

Joint Action MENTAL HEALTH TOGETHER

Knowledge exchange report

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Author National Institute of Health, Italy

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1.2 Statement of originality

The content of the deliverable is original and created solely by the contributors of the JA Mentor project.





1.3 Table of contents

1 Document Properties	7
1.1 Document revision history	1
1.2 Statement of originality	1
1.3 Table of contents	
1.4 Abbreviations and Acronyms	
1.5 List of templates	
2 About the MENTOR project	
2.1 Purpose of this document 2.2 Task 5.4	6
2.2.1 Task description	7 8 9
2.3 Contacts	
2.3.1 Coordinator contact	13
D5.4.1. Knowledge exchange report	15
Methodologies and process	15
Local policies	
Survey developmentSurvey dissemination and analysis	
Results Participants and respondents	17
PART 1. Organization of Mental Health and Social Services (e.g., Local Units, Hosp Residential Settings)	
PART 2 Intervention delivered	
PART 3. Benefits and fundings	61
PART 4. Presence of Mental Health and Social Sector information systems	78
PART 7. Local experiences on Personal Health Budget or health-social care integs	grated
PART 8. Strengths and challenges	
Changes and suggestions	
5.4.2 Definition of an integrated care pathway shared among EU Member States	





Synergies	106
Template 1: Strategic Guidelines: Designing the Health Budget with o	a
Person-Centered Approach	0
Template 2: Survev in English	8





1.4 Abbreviations and Acronyms

EU	European Union		
JA	Joint Action		
MENTOR	Mental Health Together		
PLE	People with Lived Experience		
WP	Work package		

	List of abbreviations – WP5.4 participants				
ASL of Turin	Azienda Sanitaria Locale Città di Torino (Italy)				
BIOSISTEMAK	Asociación Instituto De Investigación En Sistemas De Salud- Biosistemak				
FFIS	Fundacion para la Formacion e Investigacion Sanitarias de la Region de Murcia				
FRCB- IDIBAPS/HCB	Fundació Recerca Clínic Barcelona-IDIBAPS/ Hospital Clínic de Barcelona				
FUNDESALUD	Fundacion para la Formacion e Investigacion de los Profesionales de la Salud de Extremadura Fundesalud				
GENCAT	Departament de Salut - Generalitat de Catalunya				
ICO	Institut Catala D'oncologia				
IDIVAL	Fundacion Instituto de Investigacion Marques de Valdecilla				
ISS	Istituto Superiore di Sanità				
Lombardy Region	Regione Lombardia				
MOSA	Sotsiaalministeerium				
NCMHFAD	Centrul National de Sanatate Mintala Si Lupta Antodrog				
NHF	National Health Fund				
PHC	State Institution Public Health Center of the Ministry of Health of Ukraine				
PHCI	Primary Healthcare of the Capital Area				





ProMIS	Azienda ULSS 4 Veneto Orientale			
RDS	Southern Region of Denmark			
SAS	Servicio Andaluz de Salud			
SHSO-MHS	Organismos Kratikon Ypiresion Ygeias			
SMS	Servicio Murciano de Salud			
UNIMIBI	Università degli Studi di Milano-Bicocca			

1.5 List of templates

- Template 1: Strategic Guidelines: Designing the Health Budget with a Person-Centered Approach: available here
- Template 2: Survey in Englis





2 About the MENTOR project

MENTOR aims to promote mental health by sharing experiences across a wide spectrum, from political initiatives to clinical professional practices. It incorporates evidence-based best practices and adapts initiatives to achieve long-term sustainability, enhancing mental health and well-being at individual and population levels.

MENTOR objectives:

- 1. Ensure efficient dissemination of MENTOR activities/outcomes.
- 2. Promote the sustainability and implementation of MENTOR outcomes through the different mental health care systems across the Europe region.
- 3. Strengthen the capacity of mental health literacy by developing policy recommendations and intervention tools targeted to vulnerable groups and fighting stigma.
- 4. Contribute to increasing access to evidence-based practices and innovative mental health monitoring, promotion and prevention approaches to manage mental health conditions in communities.
- 5. Improve monitoring systems of mental health to heighten awareness for mental health problems and ensure earlier detection of individuals at risk, and address data-driven decisions.
- 6. Reduce social inequalities in population targeting people with mental health issues.
- 7. Foster methods to evaluate and implement MHIAP approaches at national and regional levels.
- 8. Identify evidence-based interventions for the promotion and prevention of mental health issues in the vulnerable and general populations.
- 9. Support recovery-oriented and inclusive practice in the care of people with mental health condition.
- 10. Implement personalized and comprehensive approaches to mental health.

2.1 Purpose of this document

This document serves as the Knowledge Exchange report for the JA Mental Health Together – _MENTOR Task 5.4 and has the main objective to assess the local population' needs, services and policies by a Panel of representatives from ministries, public agencies, mental health and social work professionals, municipalities and people with lived experiences. The specific aims of this Task are to:

1) Establish a panel with public and private organizations







- 2) Prepare and disseminate a survey to collect:
 - a. needs, suggestions, and critical issues reported by the population involved in each country;
 - b. information about Social and health services devoted to care of people with mental health disorders (MHDs);
 - c. country policies on integrated social-health pathway for people with MHDs.

The present Knowledge exchange report includes the analysis of the data collected and the information collected by the countries involved in the task.

2.2 Task 5.4

2.2.1 Task description

Integrated care pathway for promoting social inclusion and quality of life of people with Mental Health disorders

Personalization is a key element of healthcare policy, as underlined by the World Health Organization (WHO). It is built on the conception of a health care system centred on human principles and rights, such as equity, participation, self-determination, and non-discrimination. This means treating patients from a person-centred perspective, listening to their needs, and recognizing their abilities and freedom to choose for their own health. A person-centred approach enables different sectors to work together, using available resources and different competencies, to meet person's needs overall.

The task 5.4 helps participating partners in defining and implementing integrated care pathways for people with mental disorders within their countries and produce recommendations to promote health and social integration. Public policies, different funding sources, health, educational and social services, various professional resources, etc. will collaborate in close integration and partnership. Objective of this synergic intervention is the recovery and full inclusion in the community of people with mental health disorders. Through the innovative methodology of the personal health budget, health and social services work together to provide integrated interventions in the following four areas: health, housing, job placement, affectivity/sociability/life and relationship skills. Each person is accompanied through a tailored individual project, designed according to his/her specific needs and preferences and using available public/private/personal resources. The individual's personal empowerment is ensured by his/her full involvement and consent at every stage of the negotiation and decision-making process.

The availability or absence of economic/material resources (i.e., house, income, pension, salary, annuity...) and informal assets (educational qualifications, family support, social network, personal skills...) resources is considered in defining the person's needs and personal health budget. The latter is defined as the set of resources available from the individual and his/her context and the list of resources/interventions that integrated







services ensure or provide during the personalised project. The project is monitored, evaluated periodically, and updated accordingly.

During the task, data and information concerning public policy and mental health services' organization are collected from participating countries and analysed. People with lived experiences will be actively included in the multidisciplinary team evaluating data collected and defining the key components of the integrated health-social care pathway that will be implemented in some MS.

The personal health budget has been tested so far in different countries, including the United Kingdom, Belgium, Denmark, Italy, Finland, Austria, France, Sweden, Germany, Australia, and the United States, with different types of programs, varying from inclusion criteria related to commissioned services or the person's degree of choice. The main goal of most programs was to promote autonomy and independent living, whereas other programs focused more on improving the caregiver's system of care.

The task 5.4 will collaborate closely with task 5.3 to support the implementation of this integrated approach, through the active involvement of different sectors of the Public Health, Social and Educational System. Project partners transfer the experience, and the knowledge gained to other Member States, through these four main outcomes:

- Knowledge exchange report (D.5.4.1);
- Definition of the ICP (D.5.4.2) focusing on vulnerable people;
- Guidelines and the training material (D.5.4.3) focused on Mental health professionals;
- · Policy recommendations (D.5.4.4) for National policymakers.

2.2.2 Task structure

JA MENTOR Task 5.4 consists of 4 subtasks: Survey dissemination and analysis (5.4.1), Definition of the integrated care pathway (5.4.2), Pilot implementation and monitoring of the integrated care pathway (5.4.3), and Definition and dissemination of community-based mental health policies (5.4.4).

The Task 5.4 has a task leader (National Institute of Health, Italy), who is responsible for reaching the task's deliverables and objectives. Twenty-one Member States join the Task 5.4.





2.2.3 Task set-up

The Task 5.4 has extensive geographical coverage across Europe (22 institutions across 10 countries) – Cyprus (SHSO-MHS), Denmark (RSD), Estonia (MOSA), Germany, Iceland (PHCI), Italy (ISS, ProMIS, ASL of Turin, UNIMIBI, Lombardy Region), Poland (NHF), Romania (NCMHFAD), Spain (Biosistemak, GENCAT, FRCB-IDIBAPS, ICO, IDIVAL, FFIS, SMS, SAS, FundeSalud, SES), and Ukraine (PHC).

All countries except Iceland, Germany, and Denmark are actively participating in the Work Package (WP) and therefore provide a more in-depth analysis of the current situation and related challenges.



Each participating institution and country/region contribute valuable and complementary expertise and experience to the Task. The partners possess the necessary skills, qualifications, and resources to carry out the Task effectively. They also hold the appropriate legal and technical mandates to implement the Task's activities at the national level.

2.2.4 Healthcare, Social Support, and Mental Health Services Across Countries

2.2.4.1 Italy

Italy has a regionalized National Health Service (SSN) that provides universal coverage largely free of charge at the point of delivery, though certain services and goods require a co-payment. Italy's SSN is regionally based and organized into three levels: national, regional and local. The national level steers the health system, setting general objectives, the national benefits package, per capita funding and fundamental principles. Through yearly Budget Bills, the national government and parliament agree on expenditures, projected revenues and target priority areas. The Ministry of Health leads health care planning by defining the national benefits package, setting long-term goals, monitoring the SSN, equalizing fund allocation, and co-governing with regions and the Institutes for Care and Scientific Research (IRCCSs) (Italy, Health Research Review, de Belvis, et al., 2022).

The Department of Mental Health (DMH) is the health organization responsible for specialist mental health care in the community, as defined by the *Progetto Obiettivo "Tutela Salute Mentale 1998–2000"*. This key initiative is responsible for specialist community-based mental health care in Italy, as defined by the national mental health plan. It oversees prevention, treatment, and rehabilitation services within a defined catchment area and promotes public awareness, anti-stigma campaigns, research and professional training.

The DMH includes the following facilities:







- Community Mental Health Centres (CMHCs): Core hubs for outpatient psychiatric care and coordination of day care and residential services. They operate 12 or 24 hours daily with multidisciplinary teams (psychiatrists, psychologists, social workers, nurses, and therapists).
- **General Hospital Psychiatric Units (GHPUs)**: Provide acute inpatient care with up to 15 beds, linked closely to CMHCs to ensure care continuity. Admissions may be voluntary or compulsory (under specific legal and clinical conditions).
- **Day Centres**: Open Monday to Saturday, 8 hours per day, hosting around 20 patients daily. They offer group-based rehabilitation and empowerment programs for subacute patients.
- Residential Facilities: Community-based, non-hospital accommodations for individuals with stable but serious mental disorders requiring ongoing rehabilitation. These facilities are classified by intensity of care (high, medium, low) and vary in bed number. Despite their rehabilitative purpose, many residents stay longer than two years, suggesting they function partly as long-term care facilities.

2.2.4.2 Spain

Spain is a unitary state made up of 17 autonomous communities and 2 autonomous cities (Ceuta and Melilla) with varying degrees of operative autonomy. The National Health System (NHS) is made up of a set of health services dependent on the public authorities. It is a system coordinated between the Health Services of the National State Administration and the Autonomous Communities. According to Article 43 of the Spanish Constitution, all Spanish citizens have the right to receive public health care. The NHS is regulated by the General Health Law of 1986, which establishes public, universal and free financing and guarantees equity of access to health care. There are two levels of care coordinated with each other: a first level of primary care and a second level of specialised and hospital care. Mental health care in Spain includes the diagnosis and clinical monitoring of mental disorders, psychopharmacotherapy, individual, group or family psychotherapies (excluding psychoanalysis and hypnosis), electroconvulsive therapy and, where appropriate, hospitalisation. It shall also quarantee the necessary continuity of care, including preventive and promotional actions, treatment of chronic mental disorders and their comprehensive care, addictive behaviours (including alcoholism and gambling), psychopathological disorders of childhood/adolescence, mental health disorders derived from situations of risk or social exclusion, and information and counselling to the people linked to the patient, especially the main caregiver.

Andalucia. In Spain, mental health services are integrated into the public healthcare system and organized through a decentralized model managed by each Autonomous Community. Care is structured across primary care—where general practitioners detect and manage mild cases—and specialized services, including outpatient mental health units, day hospitals, and inpatient care. Interventions are typically multidisciplinary and include pharmacological treatment, psychotherapy, psychoeducation, and psychosocial rehabilitation. Specific guidelines and protocols are developed regionally based on national frameworks.







Cantabria. In the autonomous community of Cantabria (Spain), a region with 590,851 inhabitants, the Cantabrian Health Service is the public provider of health services, including mental health and care for addictive behaviours. The first level of care is Primary care, from where interventions are carried out in accordance with its portfolio of services, through family and community physicians and nurses. A clinical psychology program is currently being deployed in primary care, which this year will cover half of the population. The next level of care is provided by the Mental Health Units, both for adults (6 units) and for children and adolescents (3 units), which provide care for mental disorders in the region. There are several programs and units for specific pathologies: addictive behaviours, personality disorders, suicidal behaviour, eating disorders, first episodes of psychosis, resistant depression. In addition, there are short and long stay hospitalization units.

Catalonia. In Catalonia, mental health and addiction policies are guided by the Pla Director de Salut Mental i Addiccions (Mental Health and Addictions Master Plan) and the Pla de Drogues i Addiccions Comportamentals (Addiction Plan), which provide the strategic framework for planning and delivering care based on a stepped care model. This model ensures that individuals receive the appropriate level of care according to their needs, starting from Primary Health Care (PHC) and extending to specialized and hospital-based services.

At the community level, mental health services are organized through key facilities, including Centres de Salut Mental d'Adults (CSMA), Centres de Salut Mental Infantil i Juvenil (CSMIJ), Centres d'Atenció i Seguiment a les drogodependències (CAS), and specific Behavioural Addiction Units. These centres form the backbone of a continuum of care that integrates mental health into the broader health system, with PHC as the entry point. Integration is further enhanced through innovative initiatives such as:

- The Primary Care and Mental Health Collaboration Programme (PCP), which fosters coordinated work between general practitioners and mental health professionals.
- The Social Prescribing and Health Programme, which connects individuals with community-based resources to address social determinants of mental health and promote holistic well-being.

Hospital-based mental health and addiction services provide care for more acute or complex situations and include acute, subacute, and long-stay units, detoxification units, day-hospitalization, specialized emergency services, and units for dual diagnosis conditions. All services are supported by clinical guidelines, protocols, and targeted programmes to ensure evidence-based, person-centered, and rights-based care.

It is important to note that in the Spanish State, the healthcare system is decentralized, meaning that each *comunidad autónoma* (autonomous community) has its own health system with differentiated organization, planning, and service delivery. As such, mental health and addiction strategies in Catalonia reflect the specific political, social, and territorial context of the region, while aligning with broader national and international frameworks.







At the cross-sectoral level, Catalonia seeks to promote a Mental Health in All Policies (MHiAP) approach through the Pacte Nacional de Salut Mental (National Pact for Mental Health), which includes a strategic objective (no. 19) aimed at defining and progressively implementing this approach across all levels of governance and sectors. This framework encourages coordinated action across sectors such as education, social services, youth, employment, justice, and others, recognizing that mental health is shaped by multiple structural determinants. At the local level, most large municipalities have developed their own mental health, and addiction plans to adapt to their populations' specific needs. For example, the City of Barcelona has its own *Pla Municipal de Salut Mental*, designed to respond to the city's complex social, economic, and urban dynamics. This municipal plan places a strong emphasis on equity, community participation, and the protection of rights, and is aligned with broader efforts to construct an inclusive, community-based mental health system grounded in the principles of social justice and intersectionality.

2.2.4.3 Poland

The public healthcare system in Poland is primarily funded through public resources, with the National Health Fund (NFZ) budget playing a central role in contracting healthcare services from entities providing medical services. Budgeting and accounting for services are mainly based on a system of lump-sum payments, fee-for-service rates, and per diem rates in the case of hospital treatment.

In psychiatry, the dominant funding model for years was based on billing by the number of hospitalizations and procedures, which fostered an institutional approach and medicalization. However, recent years have seen the implementation of changes, such as the pilot program for Mental Health Centers (CZP), where funding is based on a capitation lump-sum model. This aims to enable more flexible, patient-centered services tailored to actual needs rather than solely medical procedures. In CZPs, funds are allocated within a predefined budget, allowing greater freedom in choosing forms of assistance (e.g., home visits, community support, therapy).

This model supports the adoption of a person-centered approach, although it is not yet widely implemented across the country. The pilot program, however, covers half of the adult population. The main systemic challenges include limited financial flexibility in traditional psychiatric services, the absence of uniform standards for implementing a person-centered approach, staffing and infrastructure shortages in certain regions, which restrict the possibility of personalized care, and a focus on "hard" services (procedures, hospitalizations) in the NFZ accounting system.

In summary, while the pilot program is testing positive examples of service billing that support a person-centered approach (as in CZPs), on a national scale, the billing system for nearly half of the adult population still largely promotes an institution- and procedure-focused model. There are significant disparities in mental health care provision between rural and urban areas.

2.2.4.4 Estonia

In Estonia main ongoing reforms shaping mental health care pathway are about introducing stepped care, developing the layer of community services and low-intensity







interventions. Responsibilities are divided between national and local level, while local municipalities remain independent defining their own services with their own resources, complemented with dedicated support from the state budget. At national level integration of health and social service systems is undergoing.

2.3 Contacts

2.3.1 Coordinator contact

Name of the contact	Role in the project	E-mail
Maria Luisa Scattoni	Task 5.4 leader	marialuisa.Scattoni@iss.it

2.3.2 Main contributors and contacts of the Task 5.4

Name of the contact	Institution	E-mail		
Martina Micai	ISS	martina.micai@iss.it		
Angela Caruso	ISS	angela.caruso@iss.it		
Letizia Gila	ISS	letizia.gila@iss.it		
Francesca Fulceri	ISS	francesca.fulceri@iss.it		
Mara Sabbioni	ISS	mara.sabbioni@iss.it		
María del Pilar López Acuña	FFIS	mpla1204@gmail.com		
Ana Bermejo Martínez	SMS	ana.bermejo@carm.es		
Rosa Ayesa Arriola	IDIVAL	rosa.ayesa@idival.org		
Claudia Parás Gutiérrez	IISPV	claudia.paras@iispv.cat		
Laura Florea	NCMHFAD	florea.laura@cnsm.org.ro		





Ane Fullaondo	Biosistemak	afulla ondo@kronikgune.org
Lola Verdoy	Biosistemak	dverdoy@kronikgune.org
Juan de la Torre	Biosistemak	jdelatorre@kronikgune.org
Jose Guzman Parra	SAS	jgp00004@gmail.com
Irene López Armenteros	SAS	ireloar@gmail.com
Jonathan Joseph Dawood Hristova	SAS	Jonathanjosepd@gmail.com
Jessica Marian Goodman Casanova	SAS	jmariangoodman@gmail.com
Silvia Matrai	FRCB- IDIBAPS/HCB	smatrai@recerca.clinic.cat
Fleur Braddick	FRCB- IDIBAPS/HCB	fmbooth@recerca.clinic.cat
Hugo López-Pelayo	FRCB- IDIBAPS/HCB	hlopez@clinic.cat
Jörg Utschakowski	Senate of Bremen/Health Ministry	joerg.utschakowski@gesundheit.bremen.de
Francisco Gil	ICO	fgil@iconcologia.net
Anna Casellas Grau	ICO	anna.casellas1@uvic.cat
Spyros Christou	ICO	christous@iconcologia.net

2.3.3 Acknowledgments

We sincerely thank all the representatives of local and national entities who took the time to respond to the survey. Their valuable input and collaboration were essential in making this report possible.





D5.4.1. Knowledge exchange report

The present knowledge exchange report collects the work of a Panel consisting of members from ministries, public agencies, professionals in mental health and social work, municipalities, and Persons with Lived Experience of the Member States carried out during the first year of the Joint Action MENTAL HEALTH TOGETHER (MENTOR).

Methodologies and process

Local policies

The deliverable 5.4.1 began with the assessment of the needs, services, and policies related to mental health within local populations. To guide this process, a panel was established, consisting of representatives from ministries, public agencies, public health research organisations, mental health and social work professionals, municipalities, and individuals with lived experience. This diverse panel, representing both public and private organizations, oversaw the comprehensive evaluation of the existing services and policies in place to support people with MHDs.

During weekly calls and email exchanges, all relevant materials, legislation, documents, guidelines, and tools available in each country/region on the topic were collected and utilized to shape the survey questions. The ISS translated the "Strategic Guidelines: Designing the Health Budget with a Person-Centered Approach" from Italian to English and shared them with partners to further support the development of the survey's content and questions.

Survey development

A key component of this assessment was the design of a survey, jointly developed by the team members. The survey gathered critical information in three key areas: first, the needs, suggestions, and challenges reported by the population in each country/region involved; second, details regarding social and healthcare services specifically dedicated to the care of individuals with MHDs; and third, national policies on integrated social-health pathways for individuals with MHDs.

Thirteen weekly meetings have been held between September 12, 2024, and January 29, 2025, with all active participants and observers to define the "Survey on Defining an Integrated Care Pathway for Promoting Social Inclusion and Quality of Life of People with Mental Health Disorders." ISS drafted the survey and has been continuously discussed, revised, and refined in collaboration with all partners.

The survey has been finalized in English and translated and adapted by the partners into Italian, Spanish, Ukrainian, and Polish.







The survey consists of the following sections:

- PART 1. Organization of the health and social services/ Mental Health and Social services (organization: i.e., local units, hospital or residential settings)
- PART 2. Intervention delivered
- PART 3. Benefits and fundings
- PART 4. Presence of Mental Health and Social Sector information systems
- PART 5. Personal Health budget (PHB): national policies and local experiences
- PART 6. Personal Health Budget structuring
- PART 7. Local experiences on Personal Health Budget or health-social care integrated services
- PART 8. Strengths and challenges

Survey dissemination and analysis

The survey was disseminated starting on February 3, 2025, through email invitations sent to Ministries, public agencies, mental health services, the welfare and labour sectors, individuals with lived experience, and representatives of third-sector organizations (NGOs, volunteer groups, and other non-profits working in mental health, social inclusion, or related fields). Participants completed the survey using LimeSurvey, a licensed tool of the ISS. The survey was completed anonymously. Participants were asked to indicate the country or region, the Ministry, organization, service they represented or if were person with lived experience or caregiver. They were also asked to provide the name of their organization and the name(s) of any organization(s) they contacted to gather additional information. All questions were mandatory in order to proceed with the completion of the survey.

The survey was disseminated by the representative of each Member State to all MENTOR Member State contacts to ensure a comprehensive European perspective. Although it was widely shared, including via LinkedIn, the survey was available only in five languages (English, Italian, Spanish, Ukrainian, and Polish), which may have limited full accessibility for all respondents.

ISS conducted four interim analyses (on February 12 and 24, and March 10 and 21) of the survey responses from all countries/regions. These analyses were presented to the partners in four meetings, along with a Word file containing the responses from each country, allowing them to review the test responses and share the results, actions designed to engage specific stakeholders.

The survey dissemination phase was completed on March 31, 2025.

The final analysis was shared with all Member States. The open-ended responses were translated by the ISS using AI, and each translation was validated by the respective Member







State. ISS also summarized the open-ended responses, and these summaries were reviewed and approved by each Member State. The original open-ended responses are available upon request.

The results were compiled into the present Knowledge Exchange Report, consolidating information from all participating countries/regions. This report serves as a foundation for mutual learning, helping to inform evidence-based planning and policy development across regions, ultimately leading to a more effective and inclusive approach to mental health care.

Results

The collaborative efforts of all partners have led to the successful development, translation, and dissemination of the "Survey on Defining an Integrated Care Pathway for Promoting Social Inclusion and Quality of Life of People with Mental Health Disorders." The weekly meetings ensured continuous refinement of the survey, incorporating diverse perspectives from all participating countries.

The collection and integration of national and regional materials, legislation, guidelines, and tools have ensured that the survey is contextually relevant and aligned with existing frameworks in each participating country/region. This process has strengthened the survey's foundation, enhancing its applicability across diverse healthcare and social service systems.

The translation and dissemination of the "Strategic Guidelines: Designing the Health Budget with a Person-Centered Approach" have further enriched the survey development. This has contributed to a more comprehensive and informed approach in defining an Integrated Care Pathway for promoting social inclusion and quality of life for individuals with mental health disorders.

The survey was translated into five languages (Italian, Spanish, Ukrainian, Polish, and English), facilitating broad participation across different regions and stakeholder groups. Its dissemination to Ministries, public agencies, mental health services, the welfare and labour sectors, individuals with lived experience, and third-sector organizations ensured a comprehensive representation of key actors in the field.

Participants and respondents

A total of 401 participants accessed the survey, of which 67% (N=268) completed all or part of it. The survey collected responses from 176 participants in Ukraine, 39 in Italy, 34 in Spain, 12 in Poland, one in Estonia, and one each in Germany, Romania, and Latvia (Figure 1).







Regional representation includes 30% from Ukraine, 77% from Italy, 97% from Spain, and 8% from Poland (Figure 1).



Figure 1. Regional/national responders.

In most countries, the majority of respondents were representatives of mental health services — 52% in Ukraine, 67% in Italy, and 91% in Spain. In Poland, half of the respondents came from the third sector.

In Ukraine, 33% of respondents were representatives of the Ministry of Health. In Italy, 23% were from public agencies and 12% from the Ministry of Health. In Poland, 42% of respondents represented the Ministry of Health.

Only two participants with lived experience from Ukraine, three from Italy, and two from Poland completed the survey. The least represented categories, with no representatives from any country, were the welfare and labour sectors, including the Ministries of Labour and Welfare.

Table 1. Who is representing?

	Ukraine (N=176)	Italy (N=39)	Spain (N=34)	Poland (N=12)	Romania (N=1)	Latvia (N=1)	Estonia (N=1)	Germany (N=1)
Mental health services	92	26	31	3	1	1		
Ministry of Health	58	1	1				1	1
Third sector	3	3	1	6				
Public agency	2	9	1	5				







Person with lived experience	2	3	2	
Other	45	1	1	



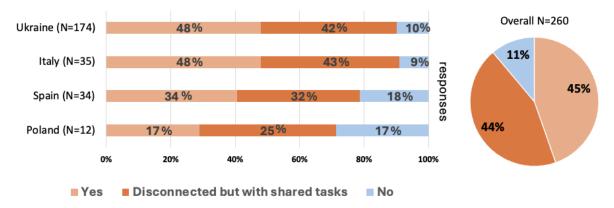




PART 1. Organization of Mental Health and Social Services (e.g., Local Units, Hospitals, Residential Settings)

The first question asked whether mental health and social services are integrated in each country. Overall, 45% of respondents indicated that the services are integrated, while 44% stated that they are disconnected but have shared tasks, and 11% that are disconnected.

In Ukraine, Italy, Spain, and Romania, the majority of respondents reported that the services are integrated. In contrast, in Poland, Latvia, and Germany, most respondents described them as disconnected but with shared tasks. A smaller proportion reported that the services are disconnected: 17% in Poland, 18% in Spain, 10% in Ukraine, and 9% in Latvia (Figure 2).



Countries with one survey	Romania	Latvia	Estonia	Germany
Yes	1			
Disconnected but with shared tasks		1	1	1
No				

Figure 2. Are mental health and social services integrated in your country?

In **Ukraine**, respondents described a well-structured integration of mental health and social services within the healthcare system. At the Primary Health Care Center (PHCC), mental health and psychological support are provided in partnership with the Department of Social Protection and the Territorial Center for Social Services. A social worker is present at the facility, and when necessary, communication is ensured between patients and relevant social service providers. Patients receive both preventive and therapeutic care according to their needs, across all levels of the healthcare system—including primary care, secondary institutions, and larger cluster and super-cluster facilities. These mental health services are part of the Medical Guarantees Program under the "Primary Medical Care" package. Integration is supported by infrastructure and takes place across healthcare facilities, social services, and resilience centers. Additionally, staff members have received training in mental health and work collaboratively with social services to provide consultations and resolve patient issues in a coordinated manner.







Respondents who described services as "disconnected but with shared tasks" indicated that integration efforts are still ongoing in Ukraine. Mental health services mainly focus on medical treatment for individuals with mental disorders, while social services offer support separately. Although generally distinct, collaboration between the two sectors does occur to provide more comprehensive care, such as joint rehabilitation and community reintegration programs.

Psychological and psychiatric care is available at the primary level, with more complex cases referred to secondary or tertiary facilities. Services are delivered by multidisciplinary teams, including psychiatrists, psychologists, social workers, and family doctors. Social services are typically provided only within dedicated institutions by trained social professionals.

Respondents who indicated that mental health and social services are not integrated reported limited or unclear collaboration. Support may be offered only during outpatient consultations or privately, if needed, while some respondents were unsure about any existing coordination between services.

In Italy, respondents who indicated that mental health and social services are integrated reported a generally structured approach to integrating social services within mental health care, with several models of collaboration in place. Social workers are present within various organizational levels (e.g., DSM, Mental Health Centers), and partnerships with municipal and third-sector services are common, particularly for managing complex or severe cases. Integration is implemented through multidisciplinary teams, formal procedures, and coordinated interventions such as internships, housing support, and vocational inclusion. However, concerns are expressed regarding the insufficiency of services, attributed to limited resources or possibly inadequate management. Overall, the emphasis is on ensuring continuity of care through coordinated efforts across sectors. Respondents who described services as "disconnected but with shared tasks" indicated that integration between health and social services is supported through formal agreements, regional plans, and specific tools, such as the Budget di Salute and integrated evaluation units (UVI/UVM). Coordination is encouraged through institutional structures like the CTSS, but in practice, integration is not always consistent. While joint management of complex cases is possible and partially implemented, full integration—especially for individuals with dual diagnoses like autism and intellectual disability—remains limited. Some progress is noted, but barriers include fragmented communication and greater difficulties in certain regions, particularly in Southern Italy. Informal or situation-specific collaborations, such as multidisciplinary meetings, help bridge some gaps by pooling resources across sectors.

In **Spain**, respondents who indicated that mental health and social services are integrated reported that social service workers—along with organizations such as FAISEM (e.g., in the Andalucía region) and mental health units—collaborate closely with mental health services, forming interdisciplinary teams that operate in both outpatient and hospital settings. Those who responded "disconnected but with shared tasks" reported that, although health and social services are not fully integrated, there is frequent collaboration through shared tasks, spaces, and coordination protocols. Social workers are embedded within mental health teams, and organizations like FAISEM contribute to joint care pathways. In some regions,







integrated models have already been implemented or are being piloted. In contrast, respondents who indicated that mental health and social services are not integrated emphasized that the two fall under separate organizational structures, making coordination challenging. While healthcare services manage health, areas such as housing, leisure, and employment integration are the responsibility of social services.

