



European Alliance for Sport and Mental Health

**SURVEY ON THE PSYCHOSOCIAL
REHABILITATION ACTIVITIES IN
MENTAL HEALTH SERVICES**



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of the European Union

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This document is the first of a number of planned products from an ERASMUS+ funded EU project titled “EASMH – European Alliance for Sport and Mental Health”.

What is EASMH?

European Alliance for Sport and Mental Health (EASMH) is a project which seeks to encourage participation in sport and physical activity (PA) for people with mental disorders. The project will increase the participation in sport of people with mental health problems, in different stages and clinical conditions, and in different EU countries through the promotion – in a proper, stable and organised way – of structured PA programs for the prevention, treatment and rehabilitation of mental disorders. The project is based on awareness-raising activities focused on the added value of sport and physical activity in psychiatry and on activities that promote innovative synergies between sport organisations and the health sector.

Project aim:

Increasing awareness and skills among mental health professionals and sports professionals, for the development of new sport-based integrated recovery and rehabilitation models for people with mental disorders.

Mental Health public and private System

- Increase awareness of the role of sport in treatment and rehabilitation programs among each level of the mental health sector: psychiatrists, psychologists, health operators, technicians of psychiatric rehabilitation.
- Highlight the necessity of more scientific evidence and knowledge regarding the specific benefits of sport in recovery programs.
- Raise public awareness on the need for specific funds for sport.

Sports Trainers and Facilities

- Increase skills and competencies of trainers to allow them to actively participate in psychiatric recovery programs.
- Promote the creation of specific training materials suitable for different specific conditions.
- Promote the presence of qualified sports trainers in the local communities and public/private health facilities.

EASMH Consortium

The Project, co-funded by the Erasmus+ Sport Programme of the European Union, is coordinated by the European Culture and Sport Organization (ECOS), in cooperation with:

- University of Constanta, “Faculty of Physical Education and Sport” – Romania
- Hämeen Liikunta ja Urheilu ry – Finnish Sport Federation Tampere Region – Finland
- European Platform for Sport Innovation – Belgium
- Everton in the Community – United Kingdom
- University of Campania “L. Vanvitelli” – Department of Psychiatry – Italy

What is the aim of this document?

The aims of this document are to:

- a.** Report the results of a survey on the psychosocial rehabilitation programs (including those based on structured physical activity/exercise and/or sport) offered by mental health services of the different EU countries participating in the EASMH project, to identify best practices in Europe in the field of sport and mental health.
- b.** Inform on the psychosocial rehabilitation activities (including sport interventions) offered in the services within each country and compare different types of rehabilitative interventions provided in different countries.
- c.** Analyse responses in the light of the training needs on sport interventions in the different EU countries; this information will be used for the development of training materials.

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1. Psychosocial rehabilitation

The WHO's Mental Health Action Plan 2013-2020 [1] has been the first formal action plan focusing on mental health prepared by WHO and, as such, is considered a landmark [2]. One of the objectives of the Plan is to promote community-based mental health and social support services, which need to encompass a recovery-base approach emphasizing the promotion of human rights, such as employment, housing, educational opportunities, and participation in community activities, for individuals with mental disorders and psychosocial disabilities, ultimately supporting them to achieve their own aspirations and goals [1]. This can be achieved by shifting the place where care is provided from mental hospitals towards non-specialized health settings, using a network of linked community-based services and supports. A second main concept which should be put in action has to do with the provision of "integrated and responsive care" which can respond to both mental and physical needs.

Psychosocial rehabilitation (PSR) is a treatment approach designed to promote personal recovery, successful community integration, and satisfactory quality of life for persons with a mental disorder. PSR programs are collaborative, person-directed, and individualized and their final aim is to help people with mental disorders develop skills and access the resources needed to live in their communities of choice as independently as possible.

As the basis for individualized goal setting and recovery, PSR approaches build upon the strengths of persons - rather than their deficits and weaknesses - and focus on the determinants of good mental health (social support, education, employment, leisure activities) with the final aim of improving persons' quality of life.

