage, low morale due to low status, low pay, poor working conditions and added psychological trauma of the pandemic.

There has been an extensive history of calls from within the EU for reform, a wealth of recommendations and strategies put forward within and outside the Commission, including from the Group of Governmental Experts on Mental Health; the European Expert Group on the Transition

from Institutional to Community-Based Care; the High-Level Group on Disability; the Mental Health Advocacy Platform; Mental Health Europe; the MEP Alliance for Mental Health; the Joint Action Working Party for Mental Health in All Policies (MHiAP); the Coalition for Mental Health and Well-Being; the Council of the EU; the Employment, Social Policy, Health and Consumer Affairs Council'; the United Nations; the International Labour Organization; the WHO and the OECD.

It is clear that the infrastructure for preparedness in responding to mental health crises, the responses of national European governments to both a higher prevalence of mental health disorders and the need to raise generalised mental well-being within communities warrant both greater research attention and strategic action plans. Any strategy must support the delivery of high-performing mental health systems to meet the challenges of increased demand. It must be "intersectional, focusing on those who face multiple and intersecting forms of discrimination, including on the basis of ethnicity, religion, sexual orientation and gender identity, migration status, age or disability".[326]

Such a dedicated mental health strategy will need to encourage broader consideration of mental health provision and building capacity across health care and other systems, to ensure that mental health is the foundation of a strong and resilient European Health Union, because it impacts on Europe economically and socially.[327] In taking the strategic lead, the EU would promote investment, planning and foster collaboration between countries, developing the linkages between many EU competencies. It would facilitate the exchange of best practice, developing better data, and more research collaboration within countries and between member states.

The report's findings suggest that the focus of an EU-wide strategy to develop mental health systems in member states should start by assessing what progress has already been made. It would use evidence of the impact of the social determinants and socio-economic inequalities of mental health in each member state to provide the basis for policy, particularly looking at what support can be tailored to vulnerable and marginalised groups.

The EU has an important role here in promoting a "mental health in all policies" and all sectors approach, fostering collaboration between different parts of government, society and the economy. Any strategy must make mental health integral to, not only health policy, but also, to other policy areas, such as social security, education, employment, housing, environment and migration. Improving the mental health of member state communities is not the sole responsibility of any one member state or any sector within it; it is a collective responsibility needing increased engagement from the EU and within member states. That includes recognising that frontline actors, outside the mental health sphere, such as teachers, line managers, GPs and employment service caseworkers, have a key role to play in securing better education and labour market outcomes for people with mental health problems. They are best placed to identify issues, address implications, and involve professionals as necessary.[328] This will involve training a range of stakeholders to identify mental ill-health and provide support within their workplaces. The EU must also lead on improving public awareness and literacy on mental health, which will help promote the sector as one that needs much better investment and status within society.

"

Any strategy must make mental health integral to, not only health policy, but also, to other policy areas, such as social security, education, employment, housing, environment and migration

"

Respondents in this study were clear about the need to create clearer pathways of care that distinguish mental health and mental illness. While they were keen to emphasise the importance of mental well-being for the whole population, they were aware that, in the desire to move away from the negative consequences of a medical model of provision, mild mental health conditions were in danger of being conflated with more serious mental illness. There is a tension there, between wanting to acknowledge the severity of some mental illness and not wanting people to be defined by a label or diagnosis. Mental health involves effective functioning in daily activities.[329] Mental illness refers collectively to all diagnosable mental disorders,[330] some of which are mild and only interfere in limited ways with daily life. Others are so severe that a person may need care in a hospital. Similar to other medical illnesses, the optimal ways to provide care depend on the illness, the severity of its impact and whether it is associated with specific life events or chronic/long term.[331]

A crucial objective of any future strategy is to facilitate Europe-wide understanding of the social determinants and inequalities of health to inform the development of a "mental health in all policy" framework, based on good mental health as a human right and as integral to developing a whole-of-society resilience to the multiple crises that member states are facing and will continue to face in the long term.[332]

What would be the consequences of not having a strategy?