In **Poland**, mental health and social services are integrated through collaboration between the Prison Service and external organizations. Some respondents indicated, instead, that the services are disconnected but with shared tasks. Psychiatric and social services are not integrated, and the existing regulations — such as the Social Assistance Act and the Mental Health Protection Act — are not compatible with each other. Although initiatives like the POWER 2 project and the activities of the Phoenix association in Kołobrzeg County exist, there is no legislative framework that enables real intersectoral cooperation, partly due to issues related to data protection (GDPR). The psychiatric reform and the pilot project of the Mental Health Centers (CZP) promote an integrated approach, but legislative changes are necessary. Currently, outside the CZP network, patients must independently seek the healthcare or social services they need. Additionally, CZPs are required to cooperate with the social care sector, while psychiatric services for children and adolescents must work with schools and families. However, this cooperation lacks clear regulatory support. Finally, some respondents indicated that there is no integration in the services and that Ministries of Health, Family, Labour and Social Policy, and Education operate independently from one another. Each develops its own programs and sets priorities without effective coordination. However, mental health requires strong interministerial cooperation, an ethical approach, respect for individual rights, and minimal bureaucracy.

In **Germany**, the participant described the relationship between mental health and social services as traditionally disconnected, with healthcare and social support provided by separate systems. However, there are now efforts to improve cooperation, especially in areas like psychiatric care, chronic illness, and nursing. Integrated care models are being developed to coordinate medical and social services, aiming for more comprehensive and holistic support.

In **Latvia**, the participant reported that social workers at the National Centre of Mental Health (NCoMH) support patients as needed, and a separate facility provides long-term social care.

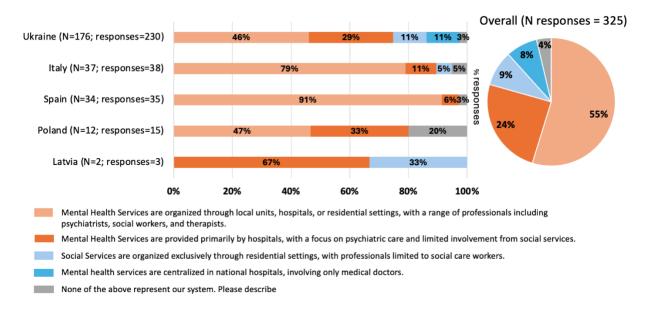
When asked which statement best describes the organization of mental health and social services in their country—including local units, hospitals, residential settings, and the types of professionals involved—55% of respondents indicated that services are delivered through local units, hospitals, or residential settings, involving a range of professionals such as psychiatrists, social workers, and therapists. Another 24% reported that mental health services are primarily provided by hospitals, with a focus on psychiatric care and limited involvement of social services. For 9% of respondents, social services are organized







exclusively through residential settings, involving only social care workers. 8% stated that mental health services are centralized in national hospitals, involving mainly medical doctors. Finally, 4% indicated that none of the provided descriptions accurately reflect their national system (See Figure 3 for country-specific results).



Countries with one survey	Romania	Estonia	Germany
Mental Health Services are organized through local units, hospitals, or residential settings, with a range of professionals including psychiatrists, social workers, and therapists.		1	1
Mental Health Services are provided primarily by hospitals, with a focus on psychiatric care and limited involvement from social services.	1		

Figure 3. Which of the following best describes the organizations (e.g., local units, hospitals, or residential settings) of mental health and social services in your country, including the types of professionals involved? Multiples selections were allowed.

In **Ukraine,** respondents who selected "none of the above represent our system" described a lack of structured integration. While some noted that mental health support is offered in primary care with limited involvement from social services, others highlighted that services are fragmented, unsystematic, or entirely absent. In some cases, psychological support is not provided at all, and mental health is considered solely the individual's responsibility.

In **Italy**, respondents explained that, although the first option exists in principle, its implementation is hindered by a structural shortage of financial, human, and professional resources, resulting in an insufficient workforce to meet actual needs.

In **Spain**, respondents noted the importance of including social educators and highlighted that mental health services primarily focus on outpatient, hospital, and residential care.



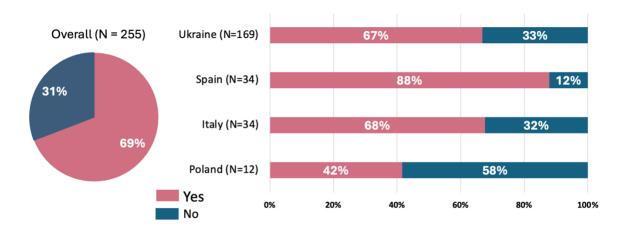




They pointed out a lack of preventive policies from other sectors, such as education and employment, and emphasized the need for stronger coordination and joint service provision between social services and mental health care.

In **Poland**, respondents described that psychiatric care services are primarily organized and funded by the National Health Fund (NFZ), based on national procedures rather than local needs. As a result, services are often uncoordinated at the local level. In areas not covered by the Mental Health Center (CZP) pilot project — which includes around 50% of the adult population — there is limited integration of mental health and social services. However, in regions where CZPs are active and functioning well, they play a key role in organizing and integrating psychiatric and social assistance services. The Mental Health Families Association is also mentioned in the responses.

69% of respondents reported that their country has specific guidelines for clinical or medical interventions and/or hospital care pathways for people with mental health disorders, while 31% stated that such guidelines are not available (See Figure 4 for country-specific results).



Countries with one survey	Romania	Latvia	Estonia	Germany
Yes	1	1	1	1
No				

Figure 4. Are there specific guidelines for clinical or medical interventions, and/or hospital care pathways in your country for people with mental health disorders?

In **Ukraine**, respondents confirmed the existence of various medical-technological documents, such as clinical guidelines, standards, and intervention protocols, regulating the provision of mental health care. These documents address a range of mental health conditions, including depression, anxiety, schizophrenia, substance use disorders, and post-traumatic stress disorder. The Ministry of Health of Ukraine has developed unified clinical







protocols for both primary and specialized care. International tools, such as the WHO's mhGAP Intervention Guide, are also used, alongside translated foreign protocols and international best practices. Respondents referred to the use of national laws, ministry orders, and guidelines developed by professional institutions, though some noted that English versions are often unavailable. While a structured framework exists, knowledge and access to these documents vary, and not all respondents were fully informed about them. A list of official links and resources on clinical protocols and mental health care in Ukraine is provided:

- https://www.dec.gov.ua/wp-content/uploads/2020/11/2020_2555_st_opioidy.pdf
- https://www.dec.gov.ua/cat_mtd/psihiatriya/ content/uploads/2020/06/MH-GAP-%D0%BA%D0%B5%D1%80%D1%96%D0%B2%D0%BD%D0%B8%D1%86%D1%82%D0%B2
 %D0%BE.pdf https://quidelines.moz.gov.ua/
- http://guidelines.moz.gov.ua/documents/2918?id=ebm00708&format=pdf
- https://zakon.rada.gov.ua/laws/show/4223-20#Text https://emed.library.gov.ua/wp-content/uploads/tainacan-items/26427/75379/Novi_klinichni_protokolv_psykhitriia.pdf
- https://guidelines.moz.gov.ua/documents#collapse3
- https://guidelines.moz.gov.ua/documents#collapse5
- https://guidelines.moz.gov.ua/documents#collapse6
- https://guidelines.moz.gov.ua/documents#collapse45
- https://guidelines.moz.gov.ua/documents#collapse61
- https://moz.gov.ua/uk/zatverdzheno-perelik-ta-porjadok-nadannja-psihosocialnih-poslug-schodo-pitan-psihichnogo-zdorov'ja---nakaz-moz
- https://zakon.rada.gov.ua/laws/show/z0126-24#Text
 https://moz.gov.ua/uk/decrees/nakaz-moz-ukrayini-vid-13-01-2025-84-pro-zatverdzhennya-standartu-medichnoyi-dopomogi-psihichni-ta-povedinkovi-rozladi-vnaslidok-vzhivannya-psihoaktivnih-rechovin-ta-stimulyatoriv-za-viklyuchennyam-opioyidiv https://moz.gov.ua/uk/decrees/nakaz-moz-ukraini-vid-09112020--2555-pro-zatverdzhennja-standartiv-medichnoi--dopomogi-psihichni-ta-povedinkovi-rozladi-vnaslidok-vzhivannja-opioidiv
- https://www.mh4u.in.ua/ya-predstavlyayu-organizacziyu-chy-gromadu/instrumenty-mhgap-dlya-gromady/ https://survey.iss.it/cori/index.php/285185?lang=en
- https://moz.gov.ua/uk/decrees/nakaz-moz-ukrayini-vid-19-07-2024-1265-prozatverdzhennya-unifikovanogo-klinichnogo-protokolu-pervinnoyi-ta-specializovanoyimedichnoyi-dopomogi-gostra-reakciya-na-stres-posttravmatichnij-stresovij-rozladporushennya-adaptaciyi https://zakon.rada.gov.ua/rada/show/v2555282-20#Text
- https://www.dec.gov.ua/wp-content/uploads/2025/01/smd_84_2025_parneopioyidy.pdf
- https://www.dec.gov.ua/wpcontent/uploads/2025/01/nakaz_84_2025_parneopioyidy.pdf
- https://www.dec.gov.ua/wp-content/uploads/2020/11/2020_2555_nakaz_opioidy.pdf
- https://www.dec.gov.ua/wpcontent/uploads/2024/07/1265_19072024_ykpmd_ptsr_dod.pdf
- https://www.dec.gov.ua/wp-content/uploads/2024/07/nkpmd_1201_10072024-1.pdf
- https://www.dec.gov.ua/wp-content/uploads/2019/11/2014_1003_vkpmd_depresiva.pdf
- https://www.who.int/ukraine/uk/publications/9789241549790
- https://www.dec.gov.ua/cat_mtd/galuzevi-standarti-ta-klinichni-nastanovi/







- https://www.dec.gov.ua/mtd/posttravmatychnyj-stresovyj-rozlad/
- https://www.dec.gov.ua
- https://zakon.rada.gov.ua/laws/show/1489-14#Text

However, some respondents indicated that there are no protocols in place for the provision of psychiatric care.

In **Spain**, respondents who indicated the existence of specific guidelines for clinical or medical interventions and/or hospital care pathways reported that mental health care is decentralized and managed by the Autonomous Communities, which implement various integrated care programs (PAI), protocols, and clinical guidelines for specific conditions—such as severe mental disorders, addictions, and psychosis—within community-based models; although services vary by region, there is a national emphasis on care continuity, coordination, and reducing stigma, especially through joint treatment of dual pathologies. Below are links to examples of process management or continuity of care programs at the national level and in some Autonomous Communities:

- Ministry of Health: Transversality and continuity in mental health care (PDF): chromeextension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.sanidad.gob.es/areas/ calidadAsistencial/estrategias/saludMental/docs/Transversalidad_y_continuidad.pd
- **Catalonia**: Proposal of strategies for the National Pact for Mental Health and Emotional Wellbeing 2024–2030
- Madrid: Social care network for people with mental illness: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://presidencia.gencat.cat/web/.content/ambits_actuacio/pacte-nacional-salut-mental/ESP_informe-Pla-de-salut-mental-28_03_24-ACCESSIBLE_96.pdf
- Galicia: Galician Health Service Mental Health Information
- Andalusia:
- Integrated care process for severe mental disorders:

 https://www.juntadeandalucia.es/organismos/saludyconsumo/areas/calidad/pai/paginas/pai-trastorno-mental-grave.html
 - https://juntadeandalucia.es/organismos/saludyconsumo/areas/calidad/pai.html
 Care process:
 - https://juntadeandalucia.es/organismos/saludyconsumo/areas/calidad/pai.html
- **Castilla-La Mancha**: Integrated care process for mental health (PAISM): chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://sanidad.castillalamancha.es/files/tmg_vimp_-_1_160412.pdf
- **Hospital del Mar** Addictions: https://drogues.gencat.cat/ca/inici/index.html
- Addictions Service, Mental Health Network of Bizkaia Osakidetza: https://www.euskadi.eus/contenidos/documentacion/doc_sosa_esme/es_def/estrat-egia_salud_mental_es.pdf
- Canary Island: Digital Health Plan 2024–2027 Canary Islands Health Service (PDF)







In **Italy**, respondents who indicated the existence of specific guidelines for clinical or medical interventions and/or hospital care pathways highlighted a comprehensive array of national and regional strategies, protocols, and clinical pathways (PDTA) aimed at guiding the management and treatment of mental health conditions in Italy. It includes references to the 2014 State-Region Conference, Ministerial and Regional PDTA, and various company-level protocols ratified across regions. Key tools include specific PDTA targeting bipolar disorder, personality disorders, schizophrenia, depression, and dual diagnosis, with additional pathways under development for acute behavioral disorders and early psychopathological onsets. The Friuli Venezia Giulia Region has formalized its Regional Mental Health Plan, while national guidelines cover areas such as autism, dementia, rare diseases, and alcohol-related conditions. Several official documents and procedural standards are available through institutional websites such as those of the Ministry of Health and Emilia-Romagna Region, reflecting a structured approach to integrated mental health care across Italy.

- **Presidency of the Council of Ministers** Strategic Guidelines: Designing the Health Budget with a Person-Centered Approach: https://ja-mentor.eu/index.php/wp5-building-bricks-for-integrated-and-comprehensive-mental-health-and-wellbeing-actions/integrated-care-pathway-for-promoting-social-inclusion-and-quality-of-life-of-people-with-mental-health-disorders/
- Friuli Venezia Giulia Region Regional Mental Health Plan: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://mtom.regione.fvg.it/storag e/2018_122/Allegato%201%20alla%20Delibera%20122-2018.pdf
- **Emilia-Romagna Region** Mental Health Documentation: https://salute.regione.emilia-romagna.it/salute-mentale/documentazione

In **Poland**, respondents who indicated the existence of specific guidelines for clinical or medical interventions and/or hospital care pathways reported that there are official documents, such as the Mental Health Protection Act and the Patient Rights and Patient Ombudsman Act, but these are not readily accessible to families and the patient's support network. The Mental Health Families Association is also mentioned in the responses. An official links on clinical protocols and mental health care in polish was provided: <a href="https://www.gov.pl/web/zdrowie/standardy-organizacyjne-i-merytoryczne-dla-podmiotow-nowego-modelu-systemu-ochrony-zdrowia-psychicznego-dla-dzieci-i-mlodziezy#:~:text=Ministerstwo%20Zdrowia%20przedstawia%20Standardy%20organizacyjne%20i%20merytoryczne%20dla,systemu%20ochrony%20zdrowia%20psychicznego%20dla%20dzieci%20i%20m%C5%82odzie%C5%BCy.

However, some respondents indicated that there are no protocols in place for the provision of psychiatric care.

In **Germany**, the respondent reported that the clinical treatment for mental illness is guided by standardised and evidence-based guidelines developed by professional bodies like the DGPPN (German Society for Psychiatry, Psychotherapy and Neurology) and the **DGPM** (German Society for Psychosomatic Medicine). These cover a wide range of mental health conditions, such as depression, schizophrenia, bipolar disorder, and substance use







disorders. The guidelines include diagnostic criteria, treatment options (e.g., medications, psychotherapy), and other interventions. In addition, care pathways outline the clinical process from emergency care through inpatient treatment to outpatient follow-up, often developed in collaboration with health insurers and healthcare organisations. There are also special guidelines for addiction treatment, covering withdrawal, rehab, and long-term support. The most up-to-date guidelines and documents can be accessed through the DGPPN website: https://www.dgppn.de.

In **Estonia**, the respondent reported that several comprehensive clinical guidelines have been developed to provide evidence-based direction for healthcare professionals. These guidelines cover the diagnosis and treatment of various diseases, offer recommendations for prevention, and outline effective strategies for patient education. They serve as detailed and visualized "roadmaps," outlining nationally agreed-upon actions and timelines for addressing specific conditions or patient groups. The primary objective is to ensure the highest possible quality of care while promoting a patient-centred approach within the healthcare system.

The pathways are described for:

- Attention deficit hyperactivity disorder
 https://www.ravijuhend.ee/tervishoiuvarav/juhendid-gp/29/aktiivsus-ja-tahelepanuhaire-diagnoosimise-ning-ravi-pohimotted
- Alcohol abuse -

https://www.ravijuhend.ee/tervishoiuvarav/juhendid/149/alkoholitarvitamise-hairega-patsiendi-kasitlus

 Generalized anxiety disorder and panic disorder <u>https://www.ravijuhend.ee/tervishoiuvarav/juhendid/220/generaliseerunud-arevushaire-ja-paanikahaire-agorafoobiaga-voi-ilma-kasitlus-perearstiabis</u>

A patient guide is a written material intended for patients that provides information about the preparation for various procedures or examinations, the disease, as well as prognosis, treatment, follow-up care and self-help methods. https://www.ravijuhend.ee/patsiendivarav/juhendid.

For mental health disorders the following guidelines are developed:

- ADHD https://www.ravijuhend.ee/patsiendivarav/juhendid/252/aktiivsus-tahelepanuhaire-ath
- Alcohol abuse <u>guidance for a family member</u>, <u>how to get help</u>, <u>how to decrease</u> <u>alcohol consumption</u>
- Anxiety coping with anxiety, generalized anxiety disorder and panic disorder
- <u>Estonian_Handbook_for_Guidelines_Development_2020.pdf</u>

In **Latvia**, the participant provided the following links for clinical guidelines, recommendations and clinical algorithms and patient pathways for mental health and substance abuse disorders:

- thttps://www.spkc.gov.lv/lv/kliniskie-algoritmi-pacientu-celi-indikatori-esf-projekts#gariga-psihiska-veseliba
- https://www.rsu.lv/sites/default/files/imce/Dokumenti/pnk/LPA_Depresijas_vadlinijas_2015.pdf



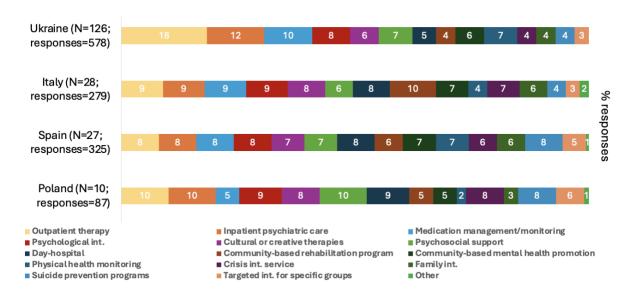




PART 2 Intervention delivered

The "Intervention Delivered" section began by asking respondents which health-focused interventions are available in their country for individuals with mental health disorders. Multiple selections were allowed. The most frequently reported interventions included: outpatient therapy, inpatient psychiatric care, medication management/monitoring, psychological interventions, cultural or creative therapies, psychological support, day-hospital programs, community-based rehabilitation programs, community-based mental health promotion, physical health monitoring, and crisis intervention services.

Some differences emerged between countries. For example, in Ukraine, outpatient therapy was the most frequently selected intervention (18%), whereas respondents from other countries tended to select all listed interventions at similar levels (See Figure 5 for country-specific results).







Countries with one survey	Romania	Latvia	Estonia	Germany
Outpatient therapy	1	1	1	1
Inpatient psychiatric care	1	1	1	1
Medication management/monitoring		1	1	1
Psychological int.	1	1	1	1
Cultural or creative therapies		1	1	1
Psychosocial support		1	1	1
Day-hospital	1	1	1	1
Community-based rehabilitation program			1	1
Community-based mental health promotion		1	1	1
Physical health monitoring		1	1	1
Crisis int. service	1		1	1
Family int.	1	1	1	1
Suicide prevention programs	1	1	1	1
Targeted int. for specific groups		1	1	1
Other			1	

Figure 5. Which of the following health-focused interventions are available in your country for individuals with mental health disorders? Multiples selections were allowed.

In Ukraine, the responses from participants who selected "outpatient therapy (e.g., group or individual counseling, psychotherapy)" highlight a wide range of professionals and institutions involved in delivering mental health services. The professionals involved are: psychologists, psychotherapists, psychiatrists, clinical psychologists, medical psychologists, and family doctors; types of services are: individual or group counseling, psychotherapy, diagnostics, psychoeducation, and prevention; healthcare institutions are: mental health centers, outpatient clinics, polyclinics, city and regional hospitals (e.g., "Kherson City Psychiatric Center", "City Clinical Hospital No. 16 of Dnipro"), and Primary Health Care Centers (PHCC); levels of care are: primary, secondary, and tertiary/specialized healthcare facilities. Respondents who selected "day-hospital intervention or daily intervention" described services typically provided in psychiatric clinics or hospitals, including mental health centers in city and regional hospitals (e.g., Kherson Regional Facility for the Provision of Psychiatric Care, Kherson City Psychiatric Center). These services allow patients to receive treatment during the day without full-time admission. The care is delivered by psychiatrists, psychologists, and nursesin structured, hospital-based settings. Respondents who selected "inpatient psychiatric care" described services provided in psychiatric hospitals or specialized inpatient facilities, such as the Kherson Regional Facility for the Provision of Psychiatric Care, the Volyn Regional Psychiatric Hospital, and several regional centers in the Kyiv region. Care is delivered by psychiatrists, psychologists, clinical and medical psychologists, psychotherapists, and social workers. Facilities include cluster and supracluster hospitals with psychiatric departments and regional specialized medical centers, where patients receive full-time treatment and monitoring. Respondents who selected "community-based rehabilitation programs" described services provided through a combination of healthcare facilities, mental health centers at city and regional children's hospitals, volunteer centers, and local government rehabilitation programs. These programs often involve outpatient rehabilitation, psychologist offices, and psychosocial services at the community level. Support is delivered by psychiatrists and psychologists, and





may include various forms of assistance for people with mental health disorders, provided through social services, community organizations, and local healthcare institutions. Respondents who selected "Medication management and monitoring" described services provided primarily by psychiatrists, along with psychotherapists, family doctors, nurses, psychologists, social workers, and narcologists. These services are offered in both inpatient settings and outpatient conditions, including facilities such as the Kherson Regional Psychiatric Assistance Facility, Lokachynska Hospital, and through organizations like the Red Cross. Medication management involves regular monitoring and support for individuals receiving psychiatric medications. Respondents who selected "Crisis intervention service" described support provided by crisis intervention centers, including the Kherson Regional Psychiatric Assistance Facility, the Kherson City Psychiatric Center, and mental health centers at city and regional children's hospitals. These services are delivered by psychiatrists, psychologists, and psychotherapists, and are designed to offer immediate psychological and psychiatric assistance during acute mental health crises. Respondents who selected "psychological intervention" described services primarily delivered by psychologists, clinical psychologists, and psychotherapists. These interventions take place in facilities such as the Kherson Regional Psychiatric Assistance Facility, the Kherson City Psychiatric Center, and mental health centers at city and regional children's hospitals. Psychological support is also provided by primary care physicians trained in managing common mental disorders using the mhGAP approach. Services include assessments, therapy, and counseling by trained mental health professionals. Respondents who selected "Psychosocial support" described services provided by a wide range of professionals, including psychologists, clinical and medical psychologists, psychotherapists, psychiatrists, nurses, social workers, family doctors, and community activists. These services are available at institutions such as the Kherson Regional Institution for Psychiatric Care, the Kherson City Psychiatric Center, mental health centers at city and regional children's hospitals, primary health care centers, and territorial social service centers. Support includes community-based programs, psychosocial services coordinated by local authorities, and initiatives promoting supported decision-making for individuals with intellectual disabilities or mental disorders. Some respondents also mentioned innovative formats such as psychology podcasts (e.g., VARTOZHYTY). Respondents who selected "Family intervention" described services provided through mental health centers at city and regional children's hospitals, the Kherson Regional Institution for Psychiatric Care, the Kherson City Psychiatric Center, social centers, and local psychosocial services. These interventions involve a multidisciplinary team including psychiatrists, psychologists, clinical and medical psychologists, psychotherapists, nurses, social workers, and family doctors. Key components of family intervention include psychoeducation and support aimed at improving the well-being of caregivers, helping families better understand and manage mental health conditions. Respondents who selected "Physical health monitoring" indicated that these services are primarily provided by family doctors and take place in primary health care centers, outpatient clinics, and city and district hospitals. The focus is on monitoring the physical health of patients within general healthcare settings. Respondents who selected "Cultural or creative therapies: Programs such as art therapy, music therapy, or other cultural activities designed to support mental healths" described these services as being provided mainly by clinical psychologists, psychotherapists,





psychologists, medical psychologists, and social workers. These therapies include activities such as art therapy, music therapy, and other cultural programs aimed at supporting mental health. Services are offered during appointments with mental health professionals and also through humanitarian hubs focused on mental health improvement using creative methods. Respondents who selected "community-based mental health promotion" mentioned the involvement of institutions such as the Kherson Regional and City Psychiatric Centers and Mental Health Centers at children's hospitals. These institutions collaborate with community social services to support the development of local mental health strategies and programs. In 2024, the Kharkiv Regional Center for Social Services organized 79 educational events with 1,956 participants and is planning a series of outreach seminars in 2025 focusing on mental health leadership, communication skills, stigma reduction, and emotional intelligence. Methodological guidelines on accessible communication in social services are also being developed. Local psychosocial services involve multidisciplinary teams including psychiatrists, psychologists, nurses, and social workers, delivered through seminars and training sessions. Respondents who selected "suicide prevention programs" cited the involvement of the Kherson Regional and City Psychiatric Centers, Mental Health Centers at children's hospitals, and Primary Health Care Centers. In cases of suspected suicide attempts among children, child services are notified, and families are referred for mandatory psychological therapy lasting at least six months. Ukraine also operates crisis helplines and specialized suicide prevention programs, offering psychological support and crisis intervention. These services are provided by psychiatrists and psychologists. Respondents who selected "targeted interventions for specific groups" mentioned the involvement of the Kherson Regional and City Psychiatric Centers, Mental Health Centers at children's hospitals, and Primary Health Care Centers. These services are delivered by psychotherapists and psychologists, focusing on the specific needs of different population groups. Respondents who selected "other" mentioned the provision of inpatient and mobile palliative care, involving clinical psychologists, as well as advanced training courses on preventing and overcoming professional burnout among public servants.

In Italy, respondents who selected "outpatient therapy" indicated that various socialfocused interventions are available for individuals with mental disorders. These include both structured institutional services and community-level initiatives. Employment integration programs are commonly mentioned, alongside coordinated actions between mental health services and local job placement agencies. While some areas report limited resources, others show active collaboration between psychiatric services, municipalities, and social cooperatives to promote psychosocial rehabilitation and social inclusion. Responders who selected "Day-hospital intervention or daily intervention" indicated that clinical and semi-residential services for individuals with mental disorders are provided by a network of mental health units spanning both adult and child/adolescent care. These services are offered within Departments of Mental Health (DDSM for adults, NPIA for minors), Community Mental Health Centers (CSM), psychiatric wards in general hospitals (SPDC), and specialized units. Day Hospitals and Day Centers also play a key role in managing acute or sub-acute conditions. The presence of multidisciplinary teams, including nurses, psychiatric rehabilitation technicians, professional educators, and developmental therapists (TNPEE), reflects the integrated and multifaceted nature of care.





These resources, however, may vary regionally. Who selected "Inpatient psychiatric care" indicated that acute and residential psychiatric care for individuals with mental disorders is mainly provided through Psychiatric Services for Diagnosis and Care (SPDC), which are widespread across different regions. These services operate within Departments of Mental Health (DSM), including both adult (DDSM) and child/adolescent (NPIA) sectors, and are supported by psychiatric clinics, specialized residential facilities (SRP), and private clinics. The workforce typically includes psychiatrists, psychologists, nurses, and psychiatric rehabilitation technicians. Territorial Psychiatric Units (UOPs) within Local Health Authorities (ASSTs) are also involved in delivering care. This highlights a structured system of acute and residential psychiatric support, though organization and capacity may vary across local contexts. Responders that selected "Community-based rehabilitation program" indicated that residential mental health services are available in various differentiated settings, with some regions reporting a significant number of beds aligned with the National Mental Health Plan. Services are managed by Departments of Mental Health (DSM), including adult and child sectors (DDSM and NPIA), and include Community Mental Health Centers (CSM), Day Centers, and Psychosocial Centers. Tools such as the "Budget di Salute" and personalized projects under Law 162 and regional legislation (e.g., Regional Law 20) are used to promote individual care pathways. Personnel involved include psychiatrists, psychologists, nurses, psychiatric rehabilitation technicians, and social workers. Interventions take place across various settings, including therapeutic communities and residential care facilities (RSDs), highlighting a multidisciplinary and territorially distributed approach to long-term care. Responders that selected "Medication management and monitoring" indicated that mental health services are offered through a network of Community Mental Health Centers (CSM), rehabilitation structures, and psychiatric clinics, covering both adults (DDSM) and children/adolescents (NPIA). Care is delivered across various DSM services, including Units for Mental Health, Child Neuropsychiatry Clinics (UONPIA), SPDCs, and affiliated centers. Staff involved typically include psychiatrists and nurses. Residential and rehabilitative care is provided through therapeutic communities and Residential Healthcare Facilities (RSDs). The system is managed through territorial agencies like ASSTs and ensures integrated care across community and institutional settings. Responders that selected "Crisis intervention service" indicated that emergency mental health services are not always structured as standalone units but are often integrated into Community Mental Health Centers (CSM) or accessed through hospital emergency departments. The main points of access include SPDC (Psychiatric Services for Diagnosis and Care) and CSMs, which operate within the broader network of the Department of Mental Health (DSM). These services are available in all territorial structures of the DSM and are supported by Psychosocial Centers and Psychiatry Units within local socio-health agencies (ASST). The response structure may vary across regions, with some areas reporting limited or less formalized emergency mental health setups. Responders that selected "Psychological intervention" indicated that mental health services for families and psychosocial support are offered through a combination of Community Mental Health Centers (CSM), rehabilitation facilities, and territorial services such as Family Counseling Centers and local authority-run "Family Spaces." Both adult and child/adolescent sectors (DDSM and NPIA) are involved. Services are delivered across residential, hospital, and semiresidential structures of the Department of Mental Health (DSM), including those in ASL





Roma 1. Psychologists are among the key professionals involved. Primary care also collaborates with mental health services in some settings. Psychiatric Units of Local Socio-Health Agencies (ASST) and Psychosocial Centers contribute to the overall provision of support. Responders that selected "Psychosocial support" indicated that social and familybased mental health interventions are offered through services managed by both the Department of Mental Health (DSM) and local authorities. This includes Family Counseling Centers and municipal social services, often in collaboration with Community Mental Health Centers (CSM). Care is provided across all DSM facilities, involving a wide range of professionals such as psychiatrists, psychologists, nurses, psychiatric rehabilitation technicians, and educators. The psychiatric units of the Local Socio-Health Agencies (ASST) also contribute to service delivery. Coordination between healthcare and social sectors is a key feature of the support provided to individuals with mental health disorders and their families. Responders that selected "Family intervention" indicated that mental health services are structured across different specialized units, including the DDSM for adult care and the NPIA for minors. Psycho-education meetings are frequently organized by the CSM and day centers to support families. Innovative practices such as Open Dialogue and Multifamily Groups are implemented to foster collaborative care involving both families and professionals. Services are provided throughout all DSM facilities, encompassing public mental health centers, psychosocial centers, family counseling, and psychiatric units of territorial health organizations, as well as private associations. The multidisciplinary teams typically consist of psychiatrists, psychologists, nurses, and psychiatric rehabilitation technicians. However, in many cases, the majority of interventions and caregiving responsibilities fall on families, often without adequate resources or support. Responders that selected "Physical health monitoring" indicated that various health-focused interventions are available for individuals with mental disorders, often coordinated across multiple specialized services. Physical health monitoring is integrated within adult and child mental health departments, specifically the DDSM (adult area) and NPIA (minors area). Preventive services are provided by local health authorities (ASL), and comprehensive care is delivered throughout DSM services. The care teams typically include psychiatrists and nurses. Additionally, specialized residential services (RSD) support people with autism and intellectual disabilities. Primary care physicians (general practitioners), psychosocial centers, and family counseling services also play key roles. Psychiatric units of territorial health organizations (ASST) further contribute to integrated care, in collaboration with DSM and general practitioners. Responders that selected "Cultural or creative therapies" indicated that cultural and recreational interventions such as art therapy, music therapy, and other activities aimed at supporting mental health are available through a range of specialized services. These programs are provided within adult and child mental health departments (DDSM and NPIA), as well as in rehabilitative day and residential facilities. Services are offered at DSM day centers, territorial rehabilitation centers, and psychiatric residential communities. The interventions often involve psychiatric rehabilitation technicians and educators. Both public and private organizations collaborate to deliver these programs, including cooperatives and associations. Mental health centers (CSM) work closely with local social services to integrate these cultural and recreational supports. Responders that selected "Community-based mental health promotion" indicated that community-based mental health promotion activities are available, aiming to reduce





stigma and raise awareness. These initiatives are often led by CSM and adult mental health departments (DDSM). Examples include programs activated by local centers such as CD Arzignano in collaboration with high schools, involving single-class interventions and annual open days at day centers. Prevention programs addressing issues like pathological gambling and fetal alcohol syndrome are also implemented. Services are offered across all DSM facilities within ASL Roma 1, although social sectors can be less receptive. The third sector organizations, psychosocial centers, and psychiatric rehabilitation staff such as technicians, educators, and nurses contribute actively. Psychiatric units of territorial health companies (ASST), private organizations, and associations also play a role in delivering these community-focused interventions. Responders that selected "Suicide prevention programs" indicated that suicide prevention programs, including emergency hotlines and structured prevention services, are available but not systematically implemented. Psychosocial centers are also involved in providing support. Responders that selected "Targeted interventions for specific groups" indicated services under the PIPSM program (Prevention and Early Intervention in Mental Health) provided by university psychiatric clinics, third-sector organizations supporting migrants, psychosocial centers, specialized outpatient clinics, Mental Health Centers (CSMs), and through shared inter-institutional protocols. Responders that selected "other" indicated additional health-focused interventions within mental health services, including the promotion and integration of Experts by Experience (ESP) in mental health and addiction services. Specialized care programs also address mental health in prison populations for both adults and minors. Regional initiatives include prevention programs targeting pathological gambling and fetal alcohol syndrome.