Intervention based on structured physical activity/exercise and/or sport

People with mental disorders (MD) have an increased risk of cardiovascular disease and premature mortality in comparison to the general population [3-5]. One of the risk factors for excess mortality in persons with MD is the inadequate level of physical activity (and the high level of sedentary behavior) that characterized this population [6,7].

In fact, there is evidence that physical activity and its structured form, exercise, are effective in preventing cardiovascular disease and reducing mortality [8]. Moreover, physical activity can contribute to improve the quality of life of people who experience mental health problems, as it provides opportunities for social interaction, and purposeful and goal-directed activity [9].

Several studies have demonstrated the efficacy of lifestyle interventions including exercise, for both physical and mental health in people MD [10-11], and these interventions have been increasingly recognized as a treatment adjunct for a wide range of mental health conditions [12,13].

Although interventions based on physical activity and sport have the potential to beneficially affect both the physical health parameters and mental health outcomes in people with MD, there is still a need to increase access to appropriate exercise programs for people with MD. Psychiatric services at all levels of care need to provide integrated care services addressing both symptoms of mental illness and physical health, as well as providing social opportunities for people with MD who very often suffer from stigma and social exclusion [14].

Exercise practitioners, as members of the multidisciplinary team, have a core role for positive lifestyle change in this population, ultimately addressing major modifiable risk factors contributing to premature mortality and facilitating stigma reduction among vulnerable populations [14].

Recently, the SPHERE project team has developed a set of guidelines designed to provide recommendations for sport practitioners (such as sports coaches, fitness instructors, etc.), and health professionals (such as psychiatrists, physiotherapists, mental health nurses, etc.), with the final aim of helping them to design, implement and evaluate sport and physical activity opportunities for people with MD [15].

2. The Survey

Two key requirements for ensuring integration of psychosocial rehabilitation – including intervention based on structured physical activity/exercise and/or sport –within mental health care settings, are represented by access to trained exercise practitioners and appropriate exercise facilities. To provide access to necessary infrastructure and human resources, it may be necessary to draw on resources from both the (mental) health and the social budgets, as well as collaborating with non-government and not-for-profit community agencies to manage financial barriers [14].

The EASMH project has developed a questionnaire to survey the offer of **psychosocial rehabilitation programs** (including those based on **structured physical activity/exercise and/or sport**) by **mental health services** of the different EU countries participating in the project. The aim was to identify best practices in Europe in the field of sport and mental health, also taking into account characteristics of the local health system contexts.

The analysis of responses will be used for the development of training materials.



ITALY

2.1 Italy

Methods

Public mental health care services. In Italy, the Department of Mental Health (DMH) is the health organization responsible for specialist mental health care in the community. The DMH includes different facilities such as community mental health centers, daycare facilities, general hospital psychiatric units, residential facilities, university clinics, and private nursing homes. **Figure 1** shows the network of mental health services in Italy. DMHs were recruited among those (n=129) present in the Italian Registry of DMHs, which is regularly published and updated by the Italian Ministry of Health.