The health shock of the pandemic, combined with economic downturn, the war in Ukraine, the likelihood of further pandemics and the climate emergency, increase the likelihood that levels of depression, anxiety and other mental health conditions increase. Depression is already the leading cause of disability worldwide and a major contributor to the global burden of disease. Unaddressed mental health problems create enormous social and economic costs. These costs impact many different sectors, including health care, business, education, law enforcement, the criminal justice system, and emergency and social services.

Good mental health "depends on the broader living conditions and quality of life experienced by individuals, families and communities".[333] [334] 90% of health inequalities in the EU can be explained by financial insecurity, poor-quality housing and neighbourhood environment, social exclusion, the lack of decent work and poor working conditions, according to the WHO.[335] Much of the economic burden of mental illness is not the cost of care, but the loss of income, due to, for example, unemployment, and a range of indirect costs due to a chronic disability early in life. The effects are especially damaging to children and people with lower economic status.[336] [337] Without addressing these inequalities, they will magnify and perpetuate across generations, across member states, creating a less cohesive, less resilient union.[338]

In this context, an EU-wide mental health strategy would improve the quality of life, strengthen cohesion and build resilience of EU citizens and their communities within and between member states.

8 POLICY RECOMMENDATIONS

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These policy recommendations are based on independent research conducted on mental health provision in France, Ireland and Poland by TASC. The research consisted of a policy review and semi-structured interviews with representatives from the mental health sector in each country. Provision in the three countries is characterised by chronic underinvestment and the lack of strategic coordination between different stakeholders. The pandemic has shown how crucial it is for governments to fund, plan and provide preventative public health, as well as essential frontline services that respond to a crisis and generate public resilience. The research concludes that the EU needs to take the strategic lead in working with member states to collaborate on an EU-wide mental health strategy to build greater resilience in their populations to meet the many challenges facing them.

The report's key recommendations for the EU are as follows:

1) Promote good mental health as having intrinsic value and as a human right:

    - raising awareness of mental health conditions;
    - actively addressing misconceptions, discrimination and stigma related to mental health;
    - destigmatising the language on mental health, moving away from the language of "mental health problems";
    - training in mental health literacy;
    - promoting public campaigns on mental health well-being throughout the life cycle.

2) Consider mental health in all policymaking as a valuable resource to the EU; one that strongly impacts on the cohesion and resilience of society. Communities prosper when the mental health needs of community members are met.

3) Emphasise that incidence and outcomes of mental health conditions cannot be improved without addressing the social determinants and inequalities of mental health.

4) Highlight the cost for member states of current underinvestment in mental health provision, unaddressed mental ill-health and mental health inequalities. These costs impact many different sectors, including health care, business, education, law enforcement, the criminal justice system, and emergency and social services.

5) Target mental health services to vulnerable groups and groups with specific needs. This includes addressing barriers to accessing the mental health system (regional inequity of provision, language barriers, fears of discrimination, not coming forward for treatment due to prioritising other needs).

6) Determine the budget, framework and benchmarks for better tools to understand and improve mental health system performance and monitoring of implementation.

7) Further invest in the mental health workforce by improving working rights and conditions; provide protective psychological support for medical and frontline social care workers who dealt with patients during the pandemic.[339]

8) Demonstrate the strategic centrality of mental health in policymaking across EU policies and adopt a "mental health in all policy" approach to employment, education, housing, income and pensions, and equality, through migration, the environment and climate, transport, cohesion policy, and taxation. This will be true at the EU level (mental health in all EU policy) and member state level (whole of government, mental health in all policies approach).

9) It will involve a multi-stakeholder, multi-sectoral approach, including international organisations, governments, NGOs, social institutions and service providers, community and voluntary groups, as well as the private sector collaborating in its production.

10) Develop clear mental health pathways in mental health policy:

    - further investing and improving diagnosis, early intervention and clinical treatment and care for those with complex mental health conditions;
    - promoting non-pharmacological interventions and involvement of family and relatives (e.g. as implemented in Denmark[340]) in pathways where possible; and
    - incorporating mental health interventions into mainstream care pathways and/or blended with traditional forms of care.

11) Develop coordination among (a) different parts of the mental health system (between psychiatrists and GPs, for example, or the transition between inpatient and community/care settings) and (b) between the mental health system and other providers, between social housing and mental health service providers, for example.