In Spain, respondents who selected "outpatient therapy (e.g., group or individual counseling, psychotherapy)" described a community-based model delivered through Adult and Child Mental Health Centers, Addictions Services, and Community Mental Health Units, offering individual and group counseling, psychotherapy, pharmacological treatment, and specialized programs such as suicide risk prevention and anxiety groups, involving multidisciplinary teams including psychiatrists, psychologists, and nurses. Respondents who selected "day-hospital intervention or daily intervention" described services delivered in day hospitals and semi-hospitalization programs for severe mental and addictive disorders, involving multidisciplinary teams—psychiatrists, psychologists, nurses, occupational therapists, and social workers—and including therapeutic communities, rehabilitation units, and specialized programs such as those for eating disorders or first psychotic episodes. Respondents who selected "inpatient psychiatric care" described a system that includes mental health rehabilitation units, day hospitals, and community rehabilitation centers, often integrated with social services (e.g. FAISEM) and supported by multidisciplinary teams—psychologists, occupational therapists, and social workers providing care through coordinated efforts between the health and social sectors. Respondents who selected "Medication management and monitoring" described a system led by psychiatrists and nurses across hospitals, day hospitals, community treatment teams, and mental health centers, with nursing staff actively involved in electronic prescription and medication oversight within various units and specialized programs. Respondents who selected "Crisis intervention service" described care led by psychiatrists in mental health





centers and hospital psychiatric emergency units, supported by assertive community and home crisis teams in some regions, with services including emergency care, suicide prevention programs, and multidisciplinary teams involving psychiatrists, psychologists, and nurses. Respondents who selected "Psychological intervention" described services delivered by clinical psychologists and psychiatrists across the mental health network including Mental Health and Addiction Centers, Community Mental Health Units, Day Hospitals, and Rehabilitation Units-covering both outpatient and inpatient care, with programs often integrated with primary care. Respondents who selected "Psychosocial support (for example, to promote general well-being for people without a formal diagnosis)" described services mainly provided by social workers and nurses in Community Mental Health Centers (CSMs) and Primary Care Centers (ABS), including programs like REBEC for emotional well-being and community health, often coordinated through primary care and, in some cases, involving the Ministry of Education. Respondents who selected "Family intervention" described multidisciplinary involvement—especially nursing staff—across all mental health service settings, including Primary Care, Mental Health and Addictions Centers, Day Hospitals, and Community Rehabilitation Centers, with contributions from family physicians, liaison geriatricians, and internists, particularly in community and longterm care contexts. Respondents who selected "Physical health monitoring" described a multidisciplinary approach involving physicians, primary care and mental health nurses, internists, and liaison geriatricians, delivered across various settings such as Mental Health and Addictions Centers, Day Hospitals, Community Rehabilitation Centers, and intensive ambulatory services. Respondents who selected "Cultural or creative therapies: Programs such as art therapy, music therapy, or other cultural activities designed to support mental health" described programs implemented in day hospitals, community rehabilitation centers, and psychosocial centers, often in collaboration with social services, municipalities, and cultural institutions (e.g., museums). These therapies are delivered by occupational therapists, social educators, and nursing staff, often supported by family/user associations, and aim to enhance mental health through artistic and cultural engagement. Respondents who selected "Community-based mental health promotion" highlighted the role of day centers, social clubs, and patient/family associations in organizing stigma-reducing and awareness-raising activities. These initiatives are carried out within Mental Health and Addictions Centers, Day Hospitals, and Community Rehabilitation Centers. Respondents who selected "Suicide prevention programs: Initiatives such as crisis hotlines or structured suicide prevention services" described a range of initiatives including national and regional suicide prevention programs (e.g., "Suicide Risk Code"), mental health awareness activities, and follow-up systems for individuals at risk. These are delivered through Mental Health and Addictions Centers, Day Hospitals, Community Rehabilitation and Primary Care Centers, involving psychiatrists, nurses, and community units. Programs often include collaboration between emergency services, psychiatry, and local health departments, with established care pathways like the Recent Suicide Attempt Code. Respondents who selected "Targeted interventions for specific groups: Services adapted for LGBTIQ+ individuals or migrants, addressing unique mental health challenges" noted that while some specialized services exist—such as Madrid's LGTBI Information and Care Program and support for transgender individuals through UAPT—they are limited and unevenly distributed. Interventions include gender perspective protocols, chemsex-related services, and interpreter support (e.g., 061





interpreter service). However, respondents emphasized the need for broader implementation of these targeted programs within the public health system. Finally, respondents who selected "Other" highlighted additional approaches such as the humanization of mental health services, psychiatric home hospitalization, and preventive training programs focused on promoting healthy lifestyles.

In Poland, respondents who selected "outpatient therapy" (e.g., group or individual counseling, psychotherapy) described mental health services as involving multiple actors, including the Ministries of Health and Justice, the National Health Fund (NFZ), and both public and private providers. Care is delivered through outpatient therapy by professionals such as psychiatrists, psychologists, and psychotherapists, under the oversight of institutions like the Patient Rights Ombudsman (PZP). Respondents who selected "dayhospital intervention or daily intervention" indicated that various forms of daily support are provided primarily in hospital settings, involving multidisciplinary teams of therapists. These services fall under the responsibility of the Ministries of Health and Justice and are financed by the NFZ. For "inpatient psychiatric care," respondents noted that services are mainly delivered in hospitals by medical staff including department heads, doctors, and nurses. These are supervised by the Ministries of Health and Justice, funded by the NFZ, and may also involve local government structures. Respondents who selected "community-based rehabilitation programs" emphasized that while medical institutions receive funding, social organizations—despite playing an important role—often lack financial support. Mental Health Centers and NGOs are also engaged in providing these services. Those selecting "medication management and monitoring" reported that medical professionals, psychiatric wards in hospitals, and day hospitals are responsible for this aspect of care. Respondents who selected "crisis intervention services" reported involvement from the Ministries of Health and Justice, the NFZ, and emergency medical services. For "psychological intervention services," respondents indicated that these are provided through the collaboration of the Ministries of Health and Justice, the NFZ, and emergency medical services. Those who selected "psychosocial support" (e.g., promoting general wellbeing for individuals without a formal diagnosis) described services offered by NGOs with grant funding, Mental Health Centers, and local social assistance agencies—though these efforts are typically uncoordinated. Respondents who selected "family intervention" explained that these services are offered by psychiatric clinics and Mental Health Centers (CZP), but are generally underfunded, unprofitable, and undervalued by the NFZ. Support is also provided by NGOs and local social services, though without integrated collaboration. For "physical health monitoring," respondents noted that this is carried out within primary health care by general practitioners and psychiatrists. Respondents selecting "cultural or creative therapies" (e.g., art therapy, music therapy, or related activities) described services available through occupational therapy workshops and activity centers, as well as day wards, clubs, Mental Health Centers, and NGOs. Regarding "community-based mental health promotion" (e.g., workshops and activities to reduce stigma and raise awareness), respondents indicated that these initiatives are mainly grant-funded and implemented by NGOs, hospitals, Mental Health Centers, and local governments—often as collaborative local projects. For "suicide prevention programs" (e.g., crisis hotlines or structured interventions), respondents reported involvement from the Ministries of Health, Justice, and Internal





Affairs (including the police), although implementation tends to be local, fragmented, and frequently led by NGOs. Respondents selecting "targeted interventions for specific groups" (e.g., LGBTIQ+ individuals or migrants) described efforts supported by local governments through social assistance, with NGOs and grassroots initiatives also actively contributing. Finally, respondents who selected "other" referred to additional services such as therapeutic hostels, training programs, and supported housing, provided by NGOs and social assistance systems.

In Germany, the responder described the "Outpatient therapy" provided by specialists such as psychotherapists, behavioral therapists, systemic therapists, psychiatrists, and peer counselors; the "Day-hospital intervention or daily intervention" as typically part of psychiatric hospitals or psychiatric departments within general hospitals. In some cases, standalone day clinics operate independently from hospitals. Responder described the "Inpatient psychiatric care" as the treatment and care of people with acute mental illnesses that still takes place in psychiatric hospitals. "Community-based rehabilitation program" was defined as rehabilitation centres for the mentally ill (RPK) community-based facilities for patients who require comprehensive help and support in the areas of medical and occupational rehabilitation; "Medication management and monitoring" as a community based mental health nursing services that support people in the community to prevent or shorten hospital admission. "Crisis intervention service" include public or state agencies organized at municipal or state level for crisis intervention, health insurance-funded home treatment teams, specialized crisis intervention teams, telephone and online counselling services, as well as police and emergency services for urgent situations. "Psychological intervention" was described including Outpatient care by psychotherapists in private practice, including psychological psychotherapists (PP) and child and adolescent psychotherapists (KJP) and clinics, such as psychosomatic and rehabilitation clinics. "Psychological support" was described as promoting general well-being through: Psychotherapists: Offer individual, couple, or group therapy (behavioral, depth psychology, systemic); Psychiatrists: Medical doctors for diagnosis, treatment, medication, and psychotherapy, often collaborating with psychotherapists; Social pedagogues and social workers: Support coping with life crises, family issues, and social integration, active in social institutions; Counselling centres: Non-profit/private centres offering help for family, addiction, violence prevention, and psychological stress; Self-help groups: Peer support for issues like addiction, depression, anxiety, grief; Telephone and online counselling: Anonymous, quick support via phone or online platforms; Psychosocial service providers in healthcare: Support in hospitals, rehab clinics, psychosomatic clinics during crises or hospitalization; Addiction counselling centres: Specialized outpatient and inpatient treatment; Company social services: Occupational health management and social workers offer employee support to maintain work ability. "Family intervention" was described as provided by Public providers: Youth welfare offices: educational support, socio-educational family assistance, child protection services and Municipal social services: socio-educational counseling and emergency interventions; Private sponsors and welfare associations: Large welfare organizations offering educational counseling, family assistance, crisis support, and child advocacy and Smaller private providers focused on family crisis intervention, mediation, counseling, or therapy; Specialist counseling centers: Support for parents and







families with parenting, divorce, and family issues and Child and youth welfare services providing therapeutic and conflict intervention; Therapeutic providers: Psychologists and family therapists offering individual and family therapy for psychological stress and conflicts and Systemic therapy centers working with whole-family approaches; Interdisciplinary providers: Multi-professional teams including social workers, psychologists, and educators offering comprehensive family support; Online services: Virtual counseling and therapy, helpful for overcoming geographic or time barriers. "Physical Health Monitoring" was described as provided by Psychosomatic and Specialist Clinics: Holistic treatment combining psychotherapeutic and medical approaches for patients with mental and physical symptoms and Monitoring physical health during psychiatric treatment, including medication effects, nutrition, and exercise; General Practitioner and Psychiatric Care: Family doctors regularly check physical health parameters and monitor medication side effects and provide physical health checkups; Rehabilitation Centers: Psychosocial rehab offers integrated care including diet, exercise, and risk factor management and Medical rehab centers coordinate doctors and therapists for both mental and physical health; Exercise and Sports Therapy: Clinics provide sports therapies to improve fitness and mental well-being and Occupational therapy promotes physical activities integrated into daily life; Outpatient Services and Counseling: Psychological counseling and social services promote healthy lifestyle habits and Nursing and support services help with medication adherence and basic health monitoring; Health Courses and Prevention Programs: Programs focus on stress management, nutrition, exercise to support physical and mental health and Prevention programs encourage healthy behaviors to stabilize conditions. Specialized Therapy for Chronic Conditions: Therapy for patients with dual diagnoses and Multidisciplinary teams coordinate comprehensive care; Self-help Groups and Online Offers: Groups offer psychological and physical health support through meetings and activities and Digital platforms and apps assist with monitoring fitness, nutrition, and therapy support. "Cultural or Creative Therapies in Germany was describes as Artistic and Creative Therapists: Art therapists use painting, drawing, sculpture to release emotional blockages, Music therapists employ singing, playing, or listening to music for emotional support, Dance and movement therapists promote body awareness and emotional expression through movement; Psychological Providers: Psychotherapists combine cognitive or depth psychology with creative methods to address trauma and conflicts, Alternative psychotherapy practitioners also integrate creative approaches; Rehabilitation Centers and Clinics: Offer creative therapies as part of mental or physical rehabilitation to aid recovery; Social Institutions and Counseling Services: Educational and family counseling centers use creative therapies for children, youth, and families in difficult situations and Community centers and social workers apply creative methods to support socially disadvantaged individuals; Associations and NGOs: Non-profits provide creative therapy programs targeting groups like people with disabilities, seniors, or trauma survivors; Art and Cultural Therapy Clinics: Specialized clinics offer diverse creative therapies, often with interdisciplinary teams including doctors, psychotherapists, and creative therapists. "Community-Based Mental Health Promotion" described as: Public institutions and municipal health departments: City and county health departments offer mental health education, crisis support, and prevention programs and Municipalities organize mental health weeks and related workshops or events; Independent welfare associations and non-





profits provide group offers, counseling, and prevention and Self-help groups run local events and workshops; Psychosocial and counseling centers: Free, low-threshold workshops on stress, mindfulness, resilience in psychosocial centers, family/youth centers. Health insurance companies: Fund community mental health projects and prevention programs such as mindfulness or resilience training; Educational institutions: Adult education centers offer courses on mental health topics, Schools and workplaces implement health education and occupational health management; Foundations and projects: Foundations fund awareness campaigns, creative community projects like theatre or art workshops; Associations and initiatives: Self-help groups and citizens' initiatives advocate for mental health, Local clubs incorporate mental health activities like yoga or discussion groups; Digital platforms and online offers: Online workshops for schools and communities and Digital self-help and prevention programs, sometimes municipality- or insurer-funded. "Suicide Prevention Programs in Germany" was described as provided by Public Institutions and State Programs: Federal and state ministries run suicide prevention campaigns and develop guidelines, social psychiatric services and crisis services provide counseling and 24/7 emergency support; Professional Societies: German Society for Suicide Prevention (DGS) focuses on research, education, and networking, DGPPN develops guidelines and offers specialist training, NaSPro coordinates national prevention efforts; Welfare Associations and Church Sponsors: Organizations provide counseling, crisis assistance, and grief support, Protestant and Catholic hotlines offer round-the-clock crisis counseling; Crisis and Counseling Services: Telephone counseling offers 24/7 support, including services dedicated to children and adolescents, German Depression Aid focuses on depression as a key suicide risk factor, and Local crisis services provide acute, on-site or telephone help; Self-Help Groups and Relatives' Associations: AGUS e.V. supports families affected by suicide, FRND runs awareness campaigns for youth, Federal Association of Grief Counseling provides support after suicide loss; Foundations and Private Initiatives; Clinics and Psychiatric Facilities: Psychiatric clinics provide acute care for suicidal patients, Day clinics and crisis intervention centers offer short-term crisis support; Research and Science: Research networks study risk factors and prevention methods, University hospitals conduct research, guideline development, and training; Online and Digital Prevention: U25 offers peer-supported online counseling for young people, Webinars and workshops raise awareness, and Digital programs support mental health and suicidality; Schools, Universities, and Workplaces. "Targeted Mental Health Interventions for Specific Groups" described as: LGBTIQ+-Adapted Services: Specialized counseling and therapy centers addressing queer life realities with culturally sensitive, identity-specific support; Psychosocial Services for Migrants and Refugees: Specialized centers offering culturally sensitive care, often with interpreters; Services for Individuals with Special Needs: Antidiscrimination and empowerment counseling and Psychological services adapted for people with disabilities, including barrier-free therapy practices; Transcultural and Culturally Sensitive Psychotherapy; Telephone and Online Counseling: Anonymous, 24/7 culturally sensitive telephone counseling; Diversity-friendly online platforms.

In **Estonia**, the respondent described that a wide range of health-focused interventions are available for individuals with mental health disorders. Outpatient therapy, including individual and group counseling or psychotherapy, is provided by hospitals, clinics, and







private practices. Day-hospital or daily interventions are accessible in hospitals and clinics. Inpatient psychiatric care is offered in hospitals. Community-based rehabilitation programs are organized by municipalities and non-governmental organizations (NGOs). Medication management and monitoring is carried out by healthcare specialists in hospitals and primary care settings. Crisis intervention services are available through municipalities, the Social Insurance Board's victim support service, and NGOs. Psychological interventions are delivered by mental health specialists in hospitals, clinics, primary care, and private practices. Psychosocial support, aimed at promoting general well-being even for those without a formal diagnosis, is provided by municipalities, the Social Insurance Board's victim support service, and NGOs. Family interventions, conducted by specialists trained in this area, are supported by municipalities and NGOs. Physical health monitoring is primarily conducted in primary care settings. Cultural and creative therapies, such as art and music therapy, are offered by creative therapists working in municipalities, hospitals, NGOs, and private practices. Community-based mental health promotion, including workshops and activities to reduce stigma and raise awareness, is conducted by NGOs and municipalities. Suicide prevention programs, such as crisis hotlines and structured prevention services, are available through hospitals and NGOs. Finally, targeted interventions for specific groups, including LGBTIQ+ individuals and migrants, are provided by NGOs, municipalities, the Social Insurance Board, and other relevant organizations.

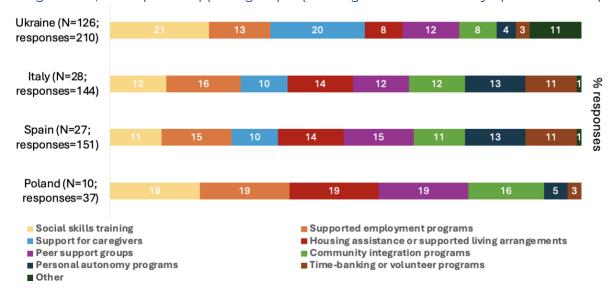
In **Latvia**, participant reported that "Outpatient therapy", "Medication management and monitoring", "Psychological intervention", and "Physical health monitoring services" are provided by state-funded hospitals and individual practices. "Day-hospital intervention", "Inpatient psychiatric care", and "Cultural or creative therapy" are offered primarily through state-funded hospitals. "Psychosocial support" is delivered by both state and private institutions. "Family intervention" services are available through state-funded hospitals, individual practices, and both state and private institutions. "Community-based mental health promotion" involves NGOs and municipalities. Lastly, "Suicide prevention programs" and "targeted interventions for specific groups" are supported by both state and private institutions.

Among the social-focused interventions available in the respondents' countries for individuals with mental health disorders, the selections varied across countries. In Ukraine, the two most frequently selected interventions were social skills training and support for caregivers. In Italy, the most commonly reported were supported employment programs and housing assistance or supported living arrangements. In Spain, respondents most often selected supported employment programs and peer support groups. In Poland, 19% of respondents selected social skills training, housing assistance or supported living





arrangements, and peer support groups (See Figure 6 for country-specific results).



Countries with one survey	Romania	Latvia	Estonia	Germany
Supported employment programs		1	1	1
Social skills training		1	1	1
Support for caregivers		1	1	1
Housing assistance or supported living arrangements		1	1	1
Peer support groups	1		1	1
Community integration programs		1	1	1
Personal autonomy programs		1	1	1
Time-banking or volunteer programs			1	1
Other				

Figure 6. Which of the following social-focused interventions are available in your country for individuals with mental health disorders? Multiple selections were allowed.

In **Ukraine**, respondents who selected "supported employment programs" mentioned the involvement of social workers and programs run by employment centers, public organizations, and specialized agencies. Key institutions include the Department of Labor, Social Protection of the Population, Healthcare authorities, and the State Employment Service. Respondents who selected "housing assistance or supported living arrangements" noted that in Ukraine, supported living programs are available through social services and charitable organizations, with support also provided by community-based social centers. Respondents who chose "Social skills training" identified psychologists, social workers, therapists, psychiatrists, medical psychologists, and educational institutions as the professionals or organizations conducting such sessions. Respondents who selected "Peer support groups" indicated that these groups are held in hospital trust rooms for HIV-





infected individuals, volunteer hubs, veteran hubs, and mental health centers. They involve psychologists and social workers and are often organized by public organizations or the Ministry of Veterans Affairs. Respondents who selected "Community integration programs" mentioned psychologists and social workers as the professionals involved. Respondents who selected "Time-banking or volunteer programs" mentioned social centers within the community and volunteer programs as key components. Respondents who selected "Support for caregivers" mentioned involvement of psychiatrists, psychologists, psychotherapists, and multidisciplinary teams including family doctors and nurses. They highlighted financial assistance, social benefits, social assistance, and mobile palliative care teams as key forms of support for caregivers of people with mental illnesses or disabilities. Respondents who selected "Other" mentioned services such as psychosocial counseling, comprehensive psychiatric and palliative care by multidisciplinary mobile teams, primary care medical assistance, and mental health programs like "How are you?". Several respondents reported no information or lack of knowledge about such programs, with some noting no programs implemented in their centers or being involved in unrelated fields. Advanced training on preventing professional burnout was also mentioned.

In Italy, respondents who selected "supported employment programs" indicated that work integration support programs for individuals with mental disorders are available mainly through adult mental health services (DDSM) and Mental Health Centers (CSM). There is close collaboration between the DSM and SIL (Work Integration Service), with dedicated occupational pathways supported by agreements with social cooperatives. The "Health Budget" approach is also used to support individual care plans. Municipalities and social services are involved, though availability varies and can sometimes be limited. Multidisciplinary teams, including psychiatric rehabilitation technicians, educators, and nurses, play active roles. Employment agencies and mental health service labor areas contribute to facilitating access to work. Cooperation between CSM and regional employment and social agencies (ASPAL and ATS/PLUS) is common. Respondents who selected "Housing assistance or supported living arrangements" indicated that supported housing and independent living assistance are available primarily through adult mental health services (DDSM) and Mental Health Centers (CSM). The Health Budget approach is also utilized to support personalized care. Local municipalities, along with CAF and Patronati, assist with public housing applications and information, although services may not always meet individual needs adequately. Psychiatric rehabilitation technicians and educators, psychosocial centers, and third sector organizations actively contribute to these supports. Residential services within mental health services also play a key role. Respondents who selected "Social skills training" indicated that social skills training programs are offered through both adult and child mental health departments (DDSM and NPIA). The Health Budget framework supports such interventions, often delivered by educators working under Law 162 or through territorial educational services. Programs are available in territorial rehabilitation centers, with active involvement from psychiatric rehabilitation technicians and educators. Third sector rehabilitation areas, psychosocial centers, psychiatric units of territorial health companies (ASST), DSM, and CSM also contribute to providing social skills training. Respondents who selected "Peer support groups" indicated that peer support groups are available mainly through adult mental





health services (DDSM). Recently, user association groups have been started, and self-help groups commonly develop within semi-residential and residential services of the DSM. Family associations often lead peer support initiatives, while institutional groups tend to be reserved for particularly severe or specific cases. Psychiatric rehabilitation technicians, educators, and Experts by Experience (ESP) are actively involved. Peer support groups, including AMA (Self-Help Mutual Aid) groups, operate within psychosocial centers and mental health services. Psychiatric units of territorial health companies (ASST) also participate in these programs. Respondents who selected "Community integration programs" indicated that community integration programs are mainly available through the adult mental health department (DDSM). These initiatives are supported annually with funding from the local health unit (ULSS) and involve five family and volunteer associations represented on the Mental Health Department Council. Educators operating under Law 162 or territorial educational services contribute significantly. Psychiatric rehabilitation technicians and educators actively participate. Programs operate within the "Fare Assieme" area, psychosocial centers, Mental Health Centers (CSM), ATS (Health Protection Agencies), and the Third Sector. Respondents reported limited availability of structured time bank or volunteering programs for individuals with mental disorders. While some do not have precise knowledge of such initiatives, others mention that in certain district areas, volunteer associations promote these types of programs. Overall, these efforts are mainly informal and driven by the voluntary sector, without a systematic or widespread presence across regions. Respondents who selected "Personal autonomy programs" indicated that personal autonomy programs—aimed at building life skills such as financial management and cooking—are primarily activated within the rehabilitation projects of day centers. The Department of Mental Health (DSM) has implemented a structured Home Assistance Program (Supported Housing) for individuals with severe mental illness, promoting independent living skills and home retention. These programs are often carried out through European-funded projects, though typically only for limited timeframes. The Third Sector is involved through co-design processes. Services are offered through rehabilitation areas, psychosocial centers, DSMs, and departmental rehabilitation services. Respondents who selected "Support for caregivers" indicated that multifamily groups and Open Dialogue approaches, are available but often inconsistently. These programs are provided through both adult and child mental health departments (DDSM and NPIA), with multifamily therapy sometimes offered in CSMs. The Department of Mental Health (DSM) has promoted the establishment of multifamily groups within territorial and residential services. However, some users report difficulties in accessing such services despite requests. Professionals involved include psychologists, psychiatric rehabilitation technicians, and educators. Services are available within rehabilitation areas, psychosocial centers, psychiatric units of territorial health companies (ASST), DSM, and CSM. Respondents who selected "Other" mentioned the availability of social inclusion programs within both the adult (DDSM) and minors (NPIA) mental health areas.

In **Spain**, respondents who selected "Supported employment programs" described initiatives coordinated by Social Services, mental health centers, and third sector entities. Key programs and providers include Ocell de Foc, Situa't, Eragintza Foundation, the INICIA Program (by AMICA and Padre Menni), FAISEM, and others like SOAE, Incorpora, SOC, and





Prelaboral (JOYA). These services are integrated within addictions and mental health networks, focusing on promoting job inclusion through partnerships between healthcare and employment support systems. Respondents who selected "Housing assistance or supported living arrangements" described a variety of services managed by social services, the Mental Health Commissioner, and third sector entities. These include unsupervised, moderately, and highly supervised residential facilities, sheltered apartments, and support programs. While these services exist, they are often insufficient. Key providers mentioned include ASCASAM, ACORDE, the Cantabrian Health Service (SCS), and FAISEM. Additional support includes guaranteed income, home care programs, and other housing-related assistance, often coordinated with local government and provincial councils. Respondents who selected "Social skills training" described services primarily offered through psychosocial rehabilitation centers (CRPS), day centers, and day hospitals, often as part of broader treatment plans. These interventions are sometimes coordinated between the mental health and social services networks, including community rehabilitation services, social clubs, and group therapy programs (e.g., for serious mental disorders or eating disorders). Provision is often supported by third sector (TS) organizations. Respondents who selected "peer support groups" described services primarily offered by associations of people with lived experience, including experts by experience. These groups are mainly available for individuals with addictive disorders but also exist for other mental health conditions. Respondents who selected "Community integration programs" described initiatives involving Health Social Work and collaboration with entities such as the Foundation for the Integration of People with Mental Illness, FAISEM, and ETIC. Respondents who selected "Time-banking or volunteer programs: Initiatives that foster social connections and mutual support through structured community engagement" described initiatives promoted by City Councils and associations such as FAISEM and Fundació FRIENDS. These programs are also supported by the Cantabrian Health Service (SCS) and aim to encourage volunteering and mutual support. Respondents who selected "Personal autonomy programs: Services that help individuals develop life skills, such as financial management or cooking, to support independent living" described services offered through Psychosocial Rehabilitation Centers (CRPS) within the mental health and social care networks, often coordinated with municipal social services. These programs aim to develop life skills (e.g., financial management, cooking) to promote independent living. They are provided by the Cantabrian Health Service (SCS) and other entities such as psychiatric services, foundations (e.g., Belloc, Fundació Lar), and the Foundation for the Integration of the Mentally III. Delivery often involves occupational therapists and nursing assistants. Respondents who selected "Support for caregivers: Programs specifically aimed at assisting families or caregivers of individuals with severe mental health disorders" described services provided by Primary Care Social Services and Provincial Council Social Services. The Cantabrian Health Service (SCS) also offers support, including the "Respir" program. Family associations are also involved in providing assistance. Respondents who selected "Other" described foundations that provide supported employment services, focusing on protected work integration. Basque Country provided the following links for:

• community integration programs (https://www.bizkaia.eus/es/tema-detalle/-/edukia/dt/11627)





- Time-banking (https://www.euskadi.eus/servicios-sociales-enfermedad-mental-transtorno-mental/web01-a2gizar/es/)
- support for caregivers: (https://www.euskadi.eus/servicios-sociales-enfermedad-mental-transtorno-mental/web01-a2gizar/es/).

In **Poland**, respondents who selected "supported employment programs" indicated that these are primarily provided by Employment Offices (county-level government) and NGOs. Regarding "housing assistance or supported living arrangements," respondents noted that social assistance services and the State Fund for the Disabled are the main institutions involved. For "social skills training," respondents reported that the services involved include supported employment services—although these are limited in number—as well as social assistance and NGOs. Those who selected "peer support groups" highlighted that services in this area are underdeveloped, lacking professional support and adequate funding. Nonetheless, they are offered by NGOs and Mental Health Centers. Respondents who chose "community integration programs" described these services as being delivered by Social Integration Centers, Social Integration Clubs, social assistance providers, and Employment Offices. For "personal autonomy programs"—services aimed at helping individuals develop life skills such as financial management or cooking to support independent living respondents mentioned day wards, community-based self-help homes, and NGOs as the main service providers. No respondents selected "support for caregivers," which refers to programs specifically designed to assist families or caregivers of individuals with severe mental health disorders. Lastly, those who selected "other" explained that social-focused interventions are not available within the Prison Service (SW).