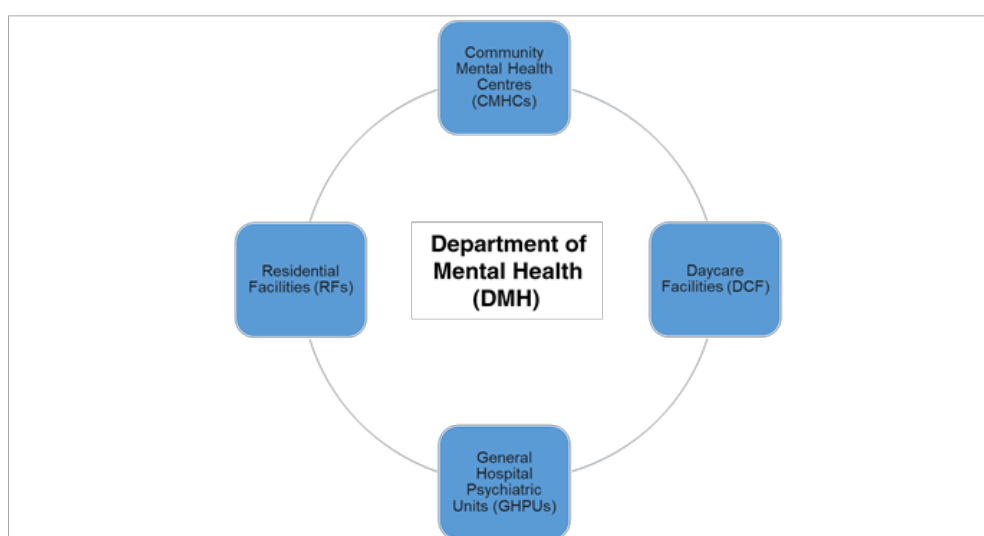


Figure 1. Network of mental health services in Italy. The DMH is the health organization responsible for specialist mental health care in the community.

Recruitment of services. Around 30% (n=40) of all Italian Departments of Mental Health (DMHs) were selected using stratified random sampling, i.e., a random selection within 4 geographical macro-areas where the DMHs are located in (Northern, Southern, and Center Italy, and Islands). These regional groupings are officially codified by the Italian National Institute of Statistics (ISTAT), which is a public research organization appointed for providing official statistics. Heads of DMHs were contacted by email and were asked to disseminate the online survey to their services.

Data analysis. Data relative to closed-ended questions (with pre-coded response options) were analyzed descriptively using frequency distribution of items. Data relative to open-ended questions were analyzed using content analysis; recurring issues were listed and described using frequency distribution.

Results

We obtained 59 responses referring to 49 different services (for those services which filled in more than one questionnaire, answers were merged and considered as a single unit).

INFORMATION ON THE MENTAL HEALTH SERVICE

Type of Service

Data are available for all respondents (n=49; 100%). No University hospitals (which was one of the options provided) participated in this survey. Most of the participants were Community mental health centers (CSMs), Community residential facilities, and Daycare centers. Additional data were collected from Substance abuse and mental health services and from Child and adolescent mental health services (“Other” option) (**Table 1**).

Table 1. Type of Service	n	%
Community mental health centers (CSM)	15	30.6%
Community residential facilities	13	26.5%
Daycare centers	10	20.4%
Substance abuse and mental health services (<i>Other</i>)	4	8.2%
Child and adolescent mental health services (<i>Other</i>)	4	8.2%
Acute psychiatric in-patient units	2	4.1%
Private clinics	1	2.0%
Total	49	100.0%

Services were split into Outpatient units (Community mental health centers, Daycare centers, Substance abuse and mental health services, Child and adolescent mental health services) and Inpatient units (Acute in-patient unit, Community residential facilities, and Private clinics). More than half of the units (67.3%) were Outpatients services (**Figure 2**).