12) Build capacity in local government to deliver community mental health services through statutory duties and powers for vulnerable groups, commissioning of voluntary and community services, provision of wider services that support mental health, and overview and scrutiny of mental health provision.

13) Develop primary and community provision and increase accessibility to them to promote prevention, early detection and early intervention of mild to moderate psychological problems, to avoid evolution of these problems into chronic and complex psychiatric disorders.[341] This includes cost-effective, complementary and person-centred approaches, such as social prescribing.[342] This will involve moving away from a hospital-centric, biometric focus to a psychosocial approach.

14) Promote the importance of investing in activities that expand social contact, that are rooted in society and relationships. This builds individual confidence and trust to mitigate the risk of further mental health inequalities.

15) Advise member states to conduct audits of current mental health provision before developing further strategies.

16) Convene member states to fix goals; set clear deadlines, commitments and necessary funding; and connect the main actors through effective partnerships, sharing data and digitalisation.[343]

17) Share information, research and best practice on the mental health system as a whole between member states.

18) Promote mental health policy evaluation. This will increase public confidence in accountability and efficiency of public services; encourage scrutiny and participation in the policy process and through wider dissemination of evaluation

results; increase awareness of positive policy outcomes for redistribution, well-being and use of public revenue.

19) Involve a wide range of stakeholders in the decision-making process of mental health policy, building awareness and gaining public trust.[344]

20) Consult people with lived experience and their representative organisations from design, implementation and monitoring to evaluation of mental health strategy.

21) Develop digital policy across member states, in particular, examining (a) equity of access in different populations, for example, urban/rural areas, older/younger; (b) attitudes of different population groups to accessing telemedicine; (c) sharing of sensitive data and (d) further development of web-based mechanisms to collect information, identify and disseminate European good practices in mental health.

Mental health in employment policy

This report recommends that developing an EU mental health strategy involves changing the narrative to acknowledge that mental health issues cannot be addressed out of context, because they are rooted in society and our relationships. As we have said, there is a strong socio-economic gradient evident in mental health. This report recommends that a future EU strategy on mental health must include reform of the relationship between employers and their employees. A "mental health in all policy" approach must have a workforce policy at its centre that will:

1) Improve workers' rights and conditions, including working hours and preventing burnout.

2) Strengthen mental health support for individuals on sick leave.

3) Reduce mental health problems in the workplace.[345]

4) Address the increase in occupational stress.

5) Revise employment law to provide terms and conditions for remote work and to set out the rights and obligations, both for workers and employees, including:

   - progressing from the recent resolution on mental health in the digital world of work and drafting a working-time directive on the right to disconnect; and

   - considering the specific mental health effects of teleworking.

6) Develop a place-based approach, in which stakeholders ensure that they are providing mentally healthy spaces.[346]

7) Train frontline actors across workplaces (not just the health sector) in mental health literacy and psychological first aid.[347]

8) Develop clarification over where responsibility for mental health support switches from the employer to the employment services and social protection.

9) Actively promote active labour market policies that:

   - support young people to make strong transitions into the labour market;

   - act as a protective factor in the recovery from mental health; and

   - provide support for jobseekers living with mental health conditions.

EU migration policy and mental health

Sixty million citizens and residents of the EU live outside their country of birth, representing over 10% of the EU's total population. The pandemic reminded us just how critical labour migration is to Europe, including in key sectors such as agriculture, health and social care. Despite moves towards a more proactive approach to migrant's social, civic and political participation, many of the most vulnerable migrant groups are more vulnerable to worse mental health outcomes compared to the population as a whole and also experience barriers to accessing healthcare in their host countries. This includes the four million Ukrainians recently registered for temporary protection in the EU. This report recommends that any strategy on mental health must:

1) Devise innovative services that adapt to migrants being on the move. This will include taking into consideration that migrants may already have been treated in more than one location by the time they come into contact with any one member state's mental health system.

2) Develop specific mental health pathways for migrants and refugees, for example, improving provision at reception centres.

3) Refer migrants and refugees to other support services, such as employment and housing organisations, at the same time as supporting their mental health.

4) The EU must provide greater financial support for smaller NGOs working with vulnerable groups, particularly displaced people (and simplify the application procedures for this funding).