In Germany, the responder indicated that "supported employment programs" are often referred to as Integration Services (IFD), Supported Employment (UB), Vocational Psychiatric Rehabilitation (RPK), or job coaching. Key features include: Integration Services (IFD): Specialized staff (social workers, psychologists, etc.) support individuals from job search to workplace stabilization, including crisis support. Funded by rehabilitation agencies; Supported Employment (UB): Based on the "first place, then train" model, with on-site learning and professional coaching; RPK Facilities: Combine medical, occupational, and psychosocial rehabilitation, specifically for people with chronic mental illness; Job Coaching: Individualized support provided during applications or directly at the workplace, by qualified professionals. These services, present across various cities, are designed to promote workplace integration and occupational participation for people with mental illness, often including employer guidance and conflict resolution. The responder indicated that "Housing assistance or supported living arrangements" are available and provided by professional staff. These services support individuals who wish to live independently but need help with daily life due to their condition. There are several models: Outpatient assisted living: Individuals live in their own apartments and receive regular support tailored to their needs, such as help with housekeeping, appointments, and psychosocial support; Assisted living in residential groups: Several people with mental illness live together with access to more intensive, often 24/7, support for daily tasks and social interaction; Therapeutic residential communities: These offer intensive care and therapeutic services through interdisciplinary teams. Major providers include Caritas, Paritätischer





Wohlfahrtsverband, Diakonie, and AWO, with additional local providers depending on the region. Access to services usually requires registration and an assessment. Costs vary by service type and financial situation. The responder indicated that "Social skills training" are various: Social Skills Training (SKT) - Offered in psychiatric clinics or by psychotherapists, focusing on communication, conflict resolution, and managing stress; Group Therapies -Provided by psychiatric facilities and outpatient clinics; SOKO (Social Competence Training) - A structured group program based on the Hinsch & Pfingsten model, available in clinics and psychosocial centers; Psychosocial Rehabilitation and Day Centers - Offer social training in protected settings, often run by organizations; Online Programs and Self-Help Groups - Digital tools and peer-led initiatives. The responder indicated that "peer support group" provided some examples for Depression & Bipolar Disorder, Anxiety Disorders, Schizophrenia & Psychosis, Borderline Personality Disorder, Obsessive-Compulsive Disorder, ADHD in Adults, PTSD & Trauma, Eating Disorders, Addiction Problems, General Recovery & Empowerment. Local self-help groups can be found via NAKOS, social psychiatric services, or self-help contact centers in most cities. The responder provided examples of "Community integration programs": Community psychiatric services - Offer support through leisure activities, meeting points, and assisted living; Inclusion and integration companies - Provide sheltered employment within regular businesses; EX-IN (Experienced Involvement) - Trains individuals with lived experience to support others; Leisure and cultural programs - Promote inclusion through sports, arts, and culture; Assisted living and participation projects - Support independent living through services; Self-help and peer support groups - Facilitate peer exchange and integration. The responder provided examples of "Time-banking or volunteer programs": Volunteer agencies - Help individuals find meaningful volunteer work; Neighbourhood help and "citizen helper" initiatives - Mentally ill people support others, such as families or seniors; Peer support & EX-IN - People with lived experience volunteer as recovery counsellors; Inclusive environmental/social projects - Encourage volunteering in community gardening or cultural inclusion; Inclusive voluntary services (FSJ/BFD) - Adapted voluntary year programs for people with mental illness; Self-help groups – Volunteers often help organise meetings and support peers. The respondent described key initiative for the "Personal autonomy programs": Assisted Living & Outpatient Support - Services like outpatient assisted living provide practical support in managing daily life; Everyday Skills Training -Programmes that offer structured courses on budgeting, nutrition, and self-management; Sociotherapy & Daily Support - Sociotherapy and psychoeducation help people with severe mental illness gain autonomy in everyday life; Financial Counselling - Services provide debt management, budget planning, and administrative support; Occupational Therapy & Rehabilitation – Workshops and rehab centres train people in life skills through structured occupational programmes; Digital Tools & Self-Learning - Online resources dedicated apps help users organise tasks and manage their daily routines. The respondent described key initiative for the "Support for caregivers": Family Groups & Peer Support – Self-help networks for relatives provide emotional relief and shared experiences; Psychoeducation & Training -Programmes offer guidance on managing mental illness and coping strategies; Counselling & Crisis Support – Social psychiatric services and crisis teams provide individual counselling and help during emergencies; Relief Services for Caregivers - Organisations provide in-home support or respite care to ease caregiver burden; Legal & Financial





Guidance – Information on care levels, benefits (SGB XI), and caregiver rights is available from local caregiver networks, health insurers, and Pflegestützpunkte (care support centres); Digital & Online Services – Tools that offer online counselling, resources, and peer forums for relatives.

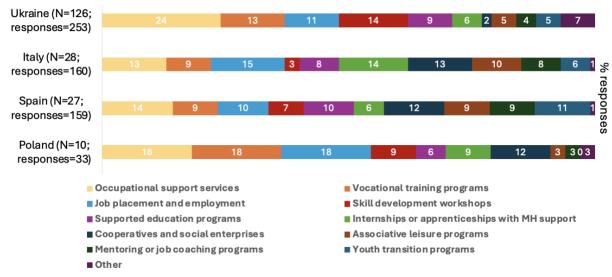
In **Estonia**, the respondent described that various social-focused interventions are available to support individuals with mental health disorders. Supported employment programs are provided by the Estonian Unemployment Insurance Fund. Housing assistance and supported living arrangements are managed by municipalities. Social skills training is offered by municipalities, the Vocational Rehabilitation Centre, and NGOs. Peer support groups are organized by NGOs, municipalities, and hospitals. Community integration programs are implemented by municipalities and NGOs to foster social inclusion. Timebanking and volunteer programs, which promote social connection and mutual support through structured community engagement, are facilitated by NGOs. Personal autonomy programs, which help individuals develop essential life skills such as financial management or cooking to support independent living, are available through NGOs and municipalities. Additionally, support for caregivers, including services specifically designed for families and caregivers of individuals with severe mental health conditions, is provided by NGOs and municipalities.

In **Latvia**, the participant reported that "Supported employment programs" and "Social skills training" are provided by the Social Integration State Agency. "Housing assistance or supported living arrangements", "Community integration programs", and "Personal autonomy programs" are under the responsibility of the Ministry of Welfare. "Support for caregivers" is provided by Municipalities.

Among the education-, training-, or work-focused interventions available in the respondents' countries for individuals with mental health disorders, selections varied across countries. In Ukraine, the most frequently selected interventions were occupational support services and skill development programs. In Italy, the most commonly reported were job placement and employment, and internships or apprenticeships with mental health support. In Spain, respondents most often selected occupational support services and cooperatives or social enterprises. In Poland, 18% of respondents selected occupational support services, vocational training programs, and job placement and employment (See Figure 7 for country-specific results).







Countries with one survey	Romania	Latvia	Estonia	Germany
Occupational support services		1	1	1
Vocational training programs		1	1	1
Job placement and employment		1	1	1
Skill development workshops		1	1	1
Supported education programs	1	1	1	1
Internships or apprenticeships with MH support			1	1
Cooperatives and social enterprises	1		1	1
Associative leisure programs		1	1	1
Mentoring or job coaching programs		1	1	1
Youth transition programs		1	1	1
Other				

Figure 7. Which of the following education, training, or work-focused interventions are available in your country for individuals with mental health disorders? Multiple selections were allowed.

In **Ukraine**, respondents who selected "Occupational support services" identified employment centers, including regional branches such as the Korosten City Employment Center and the State Employment Service, as key providers. These centers select jobs based on recommendations from medical professionals and are supported by departments of labor, social protection, and healthcare. Respondents who selected "Skill development workshops" mentioned that these sessions are typically conducted by psychologists, clinical psychologists, social workers, and medical psychologists. They are often organized through public organizations, mental health centers, and educational institutions. Specific examples include workshops held at mental health centers and hospital rehabilitation departments. Respondents who selected "Vocational training programs" mentioned that these programs are offered through educational institutions, charitable organizations, and the State Employment Service. Respondents who selected "Supported education programs" mentioned inclusive and individual education in schools, with support from psychologists,





social workers, and medical psychologists. Respondents who selected "Job placement and employment" stated that labor recommendations given during disability assessment guide employment centers in job selection. Key providers include the Korosten City Employment Center, the Zhytomyr Regional Employment Center, and the State Employment Service, which sometimes consider individual characteristics. Respondents who selected "Internships or apprenticeships with mental health support" mentioned medical psychologists, employment centers, and mental health centers as key providers. Respondents who selected "Mentoring or job coaching programs" identified psychologists, social workers, and medical psychologists as the main providers. Respondents who selected "Psychologist, social worker" noted that programs supporting young people with mental disorders in their transition to adult life are offered by educational institutions, social services, and youth organizations, often involving clinical psychologists. Respondents who selected "Associative leisure programs" stated that these programs, offering active recreation and socialization, are organized by youth organizations, social centers, specialized community groups, and sports clubs. Respondents who selected "Other" expressed a lack of knowledge about the topic or mentioned psychosocial counseling and mental health programs like "How are you?". Some highlighted severe social challenges in Ukraine, including inadequate social support, housing issues, discrimination, and the impact of these conditions on mental health. Others noted limited information, absence of educational activities, or involvement in professional development courses related to burnout prevention.

In Italy, respondents who selected "Occupational support services" indicated that occupational support services are primarily available through the adult mental health department (DDSM), especially via the Labor Integration Service (SIL). Dedicated pathways are activated through specific agreements. Services involve work groups, psychosocial centers (CPS), NIL (employment centers), SIL, third sector organizations, and labor agencies. Collaboration with municipalities, labor agencies, and professional training entities (ASPAL) is common. Mental Health Centers (CSM) actively participate in these initiatives. Respondents who selected "Skill development workshops" reported that workshops aimed at developing skills are available in both adult (DDSM) and minors (NPIA) mental health areas. These workshops are typically offered at Mental Health Centers (CSM) and Day Centers, providing opportunities for personal and professional growth. Respondents who selected "Vocational training programs" indicated that professional training programs are available mainly through the adult mental health department (DDSM) in collaboration with regional training entities. These programs are promoted at the Labor Integration Service (SIL), social services, and in cooperation with employment centers. Training is also offered at DSM Day Centers or via territorial agencies specializing in specific training. However, some report limited or isolated training programs, such as the GOL project without subsequent job placement support. These initiatives often involve internal department services, third sector organizations, labor agencies, DSM, ASPAL, and local professional training entities. Respondents who selected "Supported education programs" described those offered in both adult (DDSM) and minors (NPIA) mental health areas. These programs are primarily available at Day Centers and Mental Health Centers (CSM). They involve the active participation of Psychiatric Rehabilitation Technicians and Educators, often within





rehabilitative services and sometimes in collaboration with municipalities. Respondents who selected "Job placement and employment" indicated that job placement support is mainly provided through the adult mental health department (DDSM) and the Labor Integration Service (SIL). A collaboration protocol between DSM and SIL ensures individual user support and tutoring. However, opportunities such as internships are often limited, sometimes unpaid except for minimal reimbursements. The support network involves Psychiatric Rehabilitation Technicians, Educators, and Experts by Experience (ESP), employment agencies, municipalities, and professional training entities. Respondents who selected "Internships or apprenticeships with mental health support" report that internships and apprenticeships with mental health support are actively promoted, particularly within the adult mental health department (DDSM) and the Labor Integration Service (SIL). The network includes Psychiatric Rehabilitation Technicians, Educators, Labor Agencies, municipalities, and associated companies. Respondents who selected "Mentoring or job coaching programs" indicated that mentoring or work coaching programs are available mainly within the adult mental health department (DDSM) and the Labor Integration Service (SIL). Some regions report no such services or limited availability through local workgroups. Respondents who selected "Youth transition programs" indicated that these programs are coordinated within both adult (DDSM) and minors' (NPIA) mental health services, often integrated with the Labor Integration Service (SIL). Programs are also promoted by the Early Intervention in Mental Health Program (PIPSM) within the DSM. Local municipalities, schools, and universities participate in supporting accessible educational and employment opportunities. Respondents who selected "Cooperatives and social enterprises" indicated that cooperative and social enterprise programs aimed at promoting meaningful employment for individuals with mental health disorders are actively supported, especially through collaborations with local consortia and third sector organizations. The DDSM (adult area) works closely with the Consorzio Prisma, which brings together social cooperatives across the province. Initiatives promoted by the third sector in collaboration with the DSM of ASL Roma 1 are primarily focused on the agricultural sector. These programs involve various stakeholders, including third sector entities, psychiatric rehabilitation technicians, educators, private organizations in partnership with municipalities, and social cooperatives affiliated with the DSM. Overall, these interventions reflect a multi-actor approach aimed at integrating individuals with mental disorders into cooperative projects and entrepreneurial activities to enhance their social inclusion and employment opportunities. Respondents who selected "Associative leisure programs" indicated that recreational associative programs, such as youth groups including scout activities and Montagnaterapia, are available primarily for younger individuals with mental health disorders. These programs are promoted within local communities through parishes, gyms, youth agencies, and various associations. While these activities provide a sense of belonging, skill development, and mental well-being for adolescents, similar structured opportunities for adults are limited or absent. The initiatives involve psychiatric rehabilitation technicians, educators, local NGOs, associations, and the third sector, often coordinated under community-based frameworks like "Area Fare Assieme. Respondents who selected "Other" reported the availability of additional interventions focused on education and training for individuals with mental health disorders. These include training projects and the promotion of Experts by Experience (ESP)





within the DDSM and regional training entities. Furthermore, municipal educational recreational centers also provide support and activities that contribute to social inclusion and skill development.

In Spain, respondents who selected "Occupational support services" describe a variety of providers, including: Psychosocial Rehabilitation Centers (CRPS) integrated into the mental health and social care network, often in collaboration with contracted service providers; Community Rehabilitation Centers and Third Sector Entities (e.g., Eragintza Foundation, Fundació Tresc, Fundació Drissa); Cantabrian Health Service (SCS) and organizations like FAISEM; Services are also provided within Addictions and Mental Health Services. Respondents who selected "Skill development workshops" describe services primarily delivered by Psychosocial Rehabilitation Centers (CRPS) and Community Rehabilitation Centers, operating within the mental health and social care network, often in partnership with contracted services; Third Sector Entities, such as NGOs and foundations (e.g., Eragintza, Faisem). Programs are designed to support individuals with mental health conditions by fostering skill-building and promoting autonomy, often through coordinated efforts between public services and third-sector organizations. Respondents who selected "Vocational training programs" describe services provided through Vocational Rehabilitation Centers (CRL) within the mental health and social care network, often in collaboration with contracted services; Community Rehabilitation Centers; Cantabrian Health Service (SCS) and municipal services; Public employment initiatives such as SOC, JOYA, which support skill acquisition and integration into the labor market for individuals with mental health conditions. Respondents who selected "Supported education programs" describe services provided through Community Rehabilitation Centers, SOC (Public Employment Service), SEPE (Spanish Public Employment Service), local authorities, and external entities, Respondents who selected "Job placement and employment" describe Vocational rehabilitation centers (CRL) within the mental health and social care network, often in collaboration with contracted service providers. These services are available but may be insufficient. Community Rehabilitation Centers also play a key role; Cantabrian Health Service (SCS) provides such services. Faisem is mentioned as a provider of employment support. Programs are also supported by the Public Employment Service, including SOC and JOYA. Support comes from foundations such as Fundació Tresc and Fundació Drissa. Respondents who selected "Internships or apprenticeships with mental health support" describe the involvement of Community Rehabilitation Centers and Third Sector Entities in providing these opportunities. Support from municipal authorities. Respondents who selected "Mentoring or job coaching programs: Personalized support to help individuals with mental health disorders navigate job placement or career development" describe Labor rehabilitation centers (CRL) integrated within the mental health and social care network, often through contracted services. These programs exist but may be insufficient in coverage. The role of Community Rehabilitation Centers and Third Sector Entities. Services provided by the Cantabrian Health Service (SCS). Mention of specific initiatives such as the RAL program, Fundación Lar, the Andalusian Foundation for the Integration of the Mentally III, and Fundació Tresc and Fundació Drissa, which offer tailored job coaching and mentoring support. Respondents who selected "Youth transition programs: Services designed to assist young people with mental health disorders in





transitioning to adulthood, ensuring educational and employment opportunities are accessible" reported that such programs exist only in isolated services. Community Rehabilitation Centers are involved in supporting youth transitions. There are protocols in place between child and adolescent services (CSMIJ) and adult mental health services (CAS or CSMA). Respondents who selected "Cooperatives and social enterprises: Programs that engage individuals in cooperative projects or entrepreneurial activities to promote meaningful employment" noted that isolated initiatives exist, though they may be insufficient. Community Rehabilitation Centers play a role in these programs. Initiatives are provided by organizations such as AMICA. Specific examples include Viver Bell Lloc, Fundació Baix Montseny, La Fageda, APRodisca, and Institut Pere Mata. Respondents who selected "Associative leisure programs: Organized leisure activities, such as youth movements (scouts), which provide adolescents with a sense of belonging, skill development, and mental well-being through structured social engagement" describe these programs as decentralized at the local level. They include Social Clubs and youthfocused groups. Examples of activities and organizations mentioned are Cau, Esplai, Youth Clubs, Open Centers, and Escoltes Catalans. Specific local initiatives include El Porxo of the Fundació Pere Mata and the Social Club of the Associació Família i Salut Mental de Girona i Comarques. Basque Country provided the following links for:

• Community Rehabilitation Centers: https://www.eragintzafundazioa.eus/es/2023/06/01/eragintza-y-la-red-de-salud-mental-de-bizkaia-prorrogan-su-convenio-de-colaboracion-hasta-2027/

In **Poland**, respondents who selected "vocational training programs" described a system where these services are provided by NGOs, such as the Mental Health Families Association, funded through grants. Those who chose "internships or apprenticeships with mental health support" noted that these opportunities are offered by the Occupational Activity Center, operated by the Mental Health Families Association at Mr. Cogiro's Guesthouse and Restaurant. Respondents who selected "cooperatives and social enterprises: programs that engage individuals in cooperative projects or entrepreneurial activities to promote meaningful employment" indicated that there are currently too few services of this kind, which are typically delivered by social economy entities or NGOs. For "associative leisure programs: organized leisure activities, such as youth movements (scouts), which provide adolescents with a sense of belonging, skill development, and mental well-being through structured social engagement," respondents highlighted that these services are primarily delivered through the education system, including schools and NGOs. Finally, those who selected "others" mentioned additional services, such as support schemes funded by the PFRON (State Fund for the Rehabilitation of Disabled Persons).

In **Germany**, the respondent listed "vocational training programs" as the following: Vocational Rehabilitation (via Pension Insurance): Provides retraining, further education, and workplace adaptation through services like vocational training centers (BFW); Supported Employment (UB): Offers individualized, long-term on-the-job support to enable direct access to the general labor market without prior retraining; Integration Services (IFD): Assist with counseling, job placement, and support for maintaining employment, working closely with employers; Vocational Training Centers (BTZ): Target people returning to work







after a mental health crisis with practical and theoretical training, plus stress management; Employment Agency & Job Center Measures: Provide specialized rehab counselors, retraining funding, and employer subsidies; Inclusion Companies: Employ people with disabilities in regular work environments with added support; Workshops for People with Disabilities (WfbM): Offer vocational development for those not yet ready for the general labor market; Peer Counseling & Self-Help Groups: Peer-led support for job re-entry, stress management, and workplace mental health. These programs focus on individual needs, combining therapeutic, educational, and workplace elements to support successful employment integration. "Skill development workshops": Mindfulness and Stress Management; Communication and Social Skills Training; Creative Therapy Workshops (Painting, music, writing therapy); Everyday Life and Self-Management TraininG (Practical life skills for independence). "Vocational training programs" were describes as: Berufsförderungswerke (BFW) - Retraining and Qualifications for individuals unable to continue in their previous job for health reasons; Vocational Training Centres (BTZ) - Stress Testing & Skill Development for: people returning to work after a mental health crisis, offers: Stress tolerance testing, skill-building, internships; Supported Training (BaE Rehabilitation) offers slower-paced vocational training with psychosocial support; Inclusive Company Training for: Individuals needing a protected training environment and offers training in inclusive businesses with therapeutic and educational support; Employment Agency Programs for: Individuals seeking reorientation or skill enhancement, offers subsidized further training, adapted learning, education vouchers. "Supported education programs" were described as: Rehabilitation via German Pension Insurance (DRV) include Benefits for participation in working life (LTA), Retraining via Berufsförderungswerke (BFW), Psychosocial and professional support during qualification; Federal Employment Agency (BA) Programs include: Education vouchers, Funded training at BTZ centres, Courses in career orientation and skills development; Supported Employment & Integration Services (IFD) include Subsidised internships and employment in inclusive companies, Personalised support and counselling, Employer incentives for hiring; Programs for Young People (e.g. BaE Rehabilitation) included Adapted vocational training with reduced workload, Psychosocial care during training, Individualised educational pathways. "Job placement and employment" are delivered by public agencies and private organisations, and focus on individualised support, workplace integration, and long-term employability and Integration Services (IFD) included Job counselling and placement, Workplace coaching and mediation with employers, Financial incentives for employers; Supported Employment included Onthe-job training and coaching, Workplace integration assistance, Job customization; Workshops for People with Disabilities (WfbM) include Sheltered work settings, Vocational skills training, Long-term support and preparation for mainstream employment; Employment Agency Measures include Career counselling and job placement, Training, internships, and reintegration programs, Financial aid (e.g. wage subsidies); Inclusion and Integration Companies include Employment in inclusive companies, On-site individual support and accommodations, Prospects for mainstream job transition; Peer Mentoring & Work-Focused Support Groups includes Mentoring by experienced peers (e.g. EX-IN), Selfhelp groups focused on employment, Building professional networks. "Internships or apprenticeships with mental health support" were described as combining practical work experience with structured psychological and social support, promoting integration into







the labour market under adapted and supportive conditions and include Supported Internships and Employment offer Internships tailored to mental health needs, Psychological support throughout, Job coaching for both participants and employers; Internships and Apprenticeships in Inclusive Companies offer Roles in inclusive enterprises, Support by mentors or social workers, Adapted work conditions; In-Company Training with Social Support offer Apprenticeships in various sectors (e.g., trade, crafts, administration), Mentor support during training, Flexible work conditions (e.g., reduced hours); Internships and Apprenticeships in WfbM (Sheltered Workshops) offer Vocational training in protected settings, Psychological support during work, On-the-job training with possible future transition to open market; Internships via Employment Agency with Support offer Funded internships with structured psychological support, Assistance with workplace integration, communication, and resilience. "Mentoring or job coaching programs" include Job Coaching by Integration Specialist Services (IFD) offer One-on-one coaching for job search, onboarding, and workplace adaptation, On-site support and mediation between employer and employee, Regular problem-solving sessions; Mentoring Programs for People with Mental Illness offer Peer or professional mentoring for career orientation and development, Personalised career planning, Network building and skills enhancement; Supported Employment Programs offer: Job search and workplace integration with tailored support, Mentoring and coaching before and after employment, Guidance for both the employee and employer, Ongoing follow-up support for sustainability; Rehabilitation and Integration Programs (Federal Employment Agency) offer Rehabilitation coaches with mental health expertise, Tailored job placement and personalised coaching, Application training and jobreadiness support, Employer subsidies for hiring individuals with mental illness. "Youth transition programs" combine career counselling, psychosocial support, mentoring, and practical experience to help overcome personal and systemic barriers during this critical life phase and include Youth Vocational Assistance and Transition Management offering Career orientation and tailored counselling, Help with finding apprenticeships, writing applications, and interview preparation, Internships and career trials, Educational and psychosocial support to build resilience and skills; Transitional Assistance through Lebenshilfe offering Individual career counselling and job coaching, Skills training (e.g., communication, teamwork, time management), Mentoring for job or apprenticeship entry; Vocational Rehabilitation for Young People offering Career orientation and professional training, Psychological and coaching support, Internships and workshops for job-readiness, Workplace adaptation and labour market integration support; "Young Transition" Project – German Society for Social Work (DGSA) offering Individual and group coaching for life and work transitions, Personal and career goal setting, Soft skills training (e.g., self-organisation, stress management), Support for independence and better quality of life; Inclusive Educational Offers and Projects offering Adapted educational and training opportunities, Gradual and personalised integration into work life, Ongoing psychosocial support, Collaboration between schools, employers, and social services. "Cooperatives and social enterprises" include Social Integration Companies and Cooperatives to Create inclusive workspaces with cooperative structures, Integration Companies to Employ people with disabilities within the regular labour market, Start-Up Support and Entrepreneurial Initiatives to Empower people with mental disorders to start their own socially responsible businesses, Vocational Rehabilitation in Social Enterprises to Enable re-entry into the





workforce through supportive job placements. "Associative leisure programs" combine structured group activities, social responsibility, and community engagement, creating safe environments where adolescents can build self-esteem, resilience, and a sense of belonging and include Scout Movement (e.g. German Scout Association), Die Johanniter – Socio-Pedagogical Projects offer Internships, social projects, leisure activities with mentoring support.

In Estonia, the respondent described that a variety of education-, training-, and workfocused interventions are available to support individuals with mental health disorders. Occupational support services are provided by the Vocational Rehabilitation Centre and NGOs. Skill development workshops are organized by NGOs and municipalities to enhance personal and professional competencies. Vocational training programs are available through the Vocational Rehabilitation Centre. Supported education programs are offered by municipalities, including both general and special schools. Job placement and employment services are provided by the Estonian Unemployment Insurance Fund, which also offers internships and apprenticeships with mental health support to help individuals gain work experience in a supportive environment. In addition, the Fund offers mentoring and job coaching programs that provide personalized assistance to individuals navigating job placement or career development. Youth transition programs, aimed at helping young people with mental health disorders successfully move into adulthood and access educational and employment opportunities, are delivered by municipalities, social rehabilitation services, and NGOs. Cooperatives and social enterprises, supported by NGOs, engage individuals in meaningful employment through collaborative or entrepreneurial projects. Finally, associative leisure programs, such as youth movements like scouts, are organized by NGOs to provide adolescents with structured social engagement, opportunities for skill development, and a sense of belonging that supports mental wellbeing.

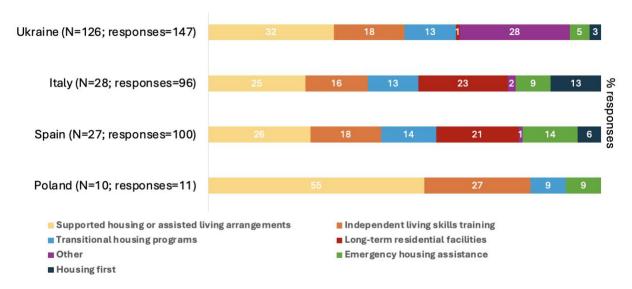
In **Latvia**, the participant reported that "Occupational support services", "Vocational training programs", "Supported education programs", "Job placement and employment", and "Mentoring or job coaching programs" are provided by the Ministry of Welfare. "Skill development workshops" are offered by both the Ministry of Welfare and NGOs. For "Youth transition programs", the participant indicated that the NCoMH has a coordinator who supports the transition process. Finally, "Associative leisure programs" are provided by the Young Guard Centre.

Among the housing-focused interventions available in the respondents' countries for individuals with mental health disorders, the most frequently selected intervention across all countries was supported housing or assisted living arrangements. In Ukraine, the option "Other" was also frequently selected (28%). In Italy and Spain, long-term residential facilities were commonly reported (23% and 21%, respectively). In Poland, independent living skills training was selected by 27% of respondents (See Figure 8 for country-specific results).









Countries with one survey	Romania	Latvia	Estonia	Germany
Supported housing or assisted living arrangements		1	1	1
Independent living skills training		1	1	1
Transitional housing programs		1	1	1
Long-term residential facilities	1	1	1	1
Other	1			
Emergency housing assistance		1	1	1
Housing first				1

Figure 8. Which of the following housing-focused interventions are available in your country for individuals with mental health disorders? Multiple selections were allowed.

In **Ukraine**, respondents who selected "Supported housing or assisted living arrangements" mentioned that support is typically provided by social workers, social services, specialized public organizations, community social centers, palliative care teams, and labor and social protection departments. Respondents who selected "Transitional housing programs" identified community social centers and the Ministry of Social Policy of Ukraine as providers. Respondents who selected "Independent living skills training" mentioned that these programs are provided by psychologists, doctor psychologists, social services, or other organizations supporting people with disabilities. Respondents who selected "Other" mostly reported no information or lack of involvement regarding housing support. Some mentioned psychosocial counseling and temporary housing programs like "E-Oselya," which is largely inaccessible. Others noted that people with mental disorders without housing often stay temporarily in medical facilities or psychiatric hospitals before moving to nursing homes. Several respondents stated that their institutions do not provide housing services or are unfamiliar with the issue.

In **Italy**, respondents who selected "Supported housing or assisted living arrangements" indicated that supported housing and assisted living interventions for individuals with





mental health disorders are actively available. These services are provided through collaboration between DDSM (adult area), social services, third sector organizations, and community resources. The ADP program offers in-home support for patients. Municipal housing, private social services, residential therapeutic communities, and local psychiatric units (ASST) also play key roles in providing housing support. Respondents who selected "Transitional housing programs" indicated that transitional housing programs for individuals with mental disorders are available in various regions, often delivered through collaborations between public mental health services and the third sector. The DDSM (adult area) is typically involved, partnering with private social organizations, religious entities, and local municipalities. Some accommodations are provided directly by religious institutions, while others are managed by local health authorities (Azienda USL) and municipal social services. These programs aim to offer temporary housing as part of a broader care pathway, often supporting individuals transitioning toward independent or supported living. Respondents who selected "Independent living skills training" reported that training programs for independent living skills are available through a variety of public and private services. These programs are often managed by the DDSM (adult mental health services) in collaboration with the third sector, including private social organizations and municipalities. The training is delivered within day centers (Centri Diurni), residential therapeutic communities, or supported housing environments. The ADP (Planned Home Assistance) pathway also provides personalized support for developing independent living abilities. Local Health Authorities (Azienda USL), Community Mental Health Centers (CSM), and municipal services frequently cooperate with the third sector to deliver these interventions. Respondents who selected "Emergency housing assistance" reported that emergency housing assistance for individuals with mental health conditions is primarily managed by municipal social services and local welfare districts ("Ambiti Sociali"). These services often operate in coordination with Mental Health Services and third sector organizations. Emergency housing solutions may also be activated through local health authorities (ATS or PLUS), in collaboration with non-profit agencies and community-based support networks. Respondents who selected "Long-term residential facilities" indicated that longterm residential facilities for individuals with mental disorders are available through a variety of services. These include public and private accredited facilities such as RSSP (Residential Psychiatric Rehabilitation Facilities), RSD (Health and Social Residences), psychogeriatric units, and therapeutic communities. These services are often managed by the Department of Mental Health (DSM), local health authorities (Azienda USL), social services, and municipalities. Several facilities are either publicly run or accredited and operated by private entities under regional agreements. Respondents who selected "Housing first" indicated that those experiencing are available for homelessness and are implemented in collaboration with public institutions and the third sector. These programs are primarily managed by Social Services (Ambiti), local health authorities (Azienda USL), municipalities and private social organizations. Some regions also rely on inter-municipal social service organizations (e.g., ATS/PLUS) working with the nonprofit sector to deliver these housing solutions.