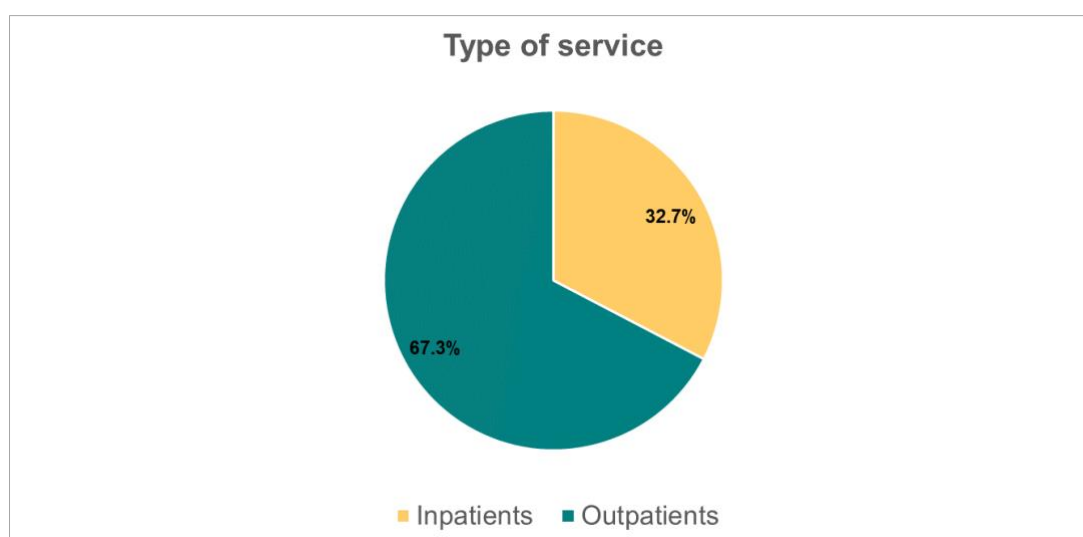


Figure 2. Type of services. The graph shows the % of Inpatients (n=16) and Outpatients units (n=33) in the sample of respondents.

Location

Data are available for all respondents (n=49; 100%). Units participating in the survey are based on 9 different Italian regions (**Table 2**). Most of the respondents are based in the Emilia Romagna region (n=20; 40.8%).

Table 2. Locations	n	%
Emilia Romagna	20	40.8%
Puglia	8	16.3%
Sicilia	8	16.3%
Lombardia	7	14.3%
Veneto	2	4.1%
Abruzzo	1	2.0%
Campania	1	2.0%
Lazio	1	2.0%
Molise	1	2.0%
Total	49	100.0%

The services participating in the survey were grouped according to the geographical macro-areas where the units are located (Northern, Southern, and Center Italy, and Islands). Most of the respondents (more than half; 59.2%) are based in Northern Italy, 22.4% of units are located in the South, and 16.3% are on the Islands (i.e., Sicily). Very little information was obtained from services located in Center Italy (n=1, 2.0%) (**Figure 3**).

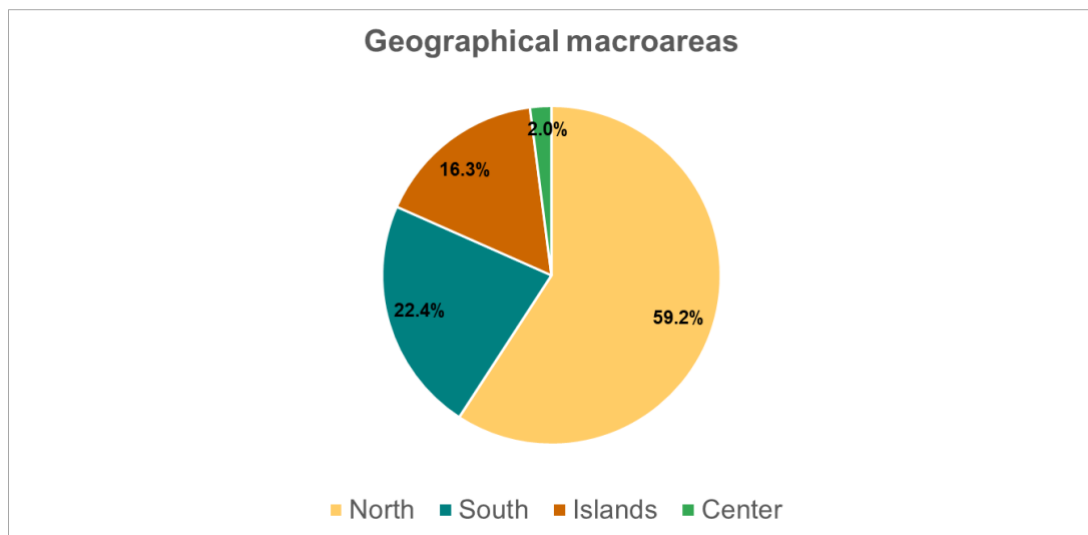


Figure 3. Location. Geographical macro-areas where the units participating in the survey are located (n=49). Regional groupings are officially codified by the Italian National Institute of Statistics.