5) Develop policy focusing on addressing and reducing stigma within migrant communities that prevents them seeking treatment either for themselves or for family members, particularly the fear that if any mental health issues are identified and treated that this will create obstacles to their future integration into their host country.

6) Provide mental health support for those providing services to refugees.

7) Providing training in mental health literacy and psychological first aid specific to migration and asylum seeking.

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APPENDICIES

APPENDICES

Appendix 1: List of organisations in each country contacted in first round of fieldwork

France

State/public bodies and research institutes

Santé Publique France

Inserm

Psycom

CN2R

CNRS

Clinics

Centre Hospitalier le Vinatier

CHUV

Associations, charities and federations

UNAFAM

Institut de psychiatrie

Santé Mentale France

INFIPP

PSSM

Fondation Fondamental

LFSM

Fondation de France

Les Ailes Déployées

Fédération France Victimes

France Dépression

Advocacy France

FNAPSY

Fondation Pierre-Deniker

Enfine

Youth

UNICEF France

ANMDA

La Maison Perchée

Bicycle

Older citizens

CNSA

Les Petits Frères des Pauvres

Haut Conseil de la Famille, de l'enfance et de l'âge

UNRPA

Migrants and refugees

Secours Catholique – Caritas France

La Cimade

Comede

Travellers and Roma

FNASAT

ANGVC

People with a disability

Handicap International

UNAPEI

Fondation handicap Malakoff Humanis

Handissimo

People on a low income/people with experience of homelessness

Les Restos du Coeur

Croix-Rouge Française

Le Secours Populaire

Fondation Abbé Pierre

Domestic abuse shelters

La Maison des femmes Saint-Denis

Ireland

State bodies and research institutes

MHC – Mental Health Commission

Health Service Executive (HSE)

HSE NOSP – National Office for Suicide Prevention

Science Foundation Ireland

National Suicide Research Foundation

Clinics

Bloomfield health

Charities, associations and NGOs

Mental Health Ireland

Mental Health Reform

Pieta House

Aware

Bodywhys

Shine

Turn2me.org

Threshold Training network

First Fortnight

3Ts

GROW

Samaritans

Cycle Against Suicide

A Lust For Life

SoS

Peer Advocacy Mental Health

My Mind

Youth

JIGSAW

Spun Out

Barnardos

Older citizens

ALONE

Age Action

Friends of the Elderly Ireland

Migrants and refugees

Cairde

MRCI

Irish Refugee Council

Immigrants Council of Ireland

Travellers and Roma

Exchange House Ireland

National Traveller Women's Forum

National Traveller Mental Health Network

Pavee Point

People with a disability

Ahead

Chime

Enable Ireland

Inclusion Ireland

Disability Federation of Ireland

People on a low income/people with experience of homelessness

OXFAM Ireland

Social Justice Ireland

ActionAid Ireland

Society of Saint Vincent de Paul

Focus Ireland

LGBTQ+

BeLong To

<H3>Regional

Dublin North City and County Mental Health Project

Dublin North City and County Project

Cork Mental Health Foundation

Poland

Mental health professionals (Anonymised)

Psychologist, first to introduce e-consultations in Poland, even before COVID-19 – works with youth

Psychiatrist actively involved in policy formation/ advises on mental health

Psychologist, psychotherapist (public hospital + private practice)

Mental health crisis consultant

Psychotherapist

Doctor

Psychiatrist

Charities, foundations and institutions

Fundacja Instytutu Psychiatrii i Neurologii

Mokotowskie Centrum Zdrowia Psychicznego

Centrum Terapii DIALOG

Polskie Towarzystwo Psychiatryczne

SWPS

Youth

Fundacja TVN

Dajemy dzieciom siłę

Domestic abuse

Stowarzyszenie Niebieska Linia

LGBTQ+

Miłość nie wyklucza

Appendix 2: List of participants (interviews)