In **Spain**, respondents who selected "Supported housing or assisted living arrangements" describe that the services are provided by Social Health Services. There is an involvement of







Third Sector Entities contracted with the Social Services of the Provincial Council. Services also provided by entities contracted with the Cantabrian Institute of Social Services (ICASS); supported housing and residential facilities under social welfare responsibility; Faisem; Andalusian Foundation for the Integration of the Mentally III, Drissa Foundation, and IAS. Respondents who selected "Transitional housing programs" describe these services as provided by social services. They are delivered by entities contracted with the Cantabrian Institute of Social Services (ICASS); Faisem. Municipal social welfare services support homelessness. Respondents who selected "Independent living skills training" describe these services as offered by Psychosocial Rehabilitation Centers (CRPS) and Day Centers within the mental health and social care network, as well as contracted providers. Municipal Social Services also contribute. Support comes from foundations such as the Andalusian Foundation for the Integration of People with Mental Illness and the Institut d'Assistència Sanitària (IAS). Occupational Therapists and Social Workers play key roles in these programs. Respondents who selected "Emergency housing assistance" describe services provided by the emergency social services network. Municipal Social Services also play a key role. Although these services are not specific to mental health, they target individuals at risk of social exclusion. The programs are delivered by municipalities and involve Social Services and Community Social Services. Respondents who selected "Long-term residential facilities" describe services provided by social services through mini-residences, and healthcare services in medium- and long-term psychiatric hospitals. Support is provided through Faisem, community social services, and foundations such as Fundació Drissa and IAS. Respondents who selected "Housing first" describe that such programs are available occasionally, depending on the locality or district. Respondents who selected "Other" describe financial benefits aimed at facilitating access to social housing, such as rental assistance programs. Basque Country provided the following links for:

- Supported housing or assisted living arrangements, Social Health Services: https://www.euskadi.eus/servicios-sociales-enfermedad-mental-transtorno-mental/web01-a2gizar/es/
- Long-term residential facilities Health and Social Services: https://www.euskadi.eus/servicios-sociales-enfermedad-mental-transtorno-mental/web01-a2gizar/es/
- Housing first: https://www.euskadi.eus/servicios-sociales-enfermedad-mental-transtorno-mental/web01-a2gizar/es/

In **Poland**, respondents who selected "supported housing or assisted living arrangements" reported that these services are provided by local government municipalities, social assistance, and PFRON (the State Fund for the Rehabilitation of Disabled Persons). Those who selected "independent living skills training" indicated that such services are delivered by NGOs and social assistance. Respondents who selected "emergency housing assistance" explained that these services are delegated to local government authorities and crisis housing facilities. Lastly, respondents who selected "other" noted that housing-focused interventions are not applicable to the Prison Service (SW).

In **Germany**, the respondent described the "Supported housing or assisted living arrangements" as designed to enable the affected persons to live as self-determined a life







as possible and at the same time to promote their mental health. "Transitional housing programs" Transitional housing provides a temporary, stable, and supportive living environment for individuals with mental disorders, especially after hospital stays or acute crises. Some examples are Transitional Homes by Caritas and Diakonie, Transitional Housing at AWO (Arbeiterwohlfahrt), Temporary Living through Lebenshilfe, Psychosocial Dormitories by Self-Help Organizations, Residential Groups as Temporary Solutions. "Independent living skills training" focus on practical skills, social integration, and professional involvement, tailored to individual needs. Some examples are Everyday Training in Assisted Living, Participants learn tasks like shopping, cooking, housekeeping, and time management, Social Skills and Communication Training Helps overcome social fears, conflict resolution, confident communication, Vocational Rehabilitation and Work Training Reintegration into labor market via internships, targeted trainings, professional courses, Psychosocial Training Programs Stabilize mental health and everyday coping skills, Self-Management Training Focus on health and daily life organization: day planning, medication management, therapy adherence, Housekeeping and Budget Management Training Teaches financial management, budgeting, household tasks. "Emergency housing assistance" are described as Psychosocial Emergency Shelters Short-term accommodation with immediate psychosocial care, Crisis Housing Safe apartments for people in acute mental health crises with intensive support, Housing First Model Provides immediate housing without preconditions (no requirement for therapy compliance beforehand), Transitional Housing Stable temporary housing after homelessness or crisis, with ongoing support, Emergency Housing Apartments Short-term housing for those at risk of homelessness due to mental illness, Residential Groups & Assisted Living for Crisis Small group living arrangements with social support during crises. "Long-term residential facilities as Residential Groups and Assisted Living, Psychiatric Nursing Homes, Long-Term Inpatient Social Psychiatric Facilities, Integrative Living Concepts, Long-Term Therapeutic Residential Communities. "Housing First" was described an innovative approach that provide people with immediate access to independent housing—without requiring them to first fulfil conditions such as participating in therapy or achieving abstinence. For example: A local initiative is active in Bremen: Housing First Bremen, On a national level, the Federal Association of Housing First supports the dissemination and implementation of the model across.

In **Estonia**, the respondent described that several housing-focused interventions are available to support individuals with mental health disorders. Supported or assisted living arrangements, as well as transitional and emergency housing programs, are provided by municipalities. Independent living skills training is offered by NGOs and social rehabilitation services. Long-term residential facilities are available through both municipalities and the private sector, including businesses and NGOs.

In **Latvia**, the participant indicated that the Ministry of Welfare is the main provider of services related to supported housing or assisted living arrangements, transitional housing programs, independent living skills training, emergency housing assistance, and long-term residential facilities.





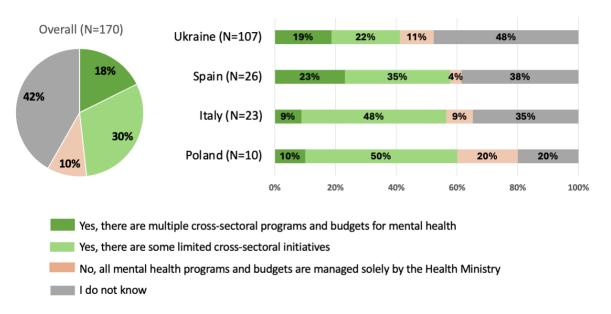


PART 3. Benefits and fundings

The "Benefits and fundings" section began by asking respondents whether there are cross-sectoral programs, strategies, and budgets for mental health disorders managed by ministries outside the Ministry of Health in their country.

Overall, the majority of respondents (42%) reported that they did not know. 30% stated that some limited initiatives exist, while 18% reported that there are multiple cross-sectoral programs and budgets for mental health. 10% responded that all mental health programs and budgets are managed solely by the Ministry of Health.

Spain and Ukraine were the countries where a higher percentage of respondents, compared to others, indicated the existence of multiple cross-sectoral programs and budgets for mental health. In contrast, in Poland, 20% of respondents stated that all mental health programs and budgets are handled exclusively by the Ministry of Health (See Figure 9 for country-specific results).



Countries with one survey	Romania	Latvia	Estonia	Germany
Yes, there are multiple cross- sectoral programs and budgets for mental health		1		
Yes, there are some limited cross-sectoral initiatives	1		1	1

Figure 9: Are there cross-sectoral programs, strategies, and budgets for mental health disorders in ministries outside the Health Ministry in your country?





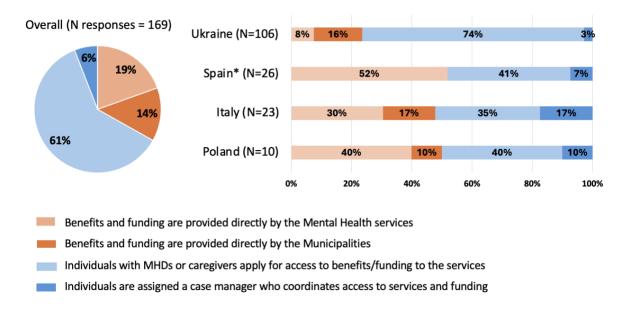


In **Ukraine**, respondent who selected "I do not know" indicated that although such programs may exist on paper within ministries, they are not implemented in practice. Many also reported having no information or awareness of these programs.

In **Germany**, the responder reported that there are indeed cross-sectoral mental health programs and strategies that extend beyond the remit of the Federal Ministry of Health. These initiatives encompass areas such as employment, education, and social inclusion, aiming to promote mental health across various societal contexts. Key ministries involved include the Federal Ministry of Labour and Social Affairs (BMAS), the Federal Ministry of Education and Research (BMBF), and the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ). Their efforts focus in particular on integrating mental health into labor market and education policies. Thus, multiple cross-sectoral programs and dedicated budgets address mental health, even outside the direct responsibility of the health sector.

In response to the question "How are the different services organized to deliver benefits and funding?", the majority of respondents (61%) indicated that individuals with mental health disorders (MHDs) or their caregivers must apply directly to services to access benefits or funding. 19% reported that benefits and funding are provided directly by Mental Health Services, 14% stated they are provided directly by Municipalities, and 6% indicated that individuals are assigned a case manager who coordinates access to services and funding.

Spain differed from the overall pattern: the majority of respondents (52%) reported that benefits and funding are provided directly by Mental Health Services (See Figure 10 for country-specific results).







Countries with one survey	Romania	Latvia	Germany
Benefits and funding are provided directly by the Municipalities	1		
Individuals with MHDs or caregivers apply for access to benefits/funding to the services		1	1

Figure 10: How are the different services organized to deliver benefits and funding. *For Spain, one survey was sent via email, the responder selected two options. Estonia selected all options and was not reported in the figure.

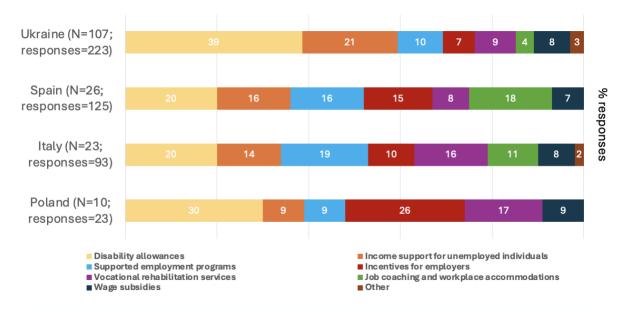
In **Germany**, the respondent reported that the organization and funding of mental health services depend on various factors, including the type of support involved—whether medical, social, or occupational—and the corresponding institutional responsibilities. In most cases, individuals with mental health conditions or their caregivers must actively apply for services or financial support themselves. This typically involves different agencies such as health insurance funds, social welfare offices, or pension insurance institutions. For instance, psychiatric treatment is generally covered by health insurance, while social support or integration assistance falls under the Social Code (SGB IX, SGB XII) and requires separate applications. Nonetheless, there are also case management approaches in place—particularly within integration assistance services or in pilot projects—aimed at improving the coordination and accessibility of care.

In response to the question "Which of the following employment-related funding/benefits are available in your country for individuals with mental health disorders?", the most frequently selected option across all countries was disability allowances. Country-specific differences emerged: in Ukraine, this was followed by income support for unemployed individuals (21%); in Spain, by job coaching and workplace accommodations (18%); in Italy, by supported employment programs (19%); in Poland, by incentives for employers (26%) (See Figure 11 for country-specific results).









Countries with one survey	Romania	Latvia	Estonia	Germany
Disability allowances	1	1	1	1
Income support for unemployed individuals	1	1	1	1
Supported employment programs		1	1	1
Incentives for employers	1	1	1	1
Vocational rehabilitation services		1	1	1
Job coaching and workplace accommodations		1	1	1
Wage subsidies	1	1		1
Other				

Figure 11: Which of the following employment fundings/benefits are available in your country for individuals with mental health disorders? Multiple selections were allowed.

In **Ukraine**, respondent who selected "Other" reported having no information or knowledge about the topic.

In **Spain**, respondents who selected "Other" described home-based services, including support with activities of daily living (ADLs), cleaning, and teleassistance.

In **Italy**, respondents who selected "Other" reported Work scholarships, reintegration internships, and IPS application.

In **Poland**, respondents who selected 'Other' explained that these employment funds/benefits are not applicable to the Prison Service (SW)

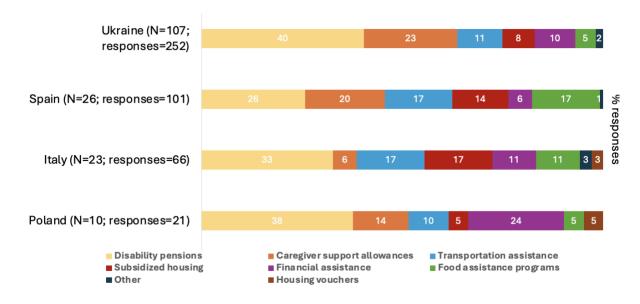
In **Germany**, the respondent described a range of employment-related support measures for people with disabilities or mental health conditions: Supported Employment Programs: These are offered through the Integration Service (Integrationsfachdienst – IFD) or specific initiatives by the Federal Employment Agency, providing tailored job placement and





support. Wage Subsidies: Employers who hire individuals with disabilities can receive integration subsidies (Eingliederungszuschüsse – EGZ) to partially offset wage costs. Incentives for Employers: Beyond wage subsidies, financial support is also available for adapting workplaces to be disability-friendly, including modifications to infrastructure or equipment. Job Coaching and Workplace Accommodations: Support such as job coaching, work assistance, and other services aimed at facilitating participation in working life (Leistungen zur Teilhabe am Arbeitsleben – LTA) is accessible, often through the IFD. Disability Allowances: Individuals with significant disabilities may be entitled to full or partial disability pensions, depending on the severity of their condition. Income Support for Unemployed Individuals: Depending on individual circumstances, support may come in the form of Unemployment Benefit I or the citizen's benefit. Vocational Rehabilitation Services: These include retraining, further qualification programs, or job placement support provided by the German Pension Insurance or the Federal Employment Agency.

In response to the question "Which of the following social funding/benefits are available in your country for individuals with mental health disorders?", the most frequently selected option across all countries was disability pensions. Country-specific differences emerged: in Ukraine and Spain, this was followed by caregivers' support allowances (23% and 20%, respectively); in Italy, by transportation assistance (17%) and subsidized housing (17%); in Poland, by financial assistance (24%) (See Figure 12 for country-specific results).







Countries with one survey	Romania	Latvia	Estonia	Germany
Disability pensions	1	1	1	1
Caregiver support allowances	1	1	1	1
Transportation assistance	1	1	1	1
Subsidized housing		1	1	1
Financial assistance	1	1	1	1
Food assistance programs		1	1	1
Other				
Housing vouchers				1

Figure 12: Which of the following social fundings/benefits are available in your country for individuals with mental health disorders? Multiple selections are allowed.

In **Ukraine**, respondents who selected "Other" mentioned subsidies for utility payments and humanitarian food assistance, while others reported having no information or not knowing.

In **Germany**, the respondent outlined various forms of support available for individuals with disabilities or mental health conditions: Disability Pensions: Provided through the German Pension Insurance in the form of reduced earning capacity pensions. Financial Assistance: Available through social welfare (under SGB XII), the citizen's allowance, or sickness benefits for those temporarily unable to work. Subsidized Housing: Offered through the general social housing system, although it is not specifically targeted at individuals with psychological disorders. Housing Vouchers: Indirect support is available in the form of housing benefits or through the assumption of accommodation costs within the framework of the citizen's allowance or social welfare. Food Assistance Programs: Provided through food banks or as part of supplementary social benefits. Transportation Assistance: Includes benefits such as the severely disabled person's ID card, which allows free or reduced-cost public transportation. Caregiver Support Allowances: Available through long-term care insurance, particularly for outpatient or home-based care.

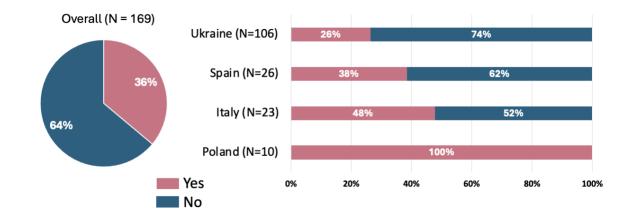
Respondents were asked whether health, social, and employment-related funding/benefits are integrated in their countries. Overall, the majority of countries responded "No" (64%), indicating a lack of integration.

In contrast with this trend, Italy and Poland reported a higher level of integration: 52% of respondents in Italy and 100% in Poland stated that health, social, and employment benefits are integrated (See Figure 13 for country-specific results).









Countries with one survey	Romania	Latvia	Estonia	Germany
Yes	1			1
No		1	1	

Figure 13: Are health, social, and employment fundings/benefits integrated?

In **Ukraine**, respondents who selected "Yes" mentioned financial support in healthcare, social security, and employment, as well as community-based social services like education and healthcare aimed at improving well-being. Some also referred to the Medical Guarantees Program, while others reported lacking specific information. Respondents who selected "No" indicated that they do not know or lack information on the topic.

In **Spain**, respondents who selected "YES" indicated that health, social, and employment benefits are integrated described that some are managed within social work teams in mental health services. The benefits are conditional on meeting specific health and socioeconomic criteria. While integration exists, there are noted deficiencies in team coordination. Disability recognition also plays a role in access to benefits.

In **Italy**, respondents who selected "YES" indicated that, in the field of mental health, there is a concerted effort to promote autonomy and social inclusion through the Health Budget and various integrated care strategies. These include formal agreements within the Socio-Health District Plan that align healthcare and social resources provided by municipalities, users, families, and voluntary organizations. Many mental health services employ a social worker to facilitate coordination. Integration is achieved through multi-source funding, often from distinct health and social sectors, brought together via networked collaboration and coordinated by a case manager. The Health Budget itself is financed by regional and municipal social funds, managed by the Mental Health Department to support employment and housing pathways for users. While the integration level varies across territories, it represents a growing model aimed at personalized and community-based care.





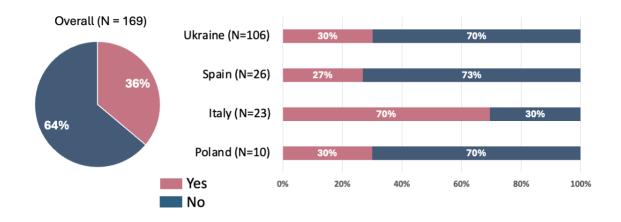


In **Germany**, the responder reported that social and employment benefits are integrated to a certain degree, but the systems remain largely separate in terms of organization and funding. Health care: Statutory health insurance covers medical costs, while rehabilitation measures are partly financed by the pension and accident insurance systems. Social welfare: Social benefits such as Unemployment Benefit II provide not only financial support but also measures aimed at labor market reintegration. Employment promotion: The Federal Employment Agency offers a range of employment promotion services—such as vocational training or integration subsidies—which can be combined with social support schemes.

In **Estonia**, the respondent selected "NO" and described that funding comes from different sources depending on the service system. Supporting structures vary and have separate budgets. At the same time, connections between service systems are established—for example, health services involve social workers who provide advice to individuals and their families, helping them navigate the service system.

Respondents were asked whether funding/benefits are allocated for specific mental health disorders (e.g., autism spectrum disorders, bipolar disorder) in their countries. Overall, the majority of countries responded "No" (64%), indicating a lack of disorder-specific funding or benefits.

In contrast with this trend, 70% of Italian respondents reported the presence of specific funding/benefits for certain mental health conditions (See Figure 14 for country-specific results).







Countries with one survey	Romania	Latvia	Estonia	Germany
Yes	1	1		1
No			1	

Figure 14: Are there fundings/benefits allocated for specific mental health disorders (i.e., autism spectrum disorders, bipolar disorder, etc.)?

In **Ukraine**, respondents who selected "Yes" mentioned various forms of support, including special schools, treatment, psychological support, and programs for children with autism. They also referred to social benefits and free medicines for people with disabilities, depending on established disability status. However, several respondents indicated uncertainty or a lack of detailed information.

In **Spain**, respondents who selected "YES" described the availability of support through recognition by Social Services for Dependency and Disability. They noted financial aid such as a grant from the Ministry of Education specifically for individuals with Autism Spectrum Disorder (ASD), aimed at psychoeducational support. Additionally, it is assumed that individuals diagnosed with a Severe Mental Disorder may have access to more extensive resources. One responder provided the link to the grant from the Ministry of Education for people with Autism Spectrum Disorder (ASD): https://autismo.org.es/actualidad/noticias/ayudas-alumnado-autismo-curso-2024-2025/.

In Italy, respondents who selected "YES" described that, in recent years, autism has become a specific focus within regional and national funding policies. A new funding stream within the Regional Fund for the Employment of People with Disabilities has been allocated for autism-related initiatives. Dedicated care pathways (PDTA) have also been established for autism spectrum disorders and eating disorders. Several interventions include voucherbased projects, age-specific regional funds (e.g., for early childhood and adults), and dedicated financing for Community Mental Health Centers (CSM) aimed at strengthening autism care capacity. Additionally, Regional Law No. 20/1999 enables the development of personalized, integrated care projects involving health authorities, municipalities, and families, though often these take the form of direct financial support rather than structured service plans. Funding sources include PNRR resources and national ministries, particularly the Ministry for Disability and the Ministry of Health. These measures cover not only autism but also conditions where disability or loss of self-sufficiency is recognized, including ADHD, DSA, and serious mental health conditions. A new funding stream has recently been approved for autism within the Regional Fund for the Employment of People with Disabilities. Dedicated care pathways for eating disorders and autism spectrum disorders (regional PDTA – Diagnostic, Therapeutic, and Assistance Pathways).

In **Poland**, respondents who selected YES described that there are fundings/benefits allocated for specific mental health disorders: according to the regulation on guaranteed







benefits in the field of psychiatric care and addiction treatment, services include interventions for addictions, behavioral addictions, and programs for the diagnosis and therapy of disorders within the autism spectrum.

In **Germany**, the responder reported that there are various financial support services available for individuals with certain mental disorders, such as autism spectrum disorders or bipolar disorder. These benefits vary depending on the individual's circumstances and may include but are not limited to: Integration Assistance: This support aims to enable people with disabilities to participate equally in social life. It encompasses services such as medical rehabilitation, assistive devices, psychotherapy, stress assessments, and occupational therapy. School Accompaniment (Integration Assistance): For children and young people with mental disabilities, including autism, school accompaniment can be requested to support everyday school activities. Promotion of Self-Help Groups: Health insurance companies and their associations fund targeted, time-limited projects and activities of self-help groups. Examples include organizing self-help events, producing group-specific informational materials, or conducting specialized workshops. Specialized Facilities and Services: Various foundations and organizations focus on the care, education, and treatment of people with mental disorders.

In **Latvia**, the participant who selected YES reported that certain programs and services are funded independently, including the Minnesota Program, the Early Intervention Program for Psychotic Disorders, among others.

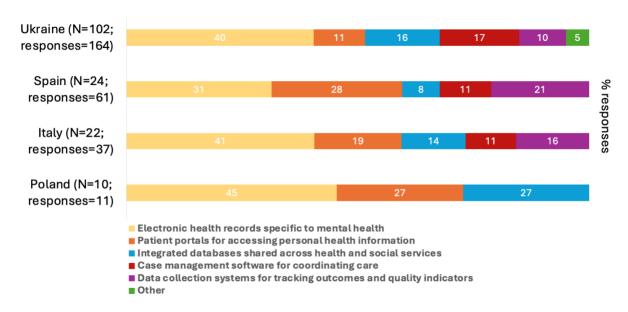




PART 4. Presence of Mental Health and Social Sector information systems

The section "Presence of Mental Health and Social Sector Information Systems" began by asking respondents which of the listed information systems are currently in place within the mental health and social sectors for individuals with mental health disorders in their country.

Across all countries, the majority of respondents indicated the presence of electronic health records specifically dedicated to mental health. The second most frequently reported system was patient portals for accessing personal health information, with an exception: in Ukraine, the second most common system was case management software for coordinating care (17%). In Poland, an integrated database shared across health and social services (27%) was also frequently selected. In Spain, a data collection system for tracking outcomes and quality indicators was also commonly reported (21%). The least commonly reported systems were case management software for coordinating care and data collection systems for tracking outcomes and quality indicators (See Figure 15 for country-specific results).







Countries with one survey	Latvia	Estonia	Germany
Electronic health records specific to mental health	1	1	1
Patient portals for accessing personal health information	1	1	
Integrated databases shared across health and social services	1		Partial (approaches exist, but not yet comprehensive)
Case management software for coordinating care	1		1
Data collection systems for tracking outcomes and quality indicators			
Other			1

Figure 15: Which of the following information systems are in place within the mental health and social sectors for individuals with MH disorders in your country? Multiple selections were allowed.

In **Ukraine**, respondents who selected "Other" indicated that the epidemic surveillance system is underdeveloped or limited to paper-based records. Most reported having no information or knowledge about the system.

In **Italy**, respondents who selected "Other" indicated that there is limited awareness among respondents regarding digital tools or data systems in mental health services. Some mention the existence of software for managing Individual Therapeutic Rehabilitation Plans (PTRI) through the BIS platform, and a data collection system for reporting to the national Mental Health Information System (SISM). However, several respondents report not knowing or not being aware of such systems, indicating potential gaps in dissemination, implementation, or training related to digital health tools in mental health services.

In **Poland**, respondents who selected "other" wrote that information systems do not exist.

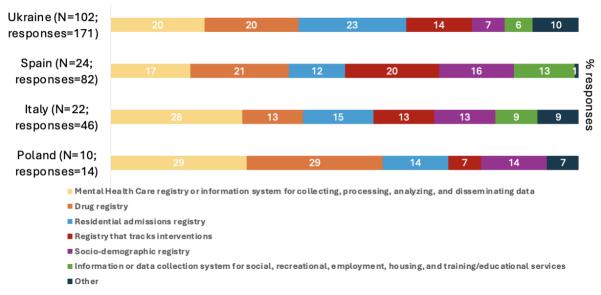
In **Germany**, the respondent described several digital tools related to mental health records and care coordination: "Electronic Health Records Specific to Mental Health": Integrated databases shared across health and social services, though currently only partially implemented with some existing but not yet comprehensive approaches. "Patient Portals": Platforms like the electronic patient record (elektronische Patientenakte, ePA) that allow individuals to access their personal health information. Data Collection Systems: Used to track outcomes and quality indicators, supporting quality assurance and research efforts. Case Management Software: Digital coordination systems designed to facilitate the management and coordination of care within healthcare settings. Other Digital Applications: This category includes various telemedicine and e-mental health solutions expanding the scope of digital support in mental health care.







Responses were relatively homogeneous across all countries when asked about the presence of registries containing data on individuals with mental health conditions. The most commonly selected registries across countries included: mental health care registries or information systems for collecting, processing, analyzing, and disseminating results; drug registries; residential admission registries; and socio-demographic registries. In contrast, information or data collection systems related to social, recreational, employment, housing, and educational or training services were among the least frequently reported by all countries (See Figure 16 for country-specific results).



Countries with one survey	Latvia	Estonia	Germany
Mental Health Care registry or information system for collecting, processing, analyzing, and disseminating data	1		Health reporting systems used for research and analysis of health trends
Drug registry	1	1	Surveys and statistical records
Residential admissions registry			Hospital statistics
Registry that tracks interventions	1	1	Data systems that are used in various contexts
Socio-demographic registry	1		Not specific to MH
Information or data collection system for social, recreational, employment, housing, and training/educational services		1	1
Other		1	

Figure 16: Does your country have any of the following registries that include data on individuals with mental health conditions? Multiple selections were allowed.

Additional information highlighted that, in Poland, suicide data are collected both by the police and the main statistical office, the latter using information from death certificates. In Spain, the SUPRA Murcia team focused on improving coordination of suicide prevention services across all administrative levels and developed a national guide for suicide risk codes







and continuity of care. A major achievement was the Ministry of Health's announcement of the 2025–2027 Suicide Prevention Action Plan. Key actions include the expansion of the Suicide Risk Code (SRC), enhancements to the computerized registry system, and sustained training and awareness initiatives. These efforts are part of JA ImpleMENTAL (2021–2024), a three-year EU Joint Action aiming to implement best practices in mental health reform and suicide prevention, building on models from Belgium and Austria across 17 EU countries.

In Ukraine, respondents who selected "Mental Health Care registry" referred to Ukraine's Electronic Health Care System, which collects data on individuals' health status, hospitalizations, treatments, and prescriptions. This system, including platforms like HEALTH24 and Ehealth24, also exchanges data with the Pension Fund for disability benefits. It supports mental health recordkeeping, with ongoing efforts to fully integrate mental health data. Some mentioned the Ministry of Health registry and noted that health information is recorded in specific facilities. Respondents who selected "Residential admissions registry" mentioned HEALTH24 and psychiatric hospitals as the main sources or systems for recording residential admissions. Respondents who selected "Registry that tracks interventions" mentioned systems such as HEALTH24, Health, and Asklep, as well as the involvement of psychologists in recording or managing intervention data. Respondents who selected "Drug registry" identified the Helsi24 program as the system used for tracking medications. Respondents who selected "Information or data collection system for social, recreational, employment, housing, and training/educational services" stated that Ukraine has information systems facilitating data exchange between social services and medical institutions. These systems cover services for people with disabilities or mental disorders, including rehabilitation, employment, and social adaptation. Lists of available services are published on official healthcare institution websites. Respondents who selected "Other" mostly reported having no information or knowledge on the topic, with some mentioning the existence of a single Electronic Health Care System.

In Spain, respondents who selected the "Socio-demographic registry" for individuals with mental health conditions described that data are collected by the National Institute of Statistics (INE), Public Health Agency, and local entities like Eustat and City Councils. The Cantabrian Health Service (SCS) also contributes. Data are gathered across care settings and shared with the administration, particularly in addiction cases, and are recorded in the SAP clinical history system. Respondents who referred to a "Mental Health Care registry or information system" mentioned that Osakidetza and the Cantabrian Health Service (SCS) manage such systems. Data on care provided—such as visits and diagnoses—are recorded across all healthcare areas and stored in the SAP clinical history system. Respondents who referred to a "Residential admissions registry" described that registration occurs within institutions and is managed by Social Services. It is also provided by the Cantabrian Health Service (SCS). Rrespondents who referred to a "Registry that tracks interventions" described the use of RAE CMDB, provided by the Cantabrian Health Service (SCS). The SAP system is used to record all care activities (visits, diagnoses, etc.) across healthcare settings. Respondents who mentioned the "Drug registry" referred to the use of SNS prescription billing data and electronic prescriptions. This system is also provided by the Cantabrian Health Service (SCS). Respondents who referred to "Information or data collection system





for social, recreational, employment, housing, and training/educational services" mentioned the use of Social History, managed by various organizations. Mental health and social services systems operate independently. Data are collected across all care areas and reported to the administration in addiction-related cases.