INFORMATION ON REHABILITATION INTERVENTIONS

Types of rehabilitation interventions provided to patients

Participants were asked to indicate the type of rehabilitation interventions provided to patients in their unit. Data are available for all respondents (n=49; 100%). **Table 3** shows the type of rehabilitation interventions offered in the sample of participants, expressed as the number (n) and the % of services offering the intervention. Since participants could list more than one intervention (multiple answers could be selected), percentages are computed out of the number of services (n=49) instead of the number of interventions listed (n=188); hence, the sum of individual percentages exceeds 100%. Only three units (which represent 6.1% of the total sample) indicated offering interventions including structured physical activity/exercise and/or sport.

Table 3. Rehabilitation interventions	n	%*
Social Skills Training	39	79.6%
VADO (Skills Assessment and Definition of Goals)	30	61.2%
Cognitive rehabilitation (CogPack etc.)	28	57.1%
Psychoeducational interventions [#]	25	51.0%
Educational interventions to improve lifestyles (diet, smoking, substances of abuse)	12	24.5%
Music therapy	12	24.5%
Theatre therapy	10	20.4%
Wellness Self-Management	7	14.3%
Assertive Community Treatment	6	12.2%
Animal-assisted therapy (Pet therapy)	6	12.2%
Supported employment	5	10.2%
Social agriculture/Horticulture	4	8.2%
Interventions including structured physical activity/exercise and/or sport	3	6.1%
Token economy	1	2.0%

* % is computed out of the number of services (n=49). [#]both in an individual setting and in a group or family setting.

Figure 4 shows the frequency of rehabilitation interventions provided by services, expressed as % of the total responding services (n=49). All interventions provided by less than 10 units were merged in the 'Other' category. Music therapy and Theatre therapy were merged in the 'Art therapy' and Pet therapy and Social agriculture in the 'Nature-based interventions' category.

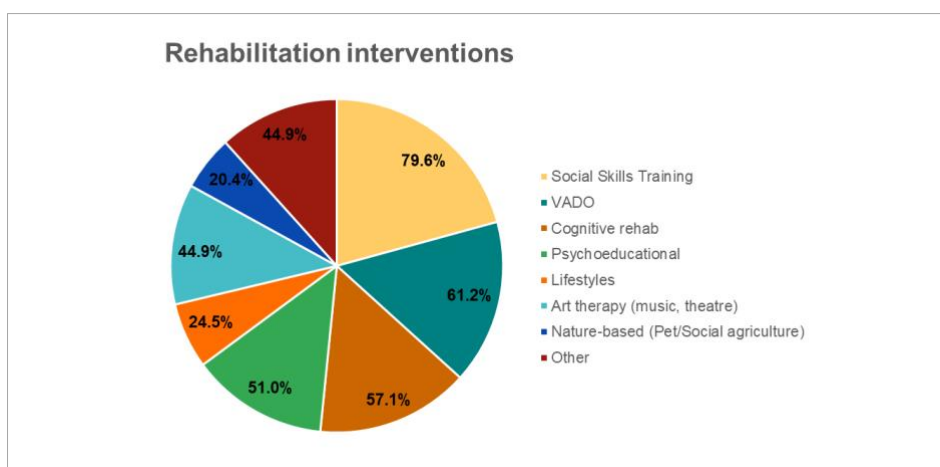


Figure 4. Types of rehabilitation interventions. Percentages are computed out of the number of services (n=49)

Professional figures involved in rehabilitation interventions

Participants were asked to indicate the professional figures involved in rehabilitation interventions in their unit. Data are available for all respondents (n=49, 100%). The vast majority of services reported the involvement of psychiatrists, psychiatric rehabilitation technicians (85.7%), nurses (79.6%), and psychologists (71.4%). About half of them reported the involvement of social workers and educators (53.1%) and healthcare social workers (44.9%). Twenty-two units reported the involvement of trained volunteers/family members (22.4%). All the other professional figures listed in the survey were reported by less than five units. Additional professional figures were reported by different units ("Other" option) (Table 4; Figure 5).