Interviews – conducted in person, over the phone and via teleconferencing

Between April and August 2022

France

1. National mental health NGO, deputy director general - 11/05/2022
2. National foundation, health - 10/05/2022
3. Displaced persons and refugee charity - 16/05/2022
4. Domestic violence charity, service coordinator - 23/05/2022
5. Refugee charity - 16/05/2022
6. Rehabilitation centre, psychosocial, professor - 25/05/2022
7. Hospital (head of psychiatry) - 02/06/2022
8. Hospital, university, professor of psychiatry - 25/05/2022
9. Mental health organisation, clinical psychologist - 15/06/2022
10. Hospital, regional centre, psychiatrist, Dr - 16/06/2022
11. Youth/adolescent specialist, psychiatrist, Dr - 05/07/2022

Ireland

1. HSE psychiatric social worker - 27/04/2022
2. National charity, head of policy and advocacy, Dr - 04/05/2022
3. Mental health charity, director of services - 17/05/2022
4. Mental health national coalition organisation, 2 people - 30/05/2022

    (1 senior project officer; policy and advocacy coordinator)

5. Mental health NGO, director of policy and research - 13/06/2022
6. Migrant health organisation, women's health coordinator - 06/07/2022
7. University hospital, clinical psychologist, head of psychology, Dr - 08/07/2022
8. Charity organisation, suicide prevention, 2 people

    (policy officer; volunteer for over a decade) - 11/07/2022

9. Charity organisation, deaf and hard of hearing, advocacy officer - 18/07/2022
10. National youth organisation, CEO (mental health) - 28/07/2022
11. National NGO, CEO (older-age services) - 09/08/2022

Appendix 3: Information for participants (interviews)

Study: Is an EU-wide approach to the mental health crisis necessary?
Participant information sheet

Study background and aims

TASC and Foundation for European Progressive studies (FEPS) carry out a comparative, cross-national study of Ireland, France and Poland on the response of different health systems and awareness of the mental health crisis that arose during the COVID-19 pandemic in Europe.

The overarching aim of our research is to discern the potential for a coordinated EU strategy to address the mental health crisis – specifically, the rise in persons experiencing depression, anxiety and loneliness/isolation. We will compare the extent to which any national mental health policy plans are tied to monitoring systems for implementation, levels of public mental health knowledge, and where the gaps are in preventative campaigns or in treatment plans. Our major objectives are (1) to examine how well the health systems, public supports and charities in these three European countries responded in the context of a public health emergency; and (2) to draw out policy recommendations for generating an informed and accountable action plan to tackle mental health within the EU.

Your participation in the study

We are hoping to interview you as a representative of [X ORG] to better understand the scale of mental health issues that have arisen, and the requisite support frameworks for meeting future needs. We are particularly interested in exploring the degree to which the pandemic exacerbated system stressors across different regions, and mental health problems among at-risk groups, especially youth, older people, refugees, single parents, low-wage workers and survivors of domestic violence.

For example, we will be asking specific questions such as the following:

- What policy responses/targeted interventions were issued to support mental health among vulnerable populations (e.g. low-wage workers and survivors of domestic violence)?
- Were certain groups impacted to a greater degree by government measures taken in response to COVID-19 (e.g. lockdowns or work-from-home orders)?
- What are some of the challenges a coordinated EU approach would face in tackling mental health at regional levels?
- Have local mental health services benefited from any innovations in digital care provisions over the last few years?
- Are there additional provisions that you think should be introduced in a post-pandemic plan to bolster mental health?

Other logistics

- If you agree to take part, you will remain anonymous in the final policy study, and we will use a false name if attributing any quotes to you or colleagues of yours.
- If you agree, the interview will be recorded, so we can quote you directly but with your anonymity protected.

If you do not want the interview to be recorded that is alright.

- Should you wish to be identified in the final policy study please let us know.
- In line with GDPR, any data collected will be stored securely and only anonymised transcription texts are to be saved for further academic publication purposes, and our final policy study publication; all other data will be deleted by December 2022.
- The interview can take place in person (if possible), on the phone or via videoconferencing. We are willing to travel to a location that is convenient for you.
- Any data collected will be treated with confidentiality. If you agree to be interviewed, you will be asked to sign a consent form, allowing data to be used as part of the report, academic and/or practitioner-oriented publications.
- We hope to speak with you sometime in April-June 2022.