In Italy, respondents who selected "Mental Health Care registry" referred to regional electronic health records that integrate data on mental health, addictions, child and adolescent neuropsychiatry, and psychological services. Additional regional platforms and systems such as SISMAS and the Flussi System specifically focus on mental health data management. These registries enable better tracking of patient demographics, treatment outcomes, and service utilization, promoting coordinated care across healthcare providers. Respondents who selected "Residential admissions registry" described that some regions or healthcare organizations maintain specific registries for admissions to residential facilities for individuals with mental health conditions. These registries are often integrated into regional or organizational socio-health electronic record systems, which collect data on mental health, addictions, child and adolescent neuropsychiatry (NPIA), and psychological services. Additionally, some services use internal systems to manage these records, enabling effective monitoring and better organization of residential rehabilitation pathways. Respondents who selected "Registry that tracks interventions" reported regional socio-health electronic records (such as the CURE system) are used to track interventions related to mental health, addictions, child and adolescent neuropsychiatry (NPIA), and psychological services. These systems provide a comprehensive way to monitor and document the care pathways for individuals with mental health conditions. Respondents who selected 'Drug registry' reported that medication data for individuals with mental health conditions are recorded in regional socio-health electronic systems, such as the CURE platform. Additionally, some internal systems are also used to track pharmaceutical treatments related to mental health. Respondents who selected "Information or data collection system for social, recreational, employment, housing, and training/educational services" reported that are integrated within the regional socio-health electronic records, such as the CURE system. Additionally, local authorities and regional departments (assessorati) also manage relevant data registries. Respondents who selected "Other" reported the use of digital clinical documentation systems in mental health services, such as the Electronic Mental Health Clinical Record, which integrates data on pharmacological treatments, PTRI (Individual Therapeutic Rehabilitation Plans), and 24-hour CSM admissions/discharges, including a register of physical restraints. Additionally, the "Cartella CURE" is identified as a socio-health record that compiles broader information on health status and service activities.

Some Local Health Authorities (ASL) have data reporting systems connected to SISM, the national Mental Health Information System. However, responses also reflect limited awareness or uneven knowledge about these tools, suggesting variability in implementation or accessibility across services.

In **Poland**, respondents who selected the "Mental Health Care registry or information system for collecting, processing, analyzing, and disseminating data" identified several







entities involved, including the Central Statistical Office (GUS), the National Health Fund (NFZ), the Voivode, and the Marshal of the Voivodeship. Those who chose the "Residential admissions registry" reported that registries exist which include data on individuals with mental health conditions, such as the residential admissions registry itself, reporting to the NFZ, and associated contracts. Respondents selecting the "registry that tracks interventions" noted that it contains inpatient treatment data and operates under the Mental Health Protection Act. Those who selected the "drug registry" indicated that it is available specifically for inpatient treatment cases. Finally, respondents who chose "other" stated that no such registries exist.

In Germany, the respondent reported that there is no central socio-demographic registry specifically dedicated to mental illness. However, some relevant data are collected through other sources: Microcensus: This large-scale household survey gathers demographic and social statistics and may include information related to health, including the prevalence of mental illness. Mental Health Registers: There is no centralized, publicly accessible mental health care registry that systematically collects comprehensive mental health data. However, health reporting systems, such as those operated by the Robert Koch Institute (RKI), provide important data for research and public health analysis, including mental health trends. Residential Admissions: The number of inpatient admissions to psychiatric institutions is tracked through hospital statistics, which include data on psychiatric care. However, this is not part of a dedicated mental health registry. Treatment Interventions: While there is no unified national registry capturing all interventions for mental illness, sector-specific data systems exist—for example, in addiction services or psychiatric care to document treatment processes. Drug Monitoring: Germany does not maintain a comprehensive national drug register, but regular surveys and statistical reports on drug use and treatment (e.g., by the Federal Centre for Health Education - BZgA) help monitor substance use trends and related care. Social, Leisure, Employment, Housing, and Education Services: A variety of programs and initiatives support social inclusion for people with mental illness. Data related to these services are partially captured through systems linked to rehabilitation and participation benefits (e.g. under SGB IX), which may include individuals with mental health conditions.

In **Estonia**, the respondent described that several registries related to individuals with mental health conditions exist. There is a registry that tracks interventions, with available but not exhaustive data; the Health Insurance Board holds information about health services provided. The drug registry is managed through the Digital Prescription system (https://tervisekassa.ee/en/people/pharmaceuticals/digital-prescription). Additionally, data on social, recreational, employment, housing, and training or educational services are collected, although these datasets are not yet integrated. Furthermore, the National Institute of Health and Research serves as the central institution responsible for compiling health and healthcare statistics in Estonia.

In **Latvia**, the respondent indicated the following sources: https://www.csp.gov.lv/lv/demografijautm_source=https%3A%2F%2Fwww.google.com%2F for the Socio-demographic registry; https://www.vmnvd.gov.lv/lv/vadibas-informacijas-







sistemas-vis-lietosana for the Mental Health Care registry and for the registry that tracks interventions; https://dati.zva.gov.lv/zalu-registrs/for the Drug registry.







PART 5. Personal Health budget (PHB): national policies and local experiences

The section "Personal Health Budget (PHB): National Policies and Local Experiences" began by asking respondents whether national guidelines, policies, or best practices exist in their country for managing mental health or personalized health budgets. A majority of respondents in Spain (73%) and Italy (71%) answered "yes," indicating the presence of such frameworks. In contrast, the proportion was lower in Ukraine (41%) and Poland (50%) (See Figure 17 for country-specific results).

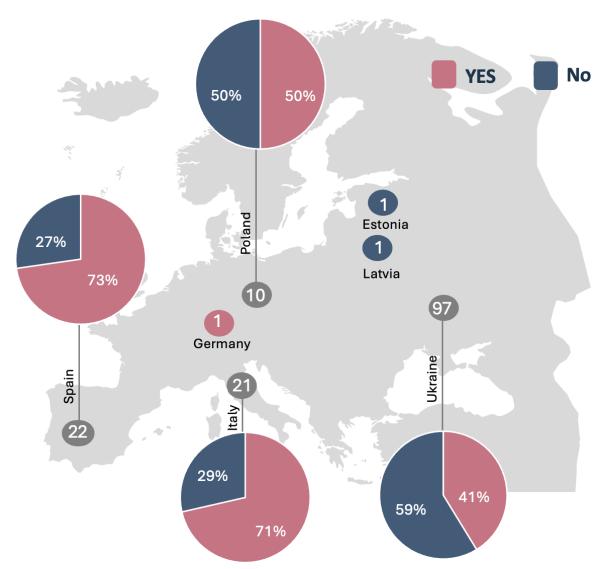


Figure 17: Are there national guidelines, policies or best practices in your country for managing mental health or personalized health budget?

In **Ukraine**, responders who selected "Yes" mentioned several national mental health initiatives and policies in Ukraine, including the National Program "How are you?", the Mental Health Protection Program until 2030, and relevant laws such as the Law on the





Mental Health System. They also referenced the National Strategy on Mental Health and policies for decentralizing psychiatric services. Some respondents were unsure or not familiar with the details. Respondents who selected "No" reported having no information.

In **Spain**, responders described the national guidelines, policies, and best practices for managing mental health and personalized health budgets as based on a combination of national and regional strategies: National Mental Health Strategy and Action Plan (2022–2024): Issued by the Ministry of Health; Autonomous Community Plans: Each region (e.g., Catalonia, Basque Country, Cantabria) develops its own mental health plans, such as: National Clinical Guidelines: Available via GuiaSalud, Quality Agency involvement and General State Budgets support implementation, Good practice guides and strategic/master plans also complement these efforts, the National Mental Health and Addictions Plan. Responders provided the following link:

- Mental Health Action Plan of the Ministry: chromeextension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.sanidad.gob.es/areas/ calidadAsistencial/estrategias/saludMental/docs/PLAN_ACCION_SALUD_MENTAL_ 2022-2024.pdf
- Mental Health Plan of Cantabria: https://scsalud.es/detalle/-/journal content/56 INSTANCE DETALLE/2162705/27233034
- Clinical guidelines of the National Health Service: https://www.fisterra.com/guias-clinicas/guiasalud-guias-practica-clinica-sistema-nacional-salud/

In **Italy**, responders described the national guidelines, policies, and best practices for managing mental health and personalized health budgets as across several Italian regions, guidelines and experimental projects related to the Budget of Health (BdS) and integrated care are currently in place or under development. Pilot projects are reported in Milan (Niguarda) and Brescia (Franciacorta), alongside broader implementation efforts in selected provinces. Regions like Friuli Venezia Giulia have actively participated in national initiatives, such as the CCM 2022 Project, which involved monitoring the outcomes of PTRI cases implemented via the BIS system. A dedicated regional conference on this topic is also scheduled. Multiple regions have published formal guidelines on the BdS methodology, such as Emilia-Romagna and Veneto, while others (e.g., Campania) have internal documents available at the ASL level. References are also made to existing guidelines and care pathways for autism and mental health, including national, international, and local PDTA protocols, although some respondents report awareness only of general recommendations or express uncertainty about available materials. This reflects a heterogeneous landscape of implementation and awareness across territories.

In **Germany**, the respondent reported that there are national guidelines for the Personal Health Budget (PHB), especially within the framework of the Social Security Code (SGB IX). PHBs allow people with mental illness or disabilities to have more autonomy in managing their health care. However, the implementation varies depending on the federal state and social welfare agency.

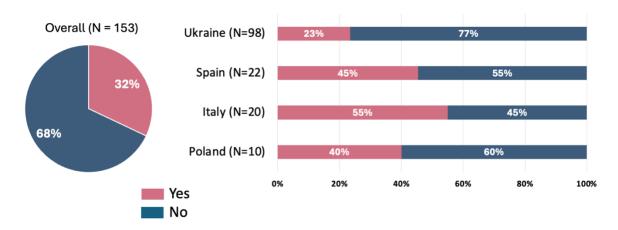






When asked whether any regulatory acts or programming documents have been adopted—either at the regional level or by individual healthcare organizations/local authorities—that explicitly mandate or support the use of the Health Budget, the majority of respondents overall answered "no" (68%).

In Italy, however, more than half (55%) reported the existence of such measures. In the other countries, the percentage of "no" responses was higher than that of "yes" responses (See Figure 18 for country-specific results).



Countries with one survey	Latvia	Estonia	Germany
Yes			1
No	1	1	

Figure 18: Have any regulatory acts or programming documents been adopted, either at the regional level or by individual healthcare companies/Local Authorities, that explicitly mandate or support the use of the Health Budget?

In **Ukraine**, respondents who selected "Yes" highlighted several official orders from the Kherson Regional Military Administration related to mental health support, financial assistance for children affected by the conflict, and the implementation of Ukraine's mental health care development plan through 2030. They also mentioned the Medical Guarantee Program, a state-funded healthcare reform initiative providing free or partially paid medical and mental health services through personal medical budgets. Key legal frameworks include the Law on State Financial Guarantees for Medical Services and related government resolutions. Additionally, they referenced subsidy programs for medicines and the National Mental Health Program "How Are You?" Some respondents noted a lack of further information. Respondents who selected "No" reported being unaware of the topic and having no available information.

In **Spain**, respondents described several regulatory acts and programming documents adopted at national and regional levels for mental health management: National Mental Health Action Plan (2022–2024) by the Ministry of Health, Mental Health Plan of Cantabria;







Action Plan of the Government of Cantabria for Cooperation, Quality Agency reports and quality indicators are used to monitor and evaluate the performance of different health resources. Responders provided the following link:

- Mental Health Action Plan of the Ministry: chromeextension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.sanidad.gob.es/areas/ calidadAsistencial/estrategias/saludMental/docs/PLAN_ACCION_SALUD_MENTAL_ 2022-2024.pdf)
- Mental Health Plan of Cantabria: https://scsalud.es/detalle/-/journal_content/56_INSTANCE_DETALLE/2162705/27233034
- Action Plan of the Government of Cantabria: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://cantabriacoopera.es/documents/6204219/28126745/Plan+de+accio%CC%81n+Cooperacio%CC%81n_170x240+web+definitivo.pdf/513f42a8-a1fc-0e1c-4d81-c4da33be4224?t=1676972523224

In **Italy**, respondents described several regulatory acts and programming documents adopted at national and regional levels for mental health management as the implementation and experimentation of the Budget of Health (BdS) model across multiple regions. A State–Regions Agreement has laid the institutional foundation for regional implementation, and each Regional Health Authority is reported to have developed its own BIS-related documentation to support operationalization. Formal regional guidelines have been published in regions like Emilia-Romagna and Veneto, with Campania also providing access to internal guidelines. Regional Council Resolutions have further supported the adoption of the model. Emilia-Romagna, in particular, has publicized the success of its experimental BdS initiatives, as detailed in regional news sources. The response also references PORA, which may indicate a local project or policy instrument. Despite this, some uncertainty remains, with a few respondents reporting a lack of knowledge, highlighting variability in dissemination and awareness.

In **Germany**, the respondent reported that there are legal frameworks supporting the use of personal budgets within the healthcare system for individuals with mental illnesses. At the federal level, the Ninth Book of the Social Code (SGB IX) introduced a legal entitlement to a personal budget, effective since January 1, 2008. This provision allows people with disabilities or chronic illnesses to receive financial benefits instead of benefits in kind, thereby enabling them to make independent decisions about the support services they require. The amount granted through the personal budget is determined based on individual needs and is not permitted to exceed the value of the equivalent in-kind services previously received. This approach enhances the autonomy and decision-making rights of affected individuals. Additionally, some federal states have enacted their own legislation concerning assistance and protective measures for people with mental illnesses. For example, in Rhineland-Palatinate, the State Law on Assistance for Mental Illnesses (PsychKHG), which came into effect on January 1, 2021, includes relevant provisions—although it does not specifically address the personal budget.





PART 6. Personal Health Budget structuring

The section "Personal Health Budget Structuring" began by asking respondents whether a person-centred approach is used in services for individuals with mental health disorders in their country.

The majority of respondents in Italy (82%), Spain (70%), and Ukraine (58%) answered "yes," indicating the use of such an approach. In contrast, most respondents in Poland (78%) answered "no" (See Figure 19 for country-specific results).

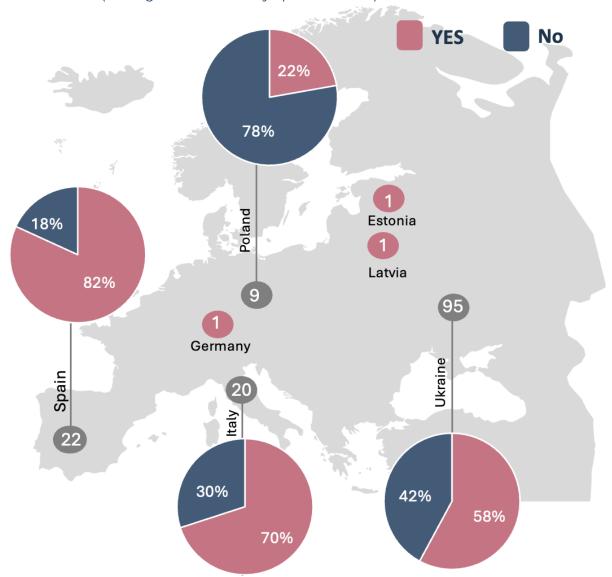


Figure 19: Is a person-centred approach used in services for individuals with mental health disorders in your country?

In **Ukraine**, respondents who selected "Yes" stated that a person-centered approach is partially used in Ukraine, depending on the service provider. This approach focuses on the individual's needs, active participation in treatment planning, respect for human rights, and support for independence. It includes social rehabilitation, individualized therapy plans,







psychological counselling, and scientifically based interventions such as CBT and psychotherapy. Programs like the First Lady's initiative and the "How are you?" program support this approach. Legal frameworks and resolutions guide the provision of social and medical services, ensuring dignity, inclusivity, and quality care for people with mental disorders across different levels of care. Respondents who selected "No" stated that the question was unclear and that they had no information.

In Spain, respondents who confirmed the use of a person-centred approach in mental health services described the following practices and frameworks: Continuity of care programs, especially for individuals with Severe Mental Disorder; use of advance directives documents in some autonomous communities; psychotherapeutic treatment plans and integrated care processes designed to provide individualized support; WHO QualityRights framework applied in certain services; Basque Country Health Plan 2030 and the Osakidetza Strategy emphasize person-centred approaches; Mental Health Plan of Cantabria; Individual treatment planning based on patient needs and available resources; Personalized care with case management; therapeutic plans shared with the patient or legal representative; implementation of individualized work plans, user satisfaction systems, and user-oriented care services. Two reponders provided the following link: Mental Plan Cantabria: https://scsalud.es/detalle/of /journal_content/56_INSTANCE_DETALLE/2162705/27233034

In **Italy**, respondents who selected YES explained that there is widespread recognition of the importance of personalized and shared care planning in mental health and social services, even though it is not always implemented in a routine or standardized way. Many responses confirm that patients and families are actively involved in the development of individualized therapeutic or rehabilitation plans (PTI, PTR, PTRI), with emphasis on the person's needs, expectations, and recovery goals. Several regions and services align with the Regional Health Plan provisions that institutionalize roles such as case managers, and they use structured tools (e.g., the Atlante portal) for registering shared, individualized care pathways. The Personalized Life Project (PDV) and laws such as Law 227, along with personalized PDTA models, reinforce this orientation. In complex cases, services adopt multidisciplinary approaches, and there is an emerging network-based model that connects formal, informal, institutional, and private actors. Some respondents also refer to initiatives like "Dopo di Noi" (After Us), indicating ongoing processes of planning for long-term care for persons with disabilities.

In **Poland**, respondents who selected YES explained that the person-centred approach is used in pilot Mental Health Centers; who selected NO specified that patient intake lasts just 15 minutes, most of which is spent entering data into the computer. The emphasis is on documentation, not on building a meaningful connection — something that takes both time and attention.

In **Germany**, the respondent selected "YES" and explained that a person-centered approach is generally applied in the care of individuals with mental illnesses. The specific needs, preferences, and goals of those affected are taken into consideration, and they are actively







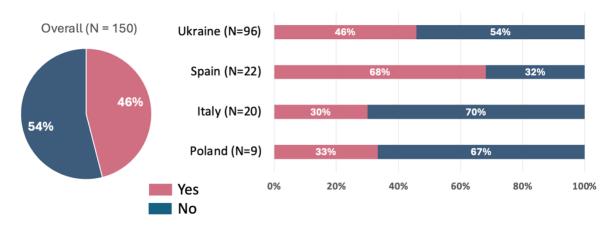
involved in planning their treatment and support. This approach is often facilitated by tools such as the Personal Budget, which helps tailor services to the individual.

In **Estonia**, the respondent described that several reforms are underway, focusing on strengthening the person-centered approach in health and social services.

In **Latvia**, the respondent who selected "Yes" explained that treatment is tailored to the individual needs of each patient.

When asked whether social prescribing is available as part of mental health services in their country, the majority of respondents overall answered "no" (54%).

However, in Spain, most respondents (68%) reported that social prescribing is available (See Figure 20 for country-specific results).



Countries with one survey	Latvia	Estonia	Germany
Yes			1
No	1	1	

Figure 20: Is social prescribing available as part of mental health services in your country?

In **Ukraine**, respondents who answered "Yes" indicated that referrals depend on the service provider's knowledge and needs of the patient. Referrals are made to mental health institutions, social services, and other support providers. Social referral is part of Ukraine's mental health reform and aims to engage individuals in social, cultural, and educational activities to improve quality of life. Referrals cover various services, including healthcare, protection, nutrition, education, social support, and financial assistance. Some mentioned community service maps and volunteer opportunities, while a few respondents had no information. Respondents who selected "No" indicated that, to their knowledge, there are no such referrals at the community level, and some reported having no information on the matter.







In **Spain**, respondents who confirmed the availability of social prescribing as part of mental health services highlighted the following: The Ministry's Localiza Salud Portal promotes social prescribing and the use of community health assets. In Cantabria, there is a Primary Care Program where all units are staffed by social services personnel integrated into primary care. Mental health professionals participate in an intersectoral commission between Health and Social Services to allocate social assistance to people with severe mental disorders. Social prescribing has been practiced for some time, although not always explicitly labeled as such ("sense posar-hi el nom de prescripció social"). This service is available within primary health care centers. Responders provided the following links:

- Social Prescription and Health Program: https://drogues.gencat.cat/ca/professionals/prevencio_de_trastorns_mentals/prsis/index.html
- Social Prescription and Health Program, Catalunia: https://drogues.gencat.cat/ca/professionals/prevencio_de_trastorns_mentals/prsis/index.html
- Primary Care Program in Cantabria: https://www.scsalud.es/cartera-de-servicios-qap

In **Italy**, respondents who answered YES explained that the concept of social prescribing appears to be relatively unknown or inconsistently applied across mental health services. While some professionals are unfamiliar with the term or have not encountered it directly, others describe practices that align with its principles, such as involving third-sector organizations, leveraging local community resources, and promoting individual well-being in non-clinical settings. There is acknowledgment that local municipalities sometimes cofinance care projects when beneficiaries lack sufficient personal resources. Formal tools such as the Multidisciplinary Evaluation Unit (UVM) and the involvement of social services by Community Mental Health Centers (CSM) are part of the integrated care approach. Although a formal social prescribing model is not yet structured in most regions, some mental health departments have begun implementing similar practices at the local level, reflecting the growing role of social and community networks in supporting mental health recovery.

In **Poland**, respondents who answered YES explained that social prescribing exists within pilot Mental Health Centers and certain NGO projects. Those who answered NO pointed out that, although it is widely recommended, there is little support for its implementation and no clear source of funding.

In **Germany**, the respondent answered NO, specifying that social prescribing is present just in some cases, supported by project funding (e.g. arts on prescription in Bremen).

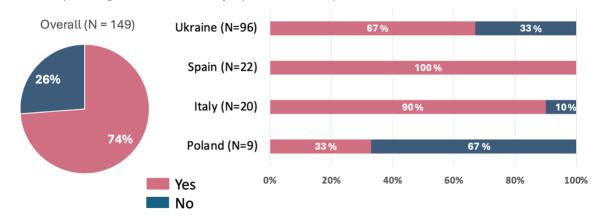
When asked whether a multiprofessional team is in place to assess psychosocial functioning and develop the care plan, the majority of respondents overall answered "yes"







(74%). However, in Poland, most respondents (67%) reported that such a team is not available (See Figure 21 for country-specific results).



Countries with one survey	Latvia	Estonia	Germany
Yes	1	1	1
No			

Figure 21: Is there a multiprofessional team in place to assess psychosocial functioning and develop the care plan?

In **Ukraine**, respondents who selected "Yes" reported that referral systems exist and involve psychiatrists, psychologists, nurses, mobile medical teams, outpatient multidisciplinary teams, psychiatric hospitals, and early intervention rehabilitation services for children. Some respondents, however, did not have detailed information. Respondents who selected "No" mostly indicated a lack of information or knowledge, with one mentioning a multidisciplinary team.

In **Spain**, respondents confirming the presence of multiprofessional teams to assess psychosocial functioning and develop care plans described: Process-based care specifically for Severe Mental Disorder; use of the PSI Program for individualized services; PIT (Individualized Treatment Plan) and commissions for severe mental disorders; A dedicated Commission for patients with Severe Mental Disorders. Teams include clinical, social, and educational professionals, working especially in cases of severe mental disorder. One responder provided the link to the PSI program: https://scientiasalut.gencat.cat/bitstream/handle/11351/3316/pla_serveis_individualitzats_psi.pdf?sequence=1&isAllowed=y

In **Poland**, respondents who selected YES explained that multiprofessional teams are present in the pilot Mental Health Centers. Such teams also exist in standard Mental Health Centers and, for children, as part of psychological-pedagogical assistance. However, while functional assessments often involve many specialists, the availability of professionals during the therapy phase is significantly more limited. It is similar in social assistance, particularly within the framework of the Blue Card Procedure. Those who selected NO, on

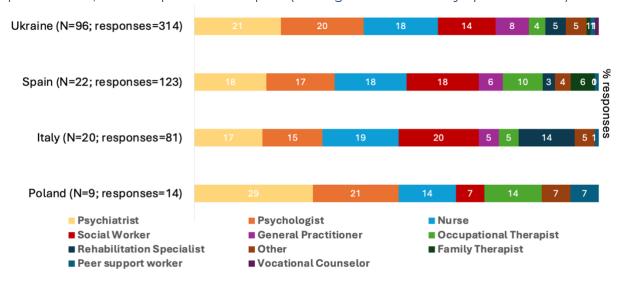




the other hand, noted that each institution tends to operate independently, and that GDPR regulations often discourage and hinder consistent collaboration.

In **Germany** the respondent selected "YES" and explained that multidisciplinary teams assess psychosocial functioning and develop the care plan, depending on the severity of the illness. This team often consists of psychiatrists, psychologists, social workers, nurses and therapists who work together to identify the needs of the affected person and plan individualized care (https://www.kbv.de/html/themen_58817.php).

When asked whether a multiprofessional team is in place to assess psychosocial functioning and develop the care plan, respondents who answered "yes" were then asked to indicate which professionals are part of the team. The most frequently selected professionals were psychiatrists, psychologists, nurses, and social workers. Less commonly included were family therapists, peer support workers, rehabilitation specialists, general practitioners, and occupational therapists (See Figure 22 for country-specific results).







Countries with one survey	Latvia	Estonia	Germany
Psychiatrist	1	1	1
Psychologist	1	1	1
Nurse	1	1	1
Social Worker	1	1	1
General Practitioner			In some cases
Occupational Therapist			1
Rehabilitation Specialist			In some cases
Other			In some cases
Family Therapist			In some cases
Peer support worker	1		In some cases
Vocational Counselor			In some cases

Figure 22: If you answered YES to the 6.3 question, which professionals are part of the team? Multiple selections were allowed.

In **Ukraine**, respondents who selected "Other" mostly reported not knowing or having no information about multidisciplinary teams. Some mentioned that such teams do not exist or are only available in non-psychiatric areas. A few specified other specialists like ergotherapists, physical therapists, anesthesiologists, oncologist-surgeons, or infectious disease specialists.

In **Spain**, respondents who selected "Other" described that team composition varies depending on the specific team. Roles mentioned include Social educator, Social Services staff from FAISEM and the Guardianship Board, Administrative personnel, Social integrator, Nursing Assistant (TCAE), Social Educator, and PSI professionals.

In **Italy**, respondents who selected "Other" described that peer support workers are currently being trained and are expected to join teams in the near future. In some cases, only a healthcare professional is involved, while others noted the absence of a formal multiprofessional evaluation team. Educators also play a role in these teams. However, there is a lack of clarity or consistency across services about the full range of professionals involved, reflecting possible regional differences or ongoing organizational developments.

In **Poland,** some respondents selected "other" and specify that teams do not exist.

In **Estonia,** the respondent specified that at the state level, collaboration between different care teams, as well as between support systems, is actively promoted.

The survey then asked which professional is usually identified as the case or care manager of the care plan. Overall, the majority of respondents indicated a health professional (60%),







followed by social workers (23%) and other roles (17%). This pattern was consistent across all countries (See Figure 23 for country-specific results).

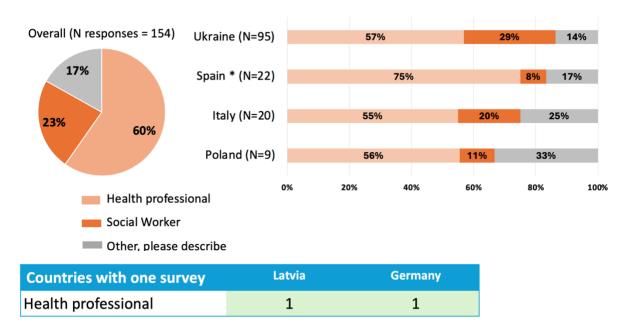


Figure 23: Who is the professional usually identified as case or care manager of the care plan?

In **Ukraine**, respondents who selected "Other" mostly indicated a lack of knowledge or information about professional competency requirements for these specialists. Several stated that there are no case managers or requirements in place, and some simply answered "no" or "none."

In **Spain**, respondents who selected "Other" described multidisciplinary teams working in an interdisciplinary way, where any professional can act as the case manager depending on the case.

In **Italy**, respondents who selected "Other" described the role of the case manager or the professional responsible for the care plan varies across services in Italy or the respondent's region. Often, the case manager is a professional educator (social health educator). It is mandatory to identify a "Program Responsible," which is chosen based on the treatment characteristics, the user's needs, or local organizational structure. Nurses sometimes fulfill this role, though some respondents report a lack of direct experience or note that this figure is not always present. In some cases, the case manager is identified on a case-by-case basis. Psychiatrists also occasionally serve as case managers.

In **Poland**, some respondents selected "other", specifying that the question is not applicable and that there are no professionals usually identified as case or care manager.

In **Germany**, the respondent selected Health professionals and described that these include psychiatric nurses, doctors (especially psychiatrists), psychotherapists or occupational







therapists who work in multi-professional teams. Moreover, in the community psychiatric sector or in social psychiatric services, social workers often take on case management, especially when it comes to social support, reintegration or help with coping with life. The respondent selected also "other" and specified that the specific responsibility depends on the organizational form of care (outpatient, inpatient, rehabilitative) as well as on the patient's individual needs planning. In the German healthcare system, there is not always a permanent case manager. Whether a case manager is involved depends on several factors: in standard outpatient care settings, such as treatment by psychiatrists or psychotherapists in private practice, case managers are typically not present; however, in more complex care models—like home treatment, social psychiatric services, or integrated care programs case management is often included; patients with severe mental illnesses, such as schizophrenia or bipolar disorder, are more likely to receive coordinated care involving a case manager, particularly within community psychiatric structures; availability also varies depending on financing and regional policies, with some health insurance providers or federal states offering specific programs that include case management, while in other areas it is not part of standard care; additionally, in institutional settings such as inpatient facilities, psychiatric outpatient clinics (PIA), or rehabilitation clinics, a permanent caregiver is often assigned to handle case coordination

In **Estonia**, the respondent described that the care manager is always a doctor responsible for overseeing the treatment process, while the case manager is usually a social worker but can also be a health professional, most often a nurse, who is part of the care team.

Finally, the section concluded by asking whether the multiprofessional assessment covers key areas such as health, housing, employment/training, social connections, and affectivity for individuals with mental health needs. Overall, the majority of respondents (63%) answered "yes." This was consistent across all countries, except for Poland, where 78% of respondents answered "no" (See Figure 24 for country-specific results).

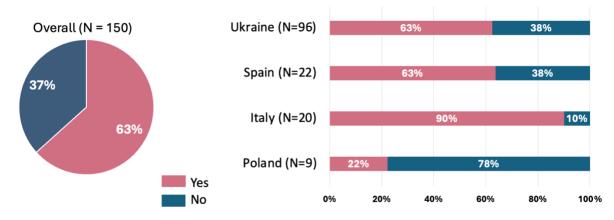


Figure 24: Does the multiprofessional assessment cover health, housing, employment/training, social connections, and affectivity for individuals with mental health needs?







PART 7. Local experiences on Personal Health Budget or health-social care integrated services

The section "Local Experiences on Personal Health Budgets or Health-Social Care Integrated Services" began by asking respondents whether, in the absence of national regulatory acts, there are any local projects or initiatives that use methodologies and/or tools to promote PHBs in their country. Overall, the majority of respondents (53%) answered "no."

However, in Spain and Italy, the most common response was "yes," with 71% and 80% respectively reporting the existence of such local experiences (See Figure 25 for country-specific results).

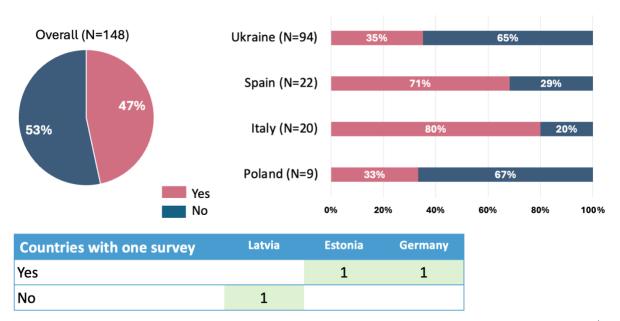


Figure 25: In the absence of the aforementioned regulatory acts, at a local level, are there any projects and/or experiences that utilize methodologies and/or tools to support the promotion of PHBs in your country?