Table 4. Professional figures	n	%*
Psychiatrists	42	85.7%
Psychiatric rehabilitation technicians	42	85.7%
Nurses	39	79.6%
Psychologists	35	71.4%
Social workers	26	53.1%
Educators	26	53.1%
Healthcare social workers (OSS)	22	44.9%
Trained volunteers / Trained family members	11	22.4%
Community workers	4	8.2%
Psychomotor therapists	4	8.2%
Occupational therapists	4	8.2%
Physiotherapist (<i>Other</i>)	3	6.1%
Logopedists (<i>Other</i>)	2	4.1%
Child and Adolescent Psychiatrists (<i>Other</i>)	2	4.1%
Pedagogist (<i>Other</i>)	2	4.1%
UISP and CONI instructors (<i>Other</i>)	1	2.0%
Other	3	6.0%

*Percentages are computed out of the number of services (n=49) instead of the number of professionals listed (n=268); hence, the sum of individual % exceeds 100%. (*Other*): answers given in the "Other" option.

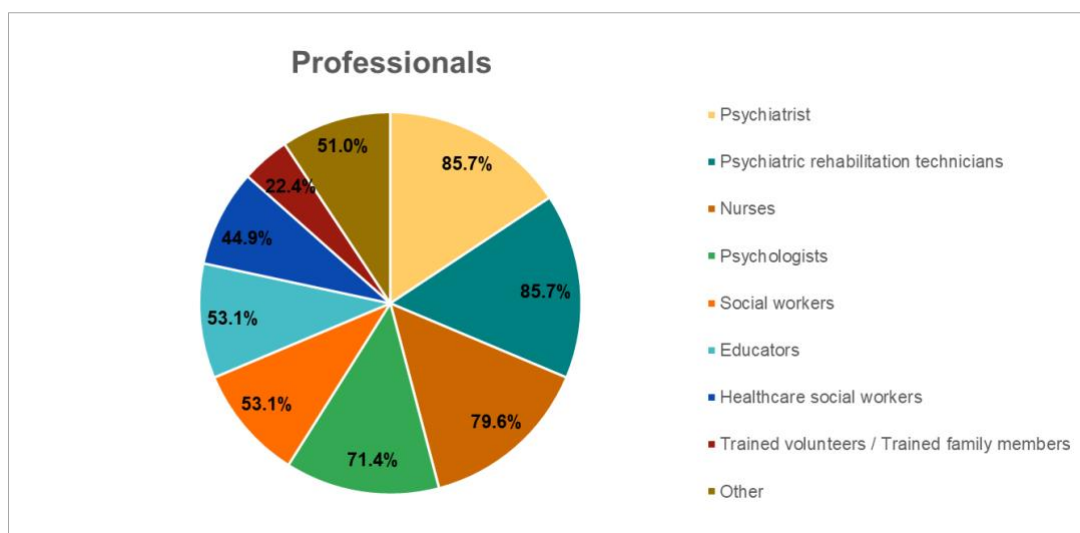


Figure 5. Professional figures involved in rehabilitation interventions. Percentages are computed out of the number of services (n=49). 'Other': professionals present in less than 10 Services.

Minimal team. We considered a “minimal team” in rehabilitation intervention as consisting of at least one psychiatrist and one psychiatric rehabilitation technician (with the other figures considered as optional). In our sample, the majority of units (73.5%) reported the involvement of such a “minimal team” in the interventions.

Training courses on rehabilitation interventions received by health care professionals

Participants were asked to indicate whether health care professionals had received *ad hoc* training courses in the last year. Data are available for all respondents (n=49, 100%). Less than half of the respondents (n= 22; 44.9%) have reported the provision of training courses.

Involvement of family members in rehabilitation interventions

Data are available for all respondents (n=49, 100%). The vast majority of units (n=46) reported the involvement of family members in interventions (“sometimes”: n=34, 69.4%; “always”: n=12, 24.5%) (**Figure 6**).