Research team

Dr Shana Cohen, Director, Think-Tank for Action on Social Change (TASC)

Dr Emily Murphy, Senior Researcher Health Inequalities, TASC

Dr Sara Bojarczuk, Postdoctoral Researcher, Centre of Migration Research, Department of Sociology, University of Warsaw; Trinity College, University of Dublin

Sophia Moran, Research Assistant, TASC

Who should I contact for more information?

Emily Murphy e-mail: emurphy@tasc.ie

Please get in touch with me if you would like to discuss the research with someone beforehand, or if you have any questions or concerns to raise about this study.

Appendix 4: Fieldwork: interview schedule (in English)

Study: Is an EU-wide approach to the mental health crisis necessary?
Interview discussion guide

Questions will vary based on the person, organisation and services provided. For Country X – insert either Poland/Ireland/France

Introduction

- Interview length (approx. 30 minutes)
- Consent/(audio/Zoom) recording
- Confidentiality of data

Organisation & profile of service users/patients

- Can you tell me about your work/organisation and the supports/services provided?
  - Role of association in meeting needs locally or nationally

Public and private mental healthcare systems: supports, services and community risks

- How effective is the current mental health system for sufferers of mental ill health?
  - Change over time: current practices versus prior to COVID-19 [in Region X]?
- In your opinion, do people suffering from increased anxiety/depression or loneliness mostly rely on public services, or on voluntary, private or charitable organisations?
- Can you think of an example where coordinated efforts between state and voluntary sectors tackled knowledge gaps within communities or implementation gaps for mental health during the pandemic?

"Mental health crisis" brought on by COVID-19 and socio-economic change

- Prior to lockdowns, were there a sufficient number of mental health programmes and services catering specifically to:
  - Children & adolescents/domestic violence survivors/people with disabilities (*will depend on interviewee re groups asked)
  - And now?
- Were any additional mental health supports provided to vulnerable or at-risk groups during the pandemic (e.g. migrants/the homeless/households under financial strain/young people who lost their jobs)?
  - For example, were extra hotlines or shelters created to provide support?
  - Now, two years on, which groups of people need the most support?

Mental well-being (health promotions) versus mental ill health (health treatment)

- Do you feel there is an awareness of mental well-being as well as mental illness in your country?
    - If so, is this information widespread, that is, reaching all communities?
    - Is this the same for urban and rural areas?
- How are preventative campaigns linked to treatment interventions for mental health?

Telemedicine roll-out: enhancing access or creating digital gaps among populations?

- Has COVID-19 affected the use of online mental healthcare or online help-seeking?
- Do you consider the current approach to telemedicine fit for purpose?
    - Is there sufficient funding allocated to address any digital gaps across the EU?

Policy framework: national/international challenges & opportunities in future

- To your knowledge, did [Country X] announce a mental health response plan during the pandemic (or if not, in recent years)?
    - Has there been transparency in tracking the functioning of any plans over time?
- Where do you see the greatest opportunities to innovate mental health services – at the community level, national level or EU level?
- What policy actions/infrastructure are most needed to create an accountable and coordinated approach to mental health outcomes within Europe?
    - What major protective factors can we safeguard for promoting mental well-being among younger and older populations in the future?
- In your view, should it fall to national governments or the EU to develop mental health strategies to coordinate responses and preparedness for global public health crises?

Thank you

- To wrap up, is there someone you recommend I speak with about this topic?

Appendix 5: Fieldwork: interview schedule (in French)

Intro

- Durée de l'entretien (30 min)
- Consentement à l'enregistrement (audio/Zoom)
- Confidentialité

Organisation et profil des utilisateurs de services/patients

- Pouvez-vous me parler de votre travail/organisation et des soutiens/services apportés ?
    - au niveau local ou national?

Systèmes de santé mentale publics et privés : soutiens, services et enjeux communautaires

- Le système actuel de santé mentale est-il efficace pour les personnes souffrant de troubles mentaux ?
    - Évolution dans le temps : Pratiques actuelles par rapport à celles d'avant COVID-19 [dans la région X] ?
- Selon vous, les personnes souffrant d'anxiété/de dépression accrue ou de solitude dépendent-elles principalement des services publics, ou des organisations bénévoles, privées ou caritatives ?
    - Pouvez-vous citer un exemple où des efforts coordonnés entre le secteur public et le secteur bénévole ont permis de combler un manque de connaissances au sein de la population ou le manque de mise en oeuvre des politiques de santé mentale pendant la pandémie ?