In **Ukraine**, Respondents who answered "Yes" reported that psychiatrists are involved in determining patients' care plans. Various local projects support inclusive education and learning, using methodologies to promote business-oriented limited engagement in Ukraine. Social initiatives aim to improve the lives of people with disabilities or those requiring special support. In housing, projects focus on adapting living spaces to be accessible, including features like special lifts, accessible bathrooms, and ramps. Employment programs promote inclusion in the labor market through specialized training, adapted workplaces, retraining services, and collaboration with local employers and organizations. Education and training initiatives ensure access for people with disabilities via adapted programs, distance learning resources, and specialist support. Socialization projects create platforms for interaction between people with disabilities and the wider community, encouraging participation in cultural and sports events. Multidisciplinary





assessments are conducted by medical and social workers to evaluate needs and develop individualized support plans. Patient involvement in planning personal projects is a key element, ensuring that their interests and needs are prioritized in social service provision. Other responses mentioned multidisciplinary teams, the national "How are you?" program, and psychological support. Some respondents noted they lacked further information. Respondents who answered "No" indicated that they do not know or have no information on the topic.

In **Spain**, respondents who confirmed projects or experiences supporting the promotion of PHBs described local-level initiatives involving services, rehabilitation networks, family and patient associations, and the Spanish Network of Healthy Cities (RECS). Key actors include Mental Health Boards, Municipal Councils for Social Welfare, and NGOs. Examples include the INICIA Employment Project and coordination with school teams. Organizations like Aprodisca and Fundación Pere Mata promote patient integration using a biopsychosocial approach. Interventions focus on social determinants of health such as housing, employment, education/training, and socialization. Regular multidisciplinary assessments involve health and social professionals with active patient participation in intervention planning.

In **Italy**, respondents who confirmed projects or experiences supporting the promotion of PHBs specified that some regional health agencies have been applying Health Budgets since 2018, with plans for expansion. Regional laws and tools regulate the operation of Health Budgets, especially for personalized pathways in housing, employment, and social inclusion, particularly for users of semi-residential rehabilitation services. The approach is often based on professional experience and supported by innovative projects and technical working groups aimed at updating the Health Budget model. National laws, such as Law 227 and Decree 62 of 2024, provide a legal framework supporting these initiatives. Personalized therapeutic plans involve the active participation of patients in care planning, while legal guardianship applies only when the person cannot manage their own savings.

In **Poland**, respondents who confirmed projects or experiences supporting the promotion of PHBs specified that at the local level, NGOs and local governments carry out initiatives, such as those led by the Phoenix Association and within the framework of psychiatric reform and Mental Health Centers.

In **Germany**, the respondent confirmed projects or experiences supporting the promotion of PHBs, however, the concept of PHBs is not uniformly established nationwide. Since January 1, 2012, statutory health insurance funds have been allowed to offer additional, voluntary benefits beyond mandatory coverage—under names like health budget, health account, flexi-bonus, or health extra. These benefits vary in type, duration, and scope, depending on the individual policies of each insurance provider. The existence and structure of a personal health budget therefore depends on the individual health insurance company and is not available in a standardised form throughout Germany. Insured persons should contact their health insurance company directly to find out whether and to what extent such additional benefits are offered.

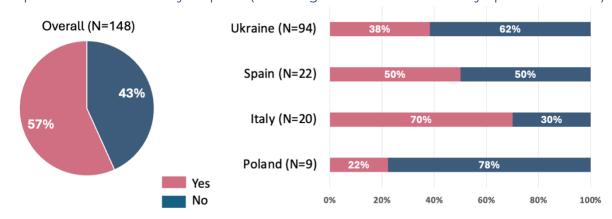






In **Estonia**, the respondent specified that at the local level, despite the absence of the aforementioned regulatory acts, there are projects and experiences that support the promotion of Personal Health Budgets (PHBs) through methodologies such as multidisciplinary assessments involving both health and social professionals in mental health case work, as well as active patient participation in project planning, supported by clearly described and disseminated care pathways.

When asked whether these projects and/or experiences are systematically implemented and dynamically updated, the majority of respondents overall answered "yes" (57%). In contrast, most respondents in Ukraine (62%) and Poland (78%) answered "no." In Spain, responses were evenly split (See Figure 26 for country-specific results).



Countries with one survey	Latvia	Estonia	Germany
Yes		1	
No	1		1

Figure 26: Are these projects and/or experiences systematically implemented and dynamically updated?

In **Germany**, the respondent who selected "No" explained that such projects and experiences are not always systematically implemented or regularly updated. While numerous local initiatives and pilot projects promote the Personal Health Budget (PHB) and the integration of health and social care, their implementation is often fragmented and inconsistent. These efforts frequently depend on regional circumstances, available resources, and the level of political support. As a result, there is no nationwide, standardised approach, and both adaptations and updates vary significantly across regions and institutions.





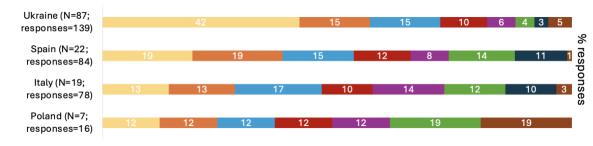
PART 8. Strengths and challenges

The final section of the survey asked respondents to identify and describe the strengths and challenges encountered in their country or regional experiences with Personal Health Budgets.

Regarding strengths, the most frequently cited across all countries—in Ukraine (42%), Spain (19%), Italy (13%), and Poland (12%)—was the improvement in clinical symptoms, overall outcomes, and reduced abandonment of therapeutic and rehabilitative pathways. In Italy, Spain, and Poland, however, other strengths were cited with similar frequency, including:

- Centrality of the individual, participation in the personal project, and increased autonomy for individuals with mental health disorders
- Active community involvement and support networks between public, private, and community sectors
- Support for families and their associations in the inclusion process
- Discharge of patients after years of institutionalization, reintegration into the community, and facilitated return to their homes
- Economic sustainability, reduced healthcare costs, and optimization of resources, including through community-based interventions
- A culture of deinstitutionalization and a shared commitment to resource reallocation

The least frequently mentioned strength was permanent placement in supported housing, ensuring a lifelong home, and improvement in family relationships without the burden of reintegration (See Figure 27 for country-specific results).



- Improvement in clinical symptoms, overall outcomes, and reduced abandonment in therapeutic and rehabilitative pathways
- Centrality of the individual, participation in the personal project, and increased autonomy for individuals with mental health disorders
- Active community involvement, support networks between public, private, and community sectors, and support for families and their associations in the inclusion
- process
 Discharge of patients after years of placement, reintegration into the community, and facilitated return to their homes
- Economic sustainability, reduction of healthcare costs, and optimization of resource use, including community-based interventions
- \blacksquare Culture of deinstitutionalization and shared commitment of resources
- Permanent placement in supported housing, ensuring a lifelong home, and improvement in family relationships without the burden of reintegration
- Other







Countries with one survey	Latvia	Germany
Improvement in clinical symptoms, overall outcomes, and reduced abandonment in therapeutic and rehabilitative pathways		1
Centrality of the individual, participation in the personal project, and increased autonomy for individuals with mental health disorders	1	1
Active community involvement, support networks between public, private, and community sectors, and support for families and their associations in the inclusion process		1
Discharge of patients after years of placement, reintegration into the community, and facilitated return to their homes		1
Economic sustainability, reduction of healthcare costs, and optimization of resource use, including community-based interventions		1
Culture of deinstitutionalization and shared commitment of resources		1
Permanent placement in supported housing, ensuring a lifelong home, and improvement in family relationships without the burden of reintegration		1
Other		

Figure 27: Please describe the strengths encountered in your Country/Regional experiences on Personal Health budget by selecting the applicable options, and feel free to add any additional details in the open-ended response box.

In **Ukraine**, respondents who selected "Other" mostly reported no information, lack of experience in their region, or simply did not know or have relevant details.

In **Spain**, respondents who selected "Other" reported the longstanding existence of a broad, public, universal, and accessible network.

In **Italy**, respondents who selected "Other" reported the initiation of supported cohabitation pathways in collaboration with the third sector. Additionally, some projects have focused on property scouting to facilitate housing solutions. However, some respondents noted that such initiatives are not present in their areas.

In **Poland**, respondents who selected "other" reported that some NGOs, such as the Phoenix Association in Kołobrzeg County, run comprehensive community-based psychiatry programs, but these remain isolated initiatives and do not represent a systemic solution. In many areas, such programs are likely nonexistent.

In **Estonia**, the respondent specified that he has no experience on Personal Health Budget.

Regarding challenges, the most frequently cited across most countries—particularly in Ukraine (28%), Spain (24%), and Italy (18%)—was the scarcity of economic resources and limited professional and human resources. Other challenges were reported with similar frequency across countries, including:

• Difficulty in finding appropriate living arrangements and a lack of concrete sociohealth integration

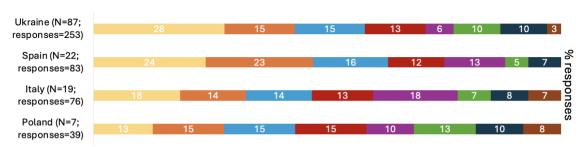






- Poor coordination among the structures involved, limited collaboration within networks, and challenges in service integration
- Social stigma and exclusion, along with a lack of adequate employment or training opportunities
- The cultural shift required to implement integrated and personalized care pathways

The least frequently mentioned challenges were: lack of practical implementation, administrative hurdles, insufficient hands-on experience, and difficulty in interfacing with local authorities and limited professional training opportunities (See Figure 28 for country-specific results).



- Scarcity of economic resources and limited professional and human resources
- Challenges in finding appropriate living arrangements and lack of concrete socio-health integration
- Poor coordination of efforts among the structures involved in the process, and challenges in working as a network and integrating services
- Social stigma and exclusion, and lack of adequate work/training opportunities
- Cultural change required to experiment with integrated and personalized pathways
- Lack of factual implementation, administrative difficulties, and lack of practical experience
- Difficulty interfacing with local authorities and limited professional training
- Other

Countries with one survey	Latvia	Germany
Scarcity of economic resources and limited professional and human resources	1	1
Challenges in finding appropriate living arrangements and lack of concrete socio-health integration	1	
Poor coordination of efforts among the structures involved in the process, and challenges in working as a network and integrating services	1	1
Social stigma and exclusion, and lack of adequate work/training opportunities	1	
Cultural change required to experiment with integrated and personalized pathways	1	1
Lack of factual implementation, administrative difficulties, and lack of practical experience	1	1
Difficulty interfacing with local authorities and limited professional training	1	
Other		

Figure 28: Please describe the challenges encountered in your Country/Regional experiences on Personal Health budget by selecting the applicable options, and feel free to add any additional details in the open-ended response box.

In **Ukraine**, respondents who selected "Other" highlighted that in their country, about one-third of the population—internally displaced persons living in poverty—face negative social and living conditions. People with mental disorders often remain overlooked by the state despite allocated funding for their treatment. Returning to adverse social environments







frequently causes relapses. Many respondents also reported having no information, no experience in their region, or simply did not know.

In **Italy**, the respondents who selected "other" included difficulties in reducing inequalities in access to various services and ensuring equitable rehabilitation and social opportunities across all territories. There are also issues with coordination between health services and local authorities. Administrative burdens on already understaffed organizations are significant, sometimes leading services to focus more on budget management than on core therapeutic functions such as individual psychotherapy and medical interventions. Additional problems include disorganized financial accounting and general administrative difficulties. Some respondents noted that challenges are not present in their context.

In **Poland**, the respondents who selected "other" described that the main challenges include centralized policies that hinder effective solutions, lack of proper legislation and inter-ministerial cooperation, insufficient financial resources, and gaps in patient rights, housing, and supported employment. Additionally, there is no clear vision or roadmap with defined success indicators

In **Estonia**, the respondent specified that he has no experience on Personal Health Budget.

Changes and suggestions

In **Ukraine**, when participants were asked "What changes are necessary in policies and services to achieve a personalized health budget?", responded:

- Improve and increase funding for mental health services
- Change the approach to treating individuals with mental illnesses
- Complete review and modernization of social rehabilitation programs
- Reform the model of integrated medical and social assistance
- Raise the status and training of mental health professionals
- Develop and enforce regulatory acts with effective state-level oversight
- Adopt adequate budgets and implement changes in local governance
- Implement an insurance-based healthcare model
- Strengthen coordination between healthcare institutions, local communities, and NGOs
- Ensure financial sustainability at both state and local levels
- Emphasize practical training over theoretical education
- Integrate social and medical services at local and regional levels
- Address the individual needs of each patient
- Create conditions for education, employment, and social integration of patients
- Promote autonomy and active participation of individuals in their care plans
- Increase the number of qualified specialists and improve resource allocation
- Involve community budgets and off-budget funding sources
- Strengthen infrastructure and material resources of psychiatric institutions







- Develop sustainable programs with long-term budget planning
- Introduce mandatory insurance coverage for mental health care
- Increase quantity and quality of services for people with disabilities
- Create clear "roadmaps" to facilitate access to social, psychological, and healthcare services
- Improve interaction between different levels of care and government bodies
- Adopt gradual and adaptive solutions to ongoing sector challenges

In Ukraine, when participants were asked "What suggestions do you have for its implementation?" responded:

- Ensure adequate and fair distribution of finances among service providers
- Implement mechanisms to monitor availability, quality, and client feedback for medical services
- Grant greater authority and independence to healthcare institutions
- Adopt city budgets that include mental health programs
- Introduce compulsory health insurance
- Secure sufficient funding to maintain psychiatric care institutions
- Coordinate all services with increased funding
- Focus on socialization, employment, and stigma reduction for people with mental disorders
- Actively involve community funds and improve collaboration with local government bodies
- Improve qualifications of specialists and increase funding for training and personal healthcare budgets
- Develop clear funding sources and mechanisms for local fund distribution
- Support coordinated interaction between government, private sector, public organizations, and local authorities
- Promote community involvement to reduce isolation and stigma
- Provide gradual psychoeducation and solve personnel/material challenges in psychosocial services
- Introduce psychologists or psychotherapists at the primary care level
- Develop national and local healthcare programs, implemented at the selfgovernment level
- Make services accessible when needed and improve coordination across mental health care levels
- Offer motivational incentives and qualification enhancement for healthcare workers
- Attract investments and charitable funds to ensure fair salaries and improve material resources
- Allocate funds for mental health protection and medication treatment programs
- Review and expand health insurance packages and psychiatric services in general hospitals
- Foster active community involvement and support networks across sectors
- Coordinate efforts among different structures and integrate services effectively







- Develop communication strategies to inform clients and providers about available social and psychological support
- Create electronic databases of vulnerable citizens to assess individual needs
- Establish mutual aid groups as part of social services
- Implement a personal healthcare budget system (OBOZ) through stages: analysis, legal framework, pilot testing, evaluation, scaling, training, monitoring, and continuous improvement
- Eliminate paid services in mental health care and expand free medication availability nationwide
- Expand specialized institutions for people with mental disorders, including shared living and geriatric facilities
- Enforce strict control over the distribution and use of funds

In **Spain**, when participants were asked "What changes are necessary in policies and services to achieve a personalized health budget?", responded:

- A cultural and model shift is needed to promote greater autonomy for people with mental health issues, along with regulatory changes.
- Population needs must be accurately assessed, including socioeconomic factors, not just population size.
- Develop a clear Mental Health Care Policy and Strategy.
- Address shortages in financial and professional resources, improve coordination between services, expand housing options, and combat social stigma.
- Adopt a citizen-centered approach with active involvement of individuals and their families in decision-making.
- Health and social services should share budgets and jointly develop policies.
- Increase funding to ensure stability for people with severe mental disorders (SMD).
- Boost mental health resources, improve staff ratios, and dedicate more resources to child and adolescent psychiatry.
- Improve integration between social services, addiction networks, justice, and mental health systems.
- Reduce bureaucracy and invest in better-trained professionals and more resources to support patients effectively.
- Establish funding systems focused on effective, efficient resources rather than onesize-fits-all solutions.
- Streamline administrative structures with clear, uniform objectives across services.
- Larger budgets are needed to hire doctors, nurses, social workers, facilitators, occupational therapists, and rehabilitation staff to help patients regain daily living skills.

In Spain, when participants were asked "What suggestions do you have for its implementation?" responded:

- Properly assess population needs, considering socioeconomic factors, not just population size.
- Develop a clear Mental Health Care Policy and Strategy.







- Adopt a citizen-centered approach with active involvement of affected individuals and their families in decision-making.
- Improve coordination between health and social services; budgets and policies should be shared and created jointly.
- Implement personalized care plans.
- Increase financial and human resources, especially for people with severe mental disorders (SMD).
- Improve staff ratios, including nurses and psychologists, and create dedicated child and adolescent psychiatry units.
- Enhance integration between social services, addiction networks, justice system, and mental health services.
- Reduce bureaucracy and provide better-trained professionals with adequate resources.
- Allocate resources also to combat stigma and improve practices.
- Establish funding systems that prioritize effectiveness and efficiency over one-sizefits-all solutions.
- Streamline administrative structures with unified rules and objectives across services.

In **Italy**, when participants were asked "What changes are necessary in policies and services to achieve a personalized health budget?", responded that to successfully implement the personalized Health Budget, it is necessary to make it the standard mode of intervention and enhance coordination among various services. This includes improving social and healthcare integration, strengthening collaboration with the third sector, and expanding inclusive opportunities across all territories. Supporting families and promoting domiciliary care are key priorities. A well-connected territorial network is essential to foster autonomy and active citizenship. Financial and administrative resources from local entities need to increase, as many budgets rely heavily on healthcare funds. Simplification of procedures and reducing the burden on overstretched health services are also crucial. Cultural and administrative changes, alongside shared responsibility and multidisciplinary cooperation with users and communities, must be promoted. Additional trained personnel and economic resources are needed to improve housing and employment opportunities. Finally, improving network work and integrating services, including affordable psychotherapy options, will support users more effectively.

In Italy, when participants were asked "What suggestions do you have for its implementation?" responded that to implement the personalized Health Budget effectively, it should become the standard mode of intervention supported by clear guidelines and strong collaboration among local health departments (DDSM), municipalities, social services, and the third sector. Establishing a common fund between health authorities and local entities dedicated to social inclusion is essential. Extending projects through dedicated meetings with municipalities and social cooperatives can enhance opportunities for users. Adequate investment in healthcare and social personnel, with decent contracts, is crucial. Continuous joint training and application of third-sector regulations should be promoted. National legislative changes and increased economic support for people with disabilities are necessary to ensure dignified futures. Creating







multidisciplinary teams for continuity and personalized care, along with long-term action plans and better socio-health integration, will improve outcomes. Emphasis on community involvement to reduce stigma and enhanced communication and coordination among operators are also key.

In **Poland**, when participants were asked "What changes are necessary in policies and services to achieve a personalized health budget?", responded that achieving a personalized health budget requires the active involvement of all stakeholders, the adoption of a recovery-oriented approach, ongoing community-based psychiatric reforms, legal amendments, patient destigmatization, and systemic changes in psychiatric care, addiction treatment, and social security coordination. In particular, the necessary changes are:

- Increase psychiatry funding to 7%.
- Enact legislation to coordinate social assistance, healthcare, and employment sectors.
- Adopt a new state and political approach to mental health treatment and rehabilitation, addressing the current lack of knowledge, empathy, and interest among politicians.
- Reform the National Health Fund's approach, moving away from the fee-for-service model, which has hindered funding for key populations, as seen in the pilot project.
- Additionally, improvements in vision, organizational capacity, IT systems, and evaluation are essential (not applicable to the Prison Service.)

In Poland, when participants were asked "What suggestions do you have for its implementation?" responded:

- The National Health Fund (NFZ) should not have a dominant or decisive role in shaping mental health policy. Instead, solutions should be developed jointly and through participatory processes
- There is a need to raise public awareness about mental health issues and to ensure adequate financial resources to support necessary changes. Funding should come from both the Ministry of Health and the NFZ, in a coordinated and transparent manner.
- While systemic changes are urgently needed, it is essential to respect the conditions tied to funding, particularly regarding its intended purposes, such as health protection and social security.
- There must be greater trust from decision-makers and politicians toward the group of dedicated experts who have long advocated for reform in both child and adolescent psychiatry as well as adult psychiatry. These professionals have worked for years to transform a flawed system by promoting community-based psychiatric care with territorial responsibility. Their approach prioritizes patients' subjectivity and recovery, supporting reintegration into work, family, and community life, rather than limiting care to isolated medical services like doctor appointments or prescriptions. Unfortunately, the payer (NFZ) continues to misunderstand the nature of mental illness, recovery, and the core principles of Mental Health Centers.
- Effective reform requires cooperation across all levels—central, regional, and local—as well as interdepartmental collaboration. This is necessary to build local strategies that







integrate healthcare, social services, and employment support. Achieving this goal also depends on appropriate legislation and strong political will.

- The implementation of an IT system with clear success indicators is necessary to monitor progress and evaluate the effectiveness of the reform.
- These points are not applicable to the Prison Service (SW).

Additional information

In **Ukraine**, the following additional information were reported:

- The government should completely review the funding model for psychiatric services.
- Narcological services should be reinstated as a separate specialized field.
- Funding psychiatric institutions through medical guarantee programs based on service volume is inadequate due to the long-term nature of mental illnesses, causing underfunding.
- State bodies, social services, and local governments often formally neglect issues faced by people with mental illnesses.
- Psychiatric reform led to the cessation of narcological services, resulting in inadequate addiction treatment and frequent patient relapses.
- Psychiatric care should be funded exclusively through state subsidies, independent
 of the National Health Service, and coordinated closely with social and rehabilitation
 services and government authorities.
- Increase financial support and longstanding allowances for psychiatric specialists.
- Implement preventive measures for psychiatric professionals to avoid burnout syndrome.
- Wartime conditions have drastically increased mental health issues, making these reforms urgent.
- Autonomous mental and psychiatric health services and institutions are necessary due to healthcare workload.
- The country's current war situation severely impacts mental health, a factor considered in related surveys.
- The personal healthcare budget should be developed at both state and community levels; currently, civil society addresses these gaps but on a small scale.
- Improve the financial situation of hospitals and ensure fair salaries for healthcare workers.
- Many organizational issues in psychiatric care exist but are beyond the scope of this survey
- Some respondents expressed no comments, questions, or information on the topic but recognize its importance.

In **Spain**, the following additional information were reported:







- Mental health requires more resources to achieve deinstitutionalization and provide adequate support.
- Many people with severe mental disorders (SMD), often combined with substance
 use, are homeless and underserved because many services exclude those with
 substance use issues.
- The system forces patients to adapt, rather than adapting to their needs.
- There is a critical shortage of staff, with many professionals nearing retirement and no effective generational replacement or workload reduction despite high demand and absenteeism.
- Lack of planning in the pension system threatens the well-being of vulnerable populations who have contributed for decades.

In **Italy**, the following additional information were reported:

- the Health Budget is primarily a cultural approach.
- Implementation requires training, commitment, and new procedures to ensure these pathways become effective, often more so than many other mental health treatments.
- Disability must be supported and valued to promote social inclusion and equal acceptance. These cultural and systemic changes are essential to enhance the quality of life and autonomy of individuals with mental health conditions.

In **Poland**, the following additional information were reported:

- Who will take on the coordinating role at the government level to ensure that the respective ministries cooperate with each other?
- When will the Mental Health Centers receive the regulations that will allow them to function properly?
- When will mechanisms for substantive, financial, and social control be established to prevent distortions and superficial actions in some Mental Health Centers?
- It is crucial to establish a National Center for Psychiatry in Poland. This institution would play a central role in overseeing the implementation of mental health reform across the country, supporting the creation and organization of Mental Health Centers in areas not yet covered by the pilot program—which currently includes only about 50% of the population—and ensuring the overall quality, consistency, and effectiveness of the services provided by coordinated Mental Health Centers.
- At present, there is a significant lack of mental health administration at the municipal, county, and provincial levels. The absence of these structures hinders the ability to plan, coordinate, and evaluate services locally. Strengthening local administration is essential to build integrated systems that connect health care, social services, employment support, and non-governmental organizations. Such coordination is key to ensuring that individuals affected by mental illness or psychological crisis are treated with dignity and provided with care that is truly responsive to their individual needs.
- Another pressing issue is the insufficient availability of training facilities for mental health professionals. There is a particular need to expand education and certification







- programs for recovery assistants and community therapists, who are vital to delivering effective community-based care.
- Mental health care in correctional facilities is provided by the Prison Health Service, which offers both outpatient and inpatient services to individuals deprived of liberty.
 These services are funded and overseen by the Ministry of Justice.

In **Germany**, the participant described many critical issues about the implementation of personalised health budget and many necessary actions for change. In fact, the use of PHB in Germany is very inconsistent as the services that can be provided with it and the implementation varies greatly from place to place. It could be important to show those affected the options they have with PHB and, if necessary, to support them in utilising them. The suggestions and the considerations provided are listed below:

1. Integration of services

In Germany, the healthcare system is often marked by siloed structures that treat sectors such as health, social services, and employment separately. Integrating these areas is a key strategy for improving the quality of care. Research on integrated care systems — for example, through the Federal Ministry of Health's "Integrated Care" project — highlights the need for collaboration between different professions and institutions in order to effectively address patients' individual needs (Federal Centre for Health Education, 2020).

2. Increased funding and resource distribution

A personalized health budget requires a redistribution and reorganisation of healthcare resources. In countries like the UK, individual budgets have proven to be a cost-effective and patient-centred alternative to traditional care systems (NHS England, 2019). Similarly, several German research reports on healthcare have highlighted the need to allocate more resources to community-based care models, pointing out the current lack of flexible funding within the existing infrastructure (Schwabe et al., 2021)

3. Flexible and personalised budget models

Policy and organisational flexibility are required to realise the potential of personal health budgets. In countries with personal health budget models (e.g. the UK), flexibility and patient control have been found to lead to better outcomes, particularly in mental health care (NHS England, 2019). Efforts are also being made in Germany to integrate more flexibility into healthcare, for example through the 'Health Regions of the Future' pilot project, which aims to investigate the regional use of health budgets (Federal Ministry of Health, 2022).

4. Training and further education for professionals

The implementation of a personal health budget model requires well-trained staff who are able to deal with flexible and individualised budgets. Studies and international comparisons, especially in countries with personal health budget models such as the UK, have shown that comprehensive training of professionals is necessary to provide optimal support to patients (NHS England, 2019). In Germany, there are already programmes for the further training of professionals in the field of mental health, but these would need to be further expanded to meet the specific requirements of the Personal Health Budget (Deutsche Gesellschaft für Psychiatrie, 2021).

5. Reduction of bureaucratic hurdles







Reducing bureaucracy is a frequently discussed topic in Germany, particularly in the context of healthcare. Many patients, especially in the field of mental health, report difficulties in accessing services due to complicated application procedures and bureaucratic hurdles. The introduction of digital platforms for the management of personal health budgets is a solution that has been successfully trialled in other countries (e.g. NHS Digital, 2019).

6. Combating social stigmatisation

Combating stigmatisation and promoting social participation are of crucial importance in mental health care. Policy measures aimed at reducing prejudice and discrimination are essential to promote social inclusion. International studies and programmes, such as the Social Inclusion Programme in the UK, show that an inclusive approach not only improves individual quality of life, but also contributes to better use of healthcare budgets (World Health Organization, 2020).

7. Cultural change in healthcare

A cultural shift towards patient-centred care is needed to meet the needs of people with mental illness. Studies show that such a change can lead to better treatment outcomes and higher patient satisfaction (World Health Organisation, 2020). In Germany, there are initial approaches to promoting patient-centred care, but these need to be further strengthened. Bibliography

- Bundeszentrale für gesundheitliche Aufklärung (BZgA), "Digitalisierung im Gesundheitswesen", 2020.
- Schwabe, C., et al., "Herausforderungen der Gesundheitsversorgung in Deutschland", 2021.
- NHS England, "Personal Health Budgets: A Review of the Evidence", 2019.
- World Health Organization, "Social Inclusion and Mental Health", 2020.
- Bundesministerium für Gesundheit, "Gesundheitsregionen der Zukunft", 2022

Final suggestions for implementing the PHB in Germany provided are: increase funding and staffing in this area, and ensure greater transparency for stakeholders regarding how the funds can be used—providing support where needed to help them access and manage these resources effectively.







5.4.2 Definition of an integrated care pathway shared among EU Member States

Based on data gathered by D.5.4.1, the essential elements of the integrated care pathway in mental health (MH) will be detailed involving: 1. members of the multidisciplinary team for the initial assessment of the current situation in the country that considers implementing an integrated care pathway; 2. Diagnostic/screening tools and questionnaires to evaluate clinical and personal outcomes; 3. standardized format for the planning and monitoring of the integrated social-health interventions. The guidance document defined will be posted on the Joint Action (JA) website to invite for feedback and suggestions from stakeholders such as MH clinical centers, people with lived experience (PLE), NGOs, municipalities, etc. All feedback will be reviewed by the Panel for potential modifications, leading to the finalization of the document. The finalized document will be translated into all the different European languages for broader accessibility and understanding.

Synergies

The collaborative development of the Survey on Defining an Integrated Care Pathway for Promoting Social Inclusion and Quality of Life of People with Mental Health Disorders (Subtask 5.4.1) has fostered valuable synergies among project partners and external stakeholders.

1. Cross-Country Exchange of Best Practices

The biweekly meetings and continuous discussions have facilitated the exchange of national and regional policies, guidelines, and strategies related to integrated mental health care. This has strengthened mutual learning and informed the survey's content with diverse perspectives, ensuring its relevance across different healthcare systems.

2. Interdisciplinary Collaboration

The involvement of Ministries, public agencies, mental health services, social welfare and labour sectors, individuals with lived experience, and third-sector organizations (NGOs, volunteer groups, and non-profits) has reinforced a multisectoral approach.

3. Use of Existing Resources and Tools

ISS translated and shared the "Strategic Guidelines: Designing the Health Budget with a Person-Centered Approach", which has provided additional methodological guidance for shaping the survey. The use of LimeSurvey, a licensed ISS tool, has ensured efficient and secure data collection.

4. Strengthened Networks for Future Actions

The survey dissemination process has reinforced connections between different institutions and stakeholders, laying the groundwork for future collaborations beyond the project's initial scope. These relationships are expected to facilitate future joint







initiatives, policy developments, and research on integrated care pathways and social inclusion strategies.

5. Alignment with Policy and Research Frameworks

The collected data will contribute not only to the project deliverables but also to broader European and national policy discussions on mental health service improvement, social inclusion, and integrated care models. The knowledge gained through this initiative aligns with existing EU frameworks and could serve as a reference for future research and policy recommendations.

These synergies, both planned and unforeseen, have enhanced the overall impact of the project, promoting a coordinated and sustainable approach to mental health care at national and international levels.





Template 1: Strategic Guidelines: Designing the Health Budget with a Person-Centered Approach

Presidency of the Council of Ministers Unified Conference

Agreement, pursuant to Article 8, paragraph 6, of Law No. 131 of June 5, 2003, between the Government, the Regions, and Local Authorities on the document titled "Strategic Guidelines: Designing the Health Budget with a Person-Centered Approach – Proposal of Qualifying Elements."