Crise de la santé mentale provoquée par le COVID-19 et changements socio-économiques

- Avant le confinement, y avait-il un suffisemment de programmes et services de santé mentale destinés spécifiquement aux
    - Enfants et adolescents/survivants de violences domestiques/personnes handicapées (*dépendra de la personne interrogée et des groupes concernés)
    - Et maintenant ?
- Des services de santé mentale supplémentaires ont-ils été fournis aux groupes vulnérables ou à risque pendant la pandémie (par exemple, les migrants, les sans-abri, les ménages à bas revenus, les jeunes ayant perdu leur emploi) ?
    - Par exemple, des lignes d'assistance téléphonique ou des refuges supplémentaires ont-ils été créés ?
    - Aujourd'hui, deux ans après, quels sont les groupes de personnes qui ont le plus besoin de soutien ?

Bien-être mental (promotion de la santé) vs. troubles psychiques (traitement)

- Pensez-vous qu'il existe une sensibilisation au bien-être mental et aux troubles psychiques en France ?
    - Si oui, cette sensibilisation est-elle répandue chez toutes les communautés ?
    - Est-ce la même chose pour les zones urbaines et rurales ?
    - Comment les campagnes de prévention sont-elles liées aux interventions de traitement de la santé mentale ?
- Consentement à l'enregistrement (audio/Zoom)
- Confidentialité

Déploiement de la télémédecine: amélioration de l'accès ou création de fossés numériques parmi les populations ?

- le COVID-19 a-t-il eu une incidence sur le recours aux soins de santé mentale en ligne ou à la recherche d'aide en ligne ?
- Considérez-vous que l'utilisation actuelle de la télémédecine est adaptée/bénéfique ?
    - Y-a-t-il suffisamment de fonds alloués pour combler les éventuelles inégalités numériques dans l'UE ?

Politiques en place: enjeux nationaux/internationaux et possibilités d'amélioration

- À votre connaissance, est-ce que la France a annoncé un plan d'intervention en santé mentale pendant la pandémie (ou sinon, au cours des dernières années) ?
    - Y a-t-il eu assez de transparence dans le suivi du fonctionnement des stratégies dans le temps ?
- Où voyez-vous les plus grandes possibilités d'innover dans les services de santé mentale – au niveau de la communauté, au niveau national ou au niveau de l'UE ?
- Quelles actions politiques/infrastructures sont les plus nécessaires pour créer une approche transparente et coordonnée en matière de santé mentale en Europe ?
- Quels sont les outils les plus importants pour promouvoir le bien-être mental des populations jeunes et âgées à l'avenir ?
    - Selon vous, est-ce le rôle des gouvernements nationaux ou de l'UE de développer des stratégies de santé mentale pour coordonner les réponses et la préparation aux crises mondiales de santé publique ?

Merci.

- Pour conclure, y a-t-il une personne avec qui vous nous recommandez de nous entretenir?

Appendix 6: Roundtable questions

1. Have member states become more proactive in tackling mental health issues since the pandemic? What barriers do they still face?

2. What kind of support could the EU provide to tackle mental health challenges in member states? How can progressives steer an upgrade of public health systems to ensure coverage, access and affordability of mental care?

3. How can EU institutions devise a European mental health strategy? What could be the feature of EU policymaking in this field? Which policy tools could have EU added value?

4. How have health systems and public supports in Ireland, France and Poland responded to the reported rise in mental health issues provoked by the COVID-19 pandemic and public health emergency?

5. What policy responses/targeted interventions were issued to support mental health and well-being during the crisis, in particular, those that target particularly at-risk and marginalised populations?

6. Have local mental health services in European countries benefited from any innovations in digital care provisions over the last two years?

7. What policy recommendations and actions are needed at EU level to better inform a coordinated approach to mental health outcomes in Europe?

END NOTES

END NOTES

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ABOUT THE AUTHORS

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Gerry Mitchell,

Gerry Mitchell is a social researcher and writer who is also experienced in political campaigning, community engagement and teaching. She has degrees from Cambridge and The London School of Economics and Political Science (LSE) where, based in the Centre for Social Exclusion, she completed a PhD in Social Policy. She has recently worked with Compass (London), the Edinburgh Voluntary Organisations' Council (EVOC), the Foundation for European Progressive Studies (Brussels), Friedrich-Ebert-Stiftung (London and Nordic countries) and the Think Tank for Action on Social Change (Ireland). She lives in Woking, Surrey where she stood as Labour's parliamentary candidate in the 2019 general election. She currently chairs local Compass and Make Votes Matter groups and co-directs a community fridge project. Her forthcoming book, co-authored with Marcos González Hernando, 'Uncomfortably Off: Why the Top 10% of Earners Should Care about Inequality' is published by Policy Press in May 2023.

Emily Murphy

Emily is a Lecturer in Sociology in the Department of Sociology at the University of Limerick. Prior to this, she worked as senior researcher on health inequalities at the Think Tank for Action on Social Change (TASC). Her research area is economic sociology, with a focus on inequality, stratification, labour markets and the life course. She studied Business, Economics and Social Studies at Trinity College Dublin, completed an MSc in Sociology at Oxford University, and holds a PhD from the University of Lausanne (NCCR LIVES).

Dr Sara Bojarczuk

Sara Bojarczuk holds a PhD in Sociology from Trinity College Dublin and MRes in Social Policy (University of Bath). Her research interests lay within the field of migration, family studies and women, social support and particularly social support networks and employment. Her PhD thesis looked at the role of social networks in mobilising support among Polish working mothers in Ireland. In her work, she uses mixed methods approach, drawing on the benefits offered by both qualitative and quantitative tools. Currently she coordinates an NCN funded project: "E-Factor: Employers' interests as underrated factor in labour migration – an institutional approach.

Shana Cohen

Dr Shana Cohen is the Director of TASC.

She has been director since 2017. In addition to her directorship, she works directly on projects involving social inclusion, economic inequality, democracy, and climate justice. For instance, she is drafting a report for Safe Ireland on how social policy can support victims of DSGBV. She has also worked on the social prescribing programme with the Coop in NEIC and policy reports on migration and social solidarity in the EU, as well as the effect of the financial crisis on the top 10% of income earners in Ireland, Sweden, Spain, and the UK. In addition to her work at TASC, Shana is an Affiliate Lecturer in the Department of Sociology, University of Cambridge.

She has published on social action and activism, as well as social change in North Africa, her original area of academic research. She has a PhD in Sociology from the University of California, Berkeley, and an AB from Princeton University. Before coming to TASC, she was Deputy Director of the Woolf Institute in Cambridge. In her role at the Institute, she became engaged with interfaith and intercultural relations in Europe, India, and the Middle East. Beyond academic research, Shana has extensive experience working with NGOs and community-based organizations in a number of countries, including Morocco, the US, the UK, and India. This work has involved project design, management, and evaluation as well as advocacy. She has consulted for the World Bank, the Grameen Bank Foundation, and other private foundations and trusts.

THE FOUNDATION FOR EUROPEAN PROGRESSIVE STUDIES (FEPS)
European Political Foundation - N° 4 BE 896.230.213
Avenue des Arts 46 1000 Brussels (Belgium)
www.feps-europe.eu
@FEPS_Europe

TASC
28 Merrion Square North, Dublin 2
Ireland. D02 AW80

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Mental health is an intrinsic human right and an invaluable resource for the European community. This policy study reflects on the current provision of mental health services in France, Ireland and Poland. The authors review EU policy, to date, on developing a mental health strategy for the union and, for each case study country, outline mental health provision and the policy context to inform the findings from interviews with representatives of its mental health sector. It finds that none of the three countries has the capacity to address the rise in demand. All countries focus on hospital treatment and lack primary and community services; have barriers to access for vulnerable groups, including stigma; and need more investment.

In light of these findings, the policy study considers the need for the EU to take the strategic lead in working with member states to collaborate on an EU-wide mental health strategy to build greater resilience in their populations to meet the many challenges facing them.

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