Record of Acts No. 104/CU of July 6, 2022

STRATEGIC GUIDELINES: DESIGNING THE HEALTH BUDGET WITH PERSON-CENTERED APPROACH

PREMISE

Mental health is a primary objective of the National Health Service, with the main goal of a modern and effective healthcare system being to identify the most efficient methodologies and tools possible.

Proper management of severe mental disorders also results in a substantial reduction of the social and economic impact these disorders impose on the system.

Scientific evidence demonstrates the importance of ensuring adequate interventions within community settings for people with severe mental disorders. This approach prevents unnecessary hospitalizations and institutionalization, which are often not effective in resolving issues, especially if prolonged over time. To effectively respond to the complexity of mental health care, it is essential to create structural conditions and innovative contexts that integrate healthcare policies and resources with those from social and community services.

In this perspective, the capacity of a community to provide responses that integrate healthcare needs with educational, employment, housing, and community engagement needs is essential. Experimenting with integrated and personalized social inclusion paths for people with severe mental disorders, often marginalized in the labor, housing, and socio-cultural markets, is a priority.

Integrated social and healthcare interventions are regulated by the DPCM of January 12, 2017, in articles 24, 25, 26, 27, 28, 57, and 60, along with current legislation on Essential Levels of Social Services - LEPS (Law 328/2000; National Plan of Social Interventions and Services 2021-2023 - adopted by inter-ministerial decree on October 22, 2021; Plan for Poverty Alleviation Interventions and Social Services 2021/2023 - adopted by inter-ministerial decree on December 30, 2021; Law 234 of December 30, 2021, "State Budget for Fiscal Year 2022 and Multi-Year Budget for 2022-2024" art. 7, paragraphs 159-171) covering assistance for minors with neuropsychiatric disorders, people with mental disorders, disabilities, addictions, HIV/AIDS, and autism spectrum disorders. These are enforceable rights for citizens, aiming to recover and/or maintain and enhance individual autonomy, counter institutionalization and segregation, and avoid transferring care responsibilities to third parties, promoting personal and community engagement.

In recent years, growing interest has focused on territorial integration experiences conducted through the "Health Budget" (BdS) organizational model, one of the most





advanced and innovative proposals for integrating healthcare with community systems in mental health across Italy.

The Health Budget combines economic, professional, human, and relational resources needed to foster supportive relational, family, and social contexts that enhance social inclusion. It is a generative tool supporting personalized Life Projects that guarantee the right to health through highly integrated and flexible social and healthcare interventions. The model also transforms the service network, guiding resource reallocation, countering new forms of institutionalization, and identifying social-economic and housing inclusion opportunities.

The Health Budget model is now expanding across Italian regions, albeit unevenly, with experiences differing in technical, professional, administrative aspects, financing methods, experimentation volume, and duration.

The Ministry of Health is tasked with actively collaborating with the Regions and Autonomous Provinces, along with their respective organizational structures, to enhance intervention models that have proven effective in specific territorial contexts, with the goal of making them transferable to a broader range of regional areas. On this topic, the Directorate General for Health Prevention of the Ministry of Health funded, in November 2019, within the expenses for programming and surveillance activities to protect human health, the project "Subject, Person, Citizen: Promoting Well-being and Social Inclusion of People with Mental Disorders through the Health Budget." The aim was to enhance the Health Budget model already implemented by several Regions. Among them, Emilia-Romagna has initiated a specific pilot project and a training pathway for all operators, with various roles, who will be involved in incorporating these practices into everyday operations. The project proposal responded to the need to map various regional/provincial experiences and to propose national guidelines or recommendations to support the Regions and Autonomous Provinces in adopting the model.

All Regions and Autonomous Provinces participated in the project, with an in-depth comparison of their experiences, leading to a unified approach through a dedicated Consensus Conference. This process resulted in the development of national guidelines and recommendations to support the model's implementation across different Regions and Autonomous Provinces. This elaboration involved all stakeholders, including individuals, families and their associations, Social and Health Services, the Third Sector, volunteer organizations, and civil society representatives.

The Project and the Health Budget (HB) model were also the focus of one of the thematic sessions at the 2nd National Conference on Mental Health – For Community Mental Health – held on June 25 and 26, titled "Work, Housing, Support for Independent Living: Actors and Tools for Social Inclusion."

The aforementioned Conference provided an opportunity to reaffirm the commitment of the Ministry of Health to promote and revitalize territorial assistance for mental health, adopting the community as a reference framework, protecting human rights and the dignity of people suffering from mental health issues, encouraging inclusive and participatory care wherever possible, and improving the quality and safety of services for the benefit of patients, their families, and service providers.

The present strategic guidelines can be considered applicable, with specific adaptations and appropriate adjustments, to all projects aimed at individuals with complex social and healthcare needs, for whom empowering and developmental interventions are appropriate.





EXPERIENCES WITH THE HEALTH BUDGET METHODOLOGY

To introduce the topic, a review of international literature was conducted, and documentation from the Regions and Autonomous Provinces was collected to identify "Best Practices" in preparation for a national Consensus Conference.

The systematic review of international literature identified 31 publications related to the Health Budget in mental health contexts, from both qualitative and quantitative perspectives. It summarized recent evidence on interventions, outcomes, and costeffectiveness of the Health Budget for individuals with mental health disorders. Of the 31 international studies selected, involving approximately 11,825 users, family members, and professionals, 6 studies were conducted in Italy between April 2013 and September 2021. The studies included in the systematic review reveal certain limitations that make it challenging to generalize the results. First, the distribution of countries among the studies is only representative of the Western world. Additionally, comparing Health Budgets across countries is complicated due to the significant differences in their respective healthcare systems. Second, many studies have small sample sizes, predominantly qualitative designs, do not use validated tools to measure outcomes, and the quality of the studies is not always satisfactory. Third, the samples in the included studies are not always representative of the studied population and often lack a comprehensive description of patient phenotypes. Finally, information on the economic resources used in the Health Budget is frequently omitted. Taking these limitations into account, we can draw some general conclusions. Positive outcomes for individuals with mental health disorders using the Health Budget have been confirmed, particularly in terms of patient choice and control over their recovery pathway. The use of the Health Budget for these individuals has shown various benefits, including patient empowerment, increased stakeholder engagement, involvement of care providers and staff in defining the Health Budget, and timely and appropriate access to treatment. Additionally, several studies have indicated that users have expressed satisfaction with the implementation of the Health Budgets.

Moreover, the Health Budget has improved clinical outcomes for users, quality of life, engagement in paid work, and experiences in employment and independent living, with positive effects extending to the entire family and support network. Evidence has shown that the Health Budget has led to significant changes in resource utilization and personalized intervention approaches, resulting in cost savings for families and National Health Systems. However, concerns about the application of the Health Budget were raised in several studies. Families found the management and procedures of the Health Budget challenging and stressful, as well as its implementation with professionals, leading them to feel less involved in their loved one's care. In some studies, professionals viewed the management of the Health Budget as an additional burden in their work.

The wealth of experiences has highlighted diverse practices and conceptions of the Health Budget, reflecting the cultures and needs of local contexts and historically developed processes, particularly regarding mental health in relation to the closure of psychiatric hospitals. However, from the mapped experiences, the need to promote the Health Budget model has emerged to facilitate cross-cutting organizational changes in welfare services. From a regulatory perspective, the need has also emerged to coordinate and integrate the provisions of the Public Procurement Code and the Third Sector Code with administrative practices capable of achieving the objectives of the Health Budget. Healthcare and social

practices should be flexible and allow for the reconfiguration of services to enhance





personalization, enabling risk/benefit assessments and the innovative use of resources from services and the community, centered on the individual.

Therefore, it is essential to define administrative procedures that enable flexibility and innovation in the application of this model. The project strategy is thus aimed at making the Health Budget increasingly clear and established within service practices, promoting its use and appropriate application at the regional level.

Below are the qualifying elements, all of which must coexist to define the Health Budget, along with the operational elements, which include appropriate administrative pathways and tools. These two areas must proceed in tandem. To ensure unity in the process and full implementation of Health Budget pathways, it is necessary to create convergence points between the clinical-care and administrative components.

QUALIFYING ELEMENTS

The Health Budget targets individuals managed by the network of territorial health services who have complex social and healthcare needs. At the heart of the Health Budget is the individual, viewed within their community context and considered in the full scope of their resources, social and healthcare needs, relationships, and goals, with respect to which they can exercise their right to self-determination. The Health Budget supports individualized projects aimed at promoting the individual's residence in their chosen home, involving various community stakeholders.

The Health Budget is publicly governed and coordinated to ensure true social-healthcare integration. The request to activate the Health Budget, which can also be initiated by the individual and/or their legal representative, must be made by a healthcare, social-healthcare, or social services professional responsible for the case. It aims to empower individuals, fully implementing their rights and upholding their civic responsibilities.

The social component ensures the rights and duties of citizenship, while the healthcare component upholds the right to health, and both contribute to the right to empowerment. Each service adheres to its own regulations to deliver interventions. The social-healthcare team, comprising at least one healthcare, social-healthcare, and social professional, must include input from the individual, any appointed legal guardian according to their mandate, and, upon the individual's request, relevant persons. The social-healthcare team, composed of at least one healthcare, social-healthcare, and social professional, must include input from the individual, any appointed guardian as per their mandate, and, at the individual's request, other significant persons. This setup ensures that the individual actively participates in assessing needs and resources and exercises their right to self-determination in shared care and the definition of their life project, where they can consciously invest their resources, including financial ones.

The empowering approach aims to build a trusting relationship to conduct a multiprofessional and multidimensional assessment of needs and resources and to define the Health Budget. This assessment must be carried out through a relationship and dialogue with the individual, using validated and standardized tools, and should explore all of the following areas:

- Clinical Area
- Psychosocial Functioning Area
- Personal and Community Needs and Resources Area





• Quality of Life Area

- a) The Health Budget integrates the individual's care pathway with their life project. Based on assessments conducted across all intervention areas (housing/living environment, education/work, socialization, and learning/expression/communication), a customized "Individualized Therapeutic Rehabilitation Project (PTRI)" is collaboratively developed with the individual, considering their preferences. The PTRI outlines actions and objectives for each area and, as a recovery-oriented care pathway, it evolves alongside the life project. Each Health Budget project must be coordinated by a designated Case Manager, who can be from either the healthcare or social sector, and who primarily oversees the coordination of the interventions defined by the team.
- b) For the Health Budget to become operational, consent is required, which is expressed through an agreement signed by the individual, detailing the objectives and commitments of all parties involved. This agreement is an integral part of the Health Budget.
- c) During the implementation phase, the Health Budget must be constantly monitored and reviewed by the social-healthcare team, at least annually, with the active participation of the individual. This monitoring and review process is coordinated by the Case Manager designated in the planning phase. Outcome indicators are also considered in the review.

To enable the application of the Health Budget and ensure the quality of the process while facilitating its adoption across all territorial areas, it is essential to define a broad and widespread strategic plan based on the qualifying and operational elements agreed upon by the Working Group. This plan should also include an appropriate collection of essential strategic information.

More specifically, it is necessary to share the strategic document containing the guidelines through a formal agreement in the Unified Conference, with a commitment from the Regions and Autonomous Provinces to adopt the content through their own measures and/or implementation plans. Additionally, a national periodic monitoring system should be established, with structured methods for implementation using indicators of process quality and outcomes in terms of quality of life.

OPERATIONAL ELEMENTS

The Health Budget places the individual at the center of the system, recognizing them as unique and irreplaceable, bearing individual values, beliefs, and choices. It also aims to rebuild and enhance family and community welfare systems.

a) **Co-Planning.** To support the pathways identified through the Health Budget, Health Agencies and Local Authorities engage in co-planning, in accordance with Article 55 of Legislative Decree 117/2017. This process involves Third Sector entities and aims to identify the needs to be met, the necessary interventions, the methods for implementing them, and the resources available. It is recommended to formalize this co-planning through a program agreement, in alignment with the provisions for local planning (Law 328/2000), to define and share the financial resources needed for implementing social and healthcare programs and interventions with the Health Budget. In the co-design phase, in addition to Third Sector entities, all potentially



interested parties in developing the Health Budget (e.g., associations, cooperatives, families, and private individuals) may be involved.

b) Formulation of Lists of Qualified Entities for Implementing Health Budget Projects. In line with the individualized project and respecting the principle of subsidiarity as per Article 118 of the Constitution and Article 55 of Legislative Decree 117/2017 (Third Sector Code), health agencies and local authorities may establish specific lists of qualified entities. These entities will actively participate in defining activities, pathways, and social-healthcare interventions (e.g., social assistance, educational, occupational, and rehabilitative services) for individuals under the care of social and health services, with projects aimed at restoring autonomy and social reintegration according to the Health Budget model. Through innovative inclusion proposals, co-managers must be able to support empowerment and the individual's active role, enabling them to become the architect of their own life project.

Reaffirming the centrality of the individual and the active role of the patient and their family members/significant figures in defining a personalized care and social inclusion pathway that addresses their specific needs, the public notice aims to ensure:

- high-quality empowerment interventions and individualized pathways that enhance projects aimed at restoring autonomy and promoting social reintegration, utilizing the Health Budget methodology;
- uniformity in the service delivery system, providing territorial areas with a standardized tool to identify entities with whom to establish comanagement contractual agreements;
- involvement of users and family members with lived experience (point f);
 - adherence to the principles of transparency, equal treatment, impartiality, and proportionality in the formation of the list and in the selection of managing entities.

In general, public administrations retain the option to use the procedures provided by Legislative Decree no. 50/2016. Regions adopt guidelines, tools, and act templates, including the possibility of a framework agreement between each Region, Health Authorities/Districts, and Municipalities/Territorial Social Areas, for the homogeneous and integrated development and implementation of the Health Budget model across the regional territory, in alignment with health and social planning.

- c) **Executive Planning.** The Lists of qualified entities established through the procedures indicated in the previous point serve as the reference for selecting participants in individual projects, following these implementation phases:
 - the individual is already under the care of health and social services, and an initial project outline is developed through a collaborative planning phase involving all parties in the project, including the individual;
 - at the end of the planning phase, the Health Budget is signed, and the Case Manager is appointed;
 - the Health Budget becomes operational upon signing the agreement/contract;
 - the Case Manager coordinates verification and monitoring actions carried out by the social-healthcare team.



d) Multidisciplinary and Multidimensional Assessment: Tools Shared and Agreed Upon by the Social-Healthcare Team

The multi-professional and multidimensional assessment is carried out by the social-healthcare team, which includes a healthcare component and a social component.

The healthcare component is represented by health and social-healthcare professionals responsible for the individual, also considering any comorbidities.

The social component is represented by the social worker from the Local Authority and other educational or social workers responsible for the individual.

Both components form the multidisciplinary team, contributing to the development of Personalized Therapeutic Rehabilitation Projects.

When team members do not have decision-making authority over funding sources, validation is required through the Multi-Professional Assessment Unit model.

The assessment includes the use of validated and standardized tools to investigate various areas: clinical, psychosocial functioning, quality of life, motivation for change, and satisfaction. The entire evaluation phase must involve the individual's participation and, upon their request, the signature of significant others.

The social-healthcare team with decision-making authority, or the Multi-Professional Assessment Unit, using the lists of qualified entities, is responsible for guiding and supporting the individual in identifying the service/pathway/intervention that can best meet their needs. This evaluation must consider the appropriateness of interventions, the quality of reception and offerings, the adequacy of structural/logistical features, and the use of financial resources in relation to different local organizational arrangements.

e) PTRI Definition: Needs/Resources, Agreement, and Monitoring

The PTRI must include:

- objectives across various areas of social determinants of health
- skills the individual needs to achieve the objectives
- human, environmental, and material (including financial) resources necessary to achieve the objectives, specifying existing resources and those to be activated through identified funding sources, in line with relevant regulations, both for the care program and the life project
- a detailed intervention plan, indicating any priorities
- involved operators and other figures, detailing roles and responsibilities
- a verification schedule
- an estimated duration of the project
- project manager: case manager
- The transition to the implementation phase of the PTRI requires the signing of an agreement that outlines the resources and commitments undertaken by each party involved. The agreement must be signed by:
- the individual
- a family member/caregiver if involved, with the consent of the assisted person
- a guardian/legal representative, if present
- the healthcare team responsible for care
- the team from the Local Authority's social service office
- a representative from a Third Sector entity or private enterprise involved in the project, chosen from the list of qualified entities



f) Involvement of Users and Family Members with Lived Experience

The involvement of associations of users and family members in the co-planning phase is recommended. In implementing the Health Budget, family members and significant figures for the individual can be involved, and the active participation of users with lived experience or facilitators should be encouraged, based on evidence consolidated in various regions/autonomous provinces through dedicated training programs.



Template 2: Survey in English

Survey on defying of an integrated care pathway for promoting social inclusion and quality of life of people with Mental Health disorders

This survey is part of the EU4Health Joint Action Mental Health Together (JA MENTOR) project, which aims to identify key information to promote equitable access to care for people with mental health conditions (MHDs), reduction of stigma, recovery and inclusion. Within the Joint Action, the specific task 5.4 aims to define and implement integrated care pathways for individuals with mental disorders, enhancing recovery and community inclusion. Personalization in healthcare, emphasized by the WHO, is rooted in equity, participation, self-determination, and non-discrimination. It focuses on a person-centered approach that integrates health, social, and educational sectors to meet individual needs.

Using the innovative personal health budget, interventions in health, housing, employment, and relational skills are tailored to individual needs and preferences, leveraging public and private resources. The approach ensures personal empowerment and is periodically monitored and updated. This initiative draws on international experiences with personal health budgets, emphasizing autonomy and integrated care, to strengthen mental health systems across Europe.

The first aim of the Task 5.4 is defining the survey for analyzing the needs, services, and policies relevant to the local population. In particular, we should collect information on:

- 1. the needs and challenges identified by the individuals with mental health disorders (MHDs) in each country;
- 2. details on social and healthcare services available for MHDs;
- 3. information regarding national policies on social and health care for people with MHDs.

The survey focuses on current mental health policies in your country or region. If you do not have the necessary information to answer the questions, we encourage you to consult or suggest us relevant authorities/professionals to obtain the required details.

It is possible to save the answers in between and resume answering the questions at a later time.

The deadline for responding is March 31, 2025.

Your timely response will be greatly appreciated.

In case you have questions regarding this survey, please send an e-mail to marialuisa.scattoni@iss.it and martina.micai@iss.it

Thank you in advance for	or your cooperation!	!	

Key terms used in the questionnaire and definitions





Mental health

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is 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 (Mental health).

Mental health policy

Mental health policy is the policy regarding the promotion of mental health, prevention of mental ill-health and mental health care.

Personalized Health Budget (PHB)

The Personalized Health budget (PHB) is designed for individuals managed by territorial healthcare services, addressing complex social and health needs. The key figure in the PHB is the individual, considered within their community context and seen through the complexity of their resources, social and health needs, relationships, and goals, ensuring their right to self-determination. It supports personalized projects aimed at promoting the individual's ability to remain in their chosen home environment by engaging various community actors.

Welfare system

A welfare system refers to a set of government programs and policies designed to provide financial support, social services, and assistance to individuals and families in need. The goal is to ensure a basic standard of living, reduce poverty, and promote social equity. Key components often include: Healthcare, Unemployment benefits, Pensions for the elderly, Social housing, Support for families, and Disability benefits. The structure and scope of welfare systems vary widely across countries, reflecting their political, cultural, and economic contexts (Béland et al., 2021, The Oxford Handbook of the Welfare State, 2nd edn).

Which Country or Region are you representing?

Who are you representing? Multiple selections are allowed.

- Ministry of Health
- Ministry of Labour
- Ministry of Welfare
- Public agencies
- Mental Health Service (professionals or organizations involved in the provision of mental health care, including clinicians, therapists, and administrators)
- Welfare and Labour Sector
- Person with Lived Experience (individuals who have direct personal experience with mental health conditions and recovery)
- Third Sector (NGO or volunteer group and other non-profit entities working in mental health, social inclusion, or related fields)
- Other (please specify)





Name of organization you are representing:

Name of organization(s) you have contacted to obtain (additional) information

PART 1. Organization of the health and social services Mental Health and Social services (organization: i.e., local units, hospital or residential settings)

1.1 Are mental health and social services integrated in your country?

- Yes
- Disconnected but with some shared tasks If YES or DISCONNECTED BUT WITH SHARED TASKS, please provide a description. For example, describe if the integration is based on infrastructure, equipe, or interventions? - The most common use of "integration" – and the meaning implied in the WHO: The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system)
- No

If NO, please describe:

- What type of organization is used for mental health services.
- What type of organization is used for social services.

1.2 Which of the following best describes the organization (e.g., local units, hospitals, or residential settings) of mental health and social services in your country, including the types of professionals involved? Multiple selections are allowed.

- A) Mental Health Services are organized through local units, hospitals, or residential settings, with a range of professionals including psychiatrists, social workers, and therapists.
- B) Mental Health Services are provided primarily by hospitals, with a focus on psychiatric care and limited involvement from social services.
- C) Social Services are organized exclusively through residential settings, with professionals limited to social care workers.
- D) Mental health services are centralized in national hospitals, involving only medical doctors.
- E) None of the above represent our system. Please describe: _____

1.3 Are there specific guidelines for clinical or medical interventions, and/or hospital care pathways in your country for people with MH disorders?

If no link is provided, please send the document(s) to marialuisa.scattoni@iss.it and martina.micai@iss.it

Yes

If YES, please provide a description in English and include the link to the current document.





Note: Include also specific guidelines focused on particular mental health disorders or drug of abuse (e.g., anxiety, substance use, alcohol abuse, etc.).

No

PART 2. Intervention delivered

2.1 Which of the following health-focused interventions are available in your country for individuals with mental health disorders? Multiple selections are allowed. If SELECTED, describe who provides it?

- A) Outpatient therapy (e.g., group or individual counseling, psychotherapy)
- B) Day-hospital intervention or daily intervention
- C) Inpatient psychiatric care
- D) Community-based rehabilitation program
- E) Medication management and monitoring
- F) Crisis intervention service
- G) Psychological intervention
- H) Psychosocial support (for example, to promote general well-being for people without a formal diagnosis)
- I) Family intervention
- J) Physical health monitoring
- K) Cultural or creative therapies: Programs such as art therapy, music therapy, or other cultural activities designed to support mental health
- L) Community-based mental health promotion: Workshops and activities aimed at reducing stigma and promoting awareness of mental health within the community
- M) Suicide prevention programs: Initiatives such as crisis hotlines or structured suicide prevention services
- N) Targeted interventions for specific groups: Services adapted for LGBTIQ+ individuals or migrants, addressing unique mental health challenges
- O) Other (please specify)____
- **2.2** Which of the following social-focused interventions are available in your country for individuals with mental health disorders? Multiple selections are allowed. We acknowledge the existence of Social Prescribing Programs, often delivered by non-health professionals, which have a clear impact on mental health and well-being. However, we have chosen not to include them in the survey, as they already represent an integrated approach to health and social care. **If selected, who provide it?**
- A) Supported employment programs
- B) Housing assistance or supported living arrangements
- C) Social skills training
- D) Peer support groups
- E) Community integration programs
- F) Time-banking or volunteer programs: Initiatives that foster social connections and mutual support through structured community engagement
- G) Personal autonomy programs: Services that help individuals develop life skills, such as financial management or cooking, to support independent living





- H) Support for caregivers: Programs specifically aimed at assisting families or caregivers of individuals with severe mental health disorders
- I) Other (please specify)____

2.3 Which of the following education, training, or work-focused interventions are available in your country for individuals with mental health disorders? Multiple selections are allowed. If selected, who provide it?

- A) Occupational support services
- B) Skill development workshops
- C) Vocational training programs
- D) Supported education programs
- E) Job placement and employment
- F) Internships or apprenticeships with mental health support
- G) Mentoring or job coaching programs: Personalized support to help individuals with mental health disorders navigate job placement or career development
- H) Youth transition programs: Services designed to assist young people with mental health disorders in transitioning to adulthood, ensuring educational and employment opportunities are accessible
- I) Cooperatives and social enterprises: Programs that engage individuals in cooperative projects or entrepreneurial activities to promote meaningful employment
- J) Associative leisure programs: Organized leisure activities, such as youth movements (scouts), which provide adolescents with a sense of belonging, skill development, and mental well-being through structured social engagement
- K) Other (please specify)____

2.4 Which of the following housing-focused interventions are available in your country for individuals with mental health disorders? Multiple selections are allowed. If selected, who provide it?

- A) Supported housing or assisted living arrangements
- B) Transitional housing programs
- C) Independent living skills training
- D) Emergency housing assistance
- E) Long-term residential facilities
- F) Housing first
- G) Other (please specify)

PART 3. Benefits and fundings

3.1 Are there cross-sectoral programs, strategies, and budgets for mental health disorders in ministries outside the Health Ministry in your country?

- G) Yes, there are multiple cross-sectoral programs and budgets for mental health
- H) Yes, there are some limited cross-sectoral initiatives
- I) No, all mental health programs and budgets are managed solely by the Health Ministry
- J) I do not know

3.2 How are the different services organized to deliver benefits and funding?

A) Benefits and funding are provided directly by the Mental Health services





- B) Benefits and funding are provided directly by the Municipalities
- C) Individuals with MHDs or caregivers apply for access to benefits/funding to the services
 - D) Individuals are assigned a case manager who coordinates access to services and funding

3.3 Which of the following employment fundings/benefits are available in your country for individuals with mental health disorders? Multiple selections are allowed.

- A) Supported employment programs
- B) Wage subsidies
- C) Incentives for employers
- D) Job coaching and workplace accommodations
- E) Disability allowances
- F) Income support for unemployed individuals
- G) Vocational rehabilitation services
- H) Other (please specify)

3.4 Which of the following social fundings/benefits are available in your country for individuals with mental health disorders? Multiple selections are allowed.

- A) Disability pensions
- B) Financial assistance
- C) Subsidized housing
- D) Housing vouchers
- E) Food assistance programs
- F) Transportation assistance
- G) Caregiver support allowances
- H) Other (please specify)

3.5 Are health, social, and employment fundings/benefits integrated?

- Yes
- If yes, please provide a description.
- No

3.6 Are there fundings/benefits allocated for specific mental health disorders (i.e., autism spectrum disorders, bipolar disorder, etc.)?

- Yes
- If yes, please provide a description.
- No

PART 4. Presence of Mental Health and Social Sector information systems

- 4.1 Which of the following information systems are in place within the mental health and social sectors for individuals with mental health disorders in your country? Multiple selections are allowed.
 - A) Electronic health records specific to mental health
 - B) Integrated databases shared across health and social services
 - C) Patient portals for accessing personal health information
 - D) Data collection systems for tracking outcomes and quality indicators





- E) Case management software for coordinating care
- F) Other (please specify)

4.2 Does your country have any of the following registries that include data on individuals with mental health conditions? Multiple selections are allowed. If SELECTED, please provide a description

- A) Socio-demographic registry
- B) Mental Health Care registry or information system for collecting, processing, analyzing, and disseminating data
- C) Residential admissions registry
- D) Registry that tracks interventions
- E) Drug registry
- F) Information or data collection system for social, recreational, employment, housing, and training/educational services
- G) Other (please specify)

PART 5. Personal Health budget (PHB): national policies and local experiences

5.1 Are there national guidelines, policies or best practices in your country for managing mental health or personalized health budget?

- Yes
- If yes, please provide a description.
- No

5.2 Have any regulatory acts or programming documents been adopted, either at the regional level or by individual healthcare companies/Local Authorities, that explicitly mandate or support the use of the Health Budget?

If a document(s) is available, please send it to marialuisa.scattoni@iss.it and martina.micai@iss.it

- Yes
- If yes, please provide a description.
- No

Or provide a brief description below

PART 6. Personal Health Budget structuring

6.1 Is a person-centred approach used in services for individuals with mental health disorders in your country?

- Yes
- If yes, please provide a description.
- No

6.2 Is social prescribing available as part of mental health services in your country?

- Yes
- If yes, please provide a description.
- No





6.3 Is there a multiprofessional team in place to assess psychosocial functioning and develop the care plan?

- Yes (If yes, see question 6.3.1)
- No

6.3.1 If you answered YES to the 6.3 question, which professionals are part of the team? Multiple selections are allowed.

- A) Psychiatrist
- B) Psychologist
- C) Social Worker
- D) Nurse
- E) Occupational Therapist
- F) General Practitioner
- G) Peer support worker
- H) Rehabilitation Specialist
- I) Family Therapist
- J) Vocational Counselor
- K) Other (please, specify)

6.4 Who is the professional usually identified as case or care manager of the care plan?

- Health professional
- Social Worker
- Other, please describe

6.5 Does the multiprofessional assessment cover health, housing, employment/training, social connections, and affectivity for individuals with mental health needs?

- Yes
- No

PART 7. Local experiences on Personal Health Budget or health-social care integrated services

7.1 In the absence of the aforementioned regulatory acts, at a local level, are there any projects and/or experiences that utilize methodologies and/or tools to support the promotion of PHBs in your country? For example, interventions focused on areas such as housing, employment, education/training, socialization, or relationships; multidisciplinary assessment involving health and social professionals; or active patient participation in project planning.

- Yes
- If yes, please describe the main characteristics of these experiences/interventions below.
- No

7.2 Are these projects and/or experiences systematically implemented and dynamically updated?

Yes



No

PART 8. Strengths or challenges

8.1 Please describe the strengths encountered in your Country/Regional experiences on Personal Health budget by selecting the applicable options, and feel free to add any additional details in the open-ended response box.

- A) Centrality of the individual, participation in the personal project, and increased autonomy for individuals with mental health disorders
- B) Improvement in clinical symptoms, overall outcomes, and reduced abandonment in therapeutic and rehabilitative pathways
- C) Active community involvement, support networks between public, private, and community sectors, and support for families and their associations in the inclusion process
- D) Discharge of patients after years of placement, reintegration into the community, and facilitated return to their homes
- E) Economic sustainability, reduction of healthcare costs, and optimization of resource use, including community-based interventions
- F) Permanent placement in supported housing, ensuring a lifelong home, and improvement in family relationships without the burden of reintegration
- G) Culture of deinstitutionalization and shared commitment of resources
- H) Other, please specify

8.2 Please describe the challenges encountered in your Country/Regional experiences on Personal Health budget by selecting the applicable options, and feel free to add any additional details in the open-ended response box.

- A) Scarcity of economic resources and limited professional and human resources
- B) Poor coordination of efforts among the structures involved in the process, and challenges in working as a network and integrating services
- C) Challenges in finding appropriate living arrangements and lack of concrete sociohealth integration
- D) Lack of factual implementation, administrative difficulties, and lack of practical experience
- E) Difficulty interfacing with local authorities and limited professional training
- F) Cultural change required to experiment with integrated and personalized pathways
- G) Social stigma and exclusion, and lack of adequate work/training opportunities
- H) Other, please specify

8.3 What changes are necessary in policies and services to achieve a personalized health budget?

8.4 What suggestions do you have for its implementation?

Additional information

Please describe below questions or additional remarks you would like to report.

Ending





Could you please e-mail to <u>marialuisa.scattoni@iss.it</u> any additional information and/or relevant documents, or evaluations (if applicable).

Thank you for your cooperation!





Knowledge exchange report

Author

National Institute of Health, Italy

Task

5.4

Date of deliverable

25 June 2025

Task 5.4 Leader contact

Marialuisa.Scattoni@iss.it



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