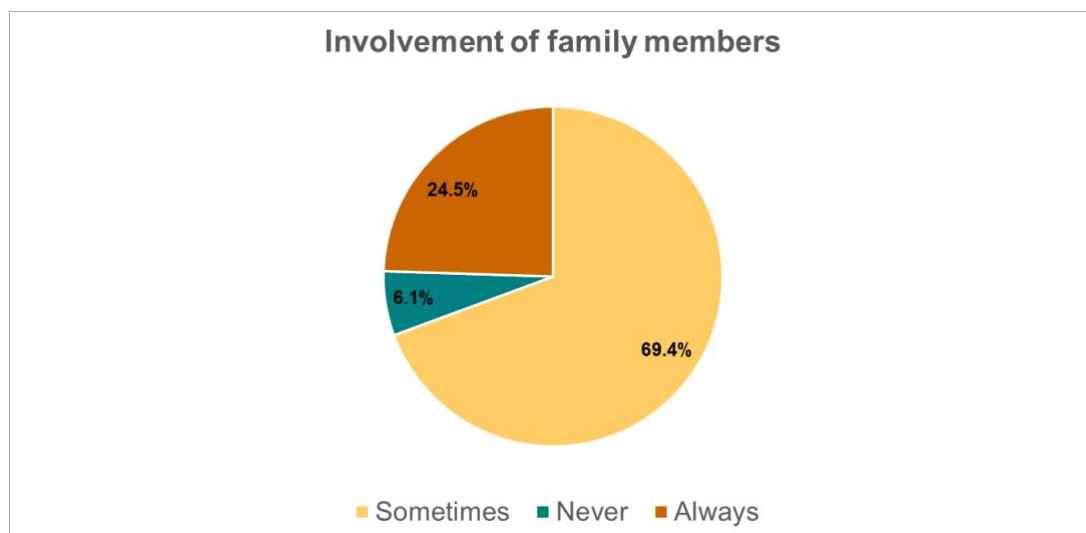


Figure 6. Involvement of family members in rehabilitation interventions. The graph shows the % of units reporting the involvement of family members “always” (n=12), “sometimes” (n=34), and “never” (n=3)

Involvement of the private social sector in rehabilitation interventions

Participants were asked to indicate whether the private social sector (i.e., Non-governmental organization-NGOs, Charities, Associations, or Foundations) is involved in rehabilitation programs. Data are available for n=48 respondents (98%). Only six units (12.5%) reported having “never” involved the private social sector in the rehabilitation programs. The vast majority of units (n=42) reported the involvement of the private social sector (“sometimes”: n=39, 81.3%; “always” n=3, 6.3%).

Monitoring

In those cases (n=42) in which the involvement of the private social sector was reported, the effectiveness of the interventions is monitored with different approaches as shown in **Table 5**.

Table 5. Monitoring of the intervention with the involvement of the social private sector	n	%
Through direct contact between the service and the NGOs/association/foundation	22	52.4%
Through the involvement of a <i>case manager</i> in rehabilitation intervention	10	23.8%
Through periodic reports of the activities	6	14.3%
Through the administration of validated assessment tools	1	2.4%
Other	2	4.8%
Not available	1	2.4%
Total	42	100.0%

Patients receiving rehabilitation interventions

Participants were asked to indicate which patients are involved in rehabilitation interventions. Data are available for all respondents (n=49, 100%). Less than half of the units reported offering these interventions to all patients (n=18; 36.7%); in other cases, the provision of interventions was reported to be based on the severity of the patients' condition (n=19; 38.8%). Fewer units reported considering patients' preference (n=8; 16.3%). Except for 4 units (8.2%) that reported providing these interventions mainly to patients with psychotic disorders, rehabilitation programs do not appear to be offered to specific clinical populations (patients with eating disorders or affective disorders, or anxiety spectrum disorders) (**Figure 7**).

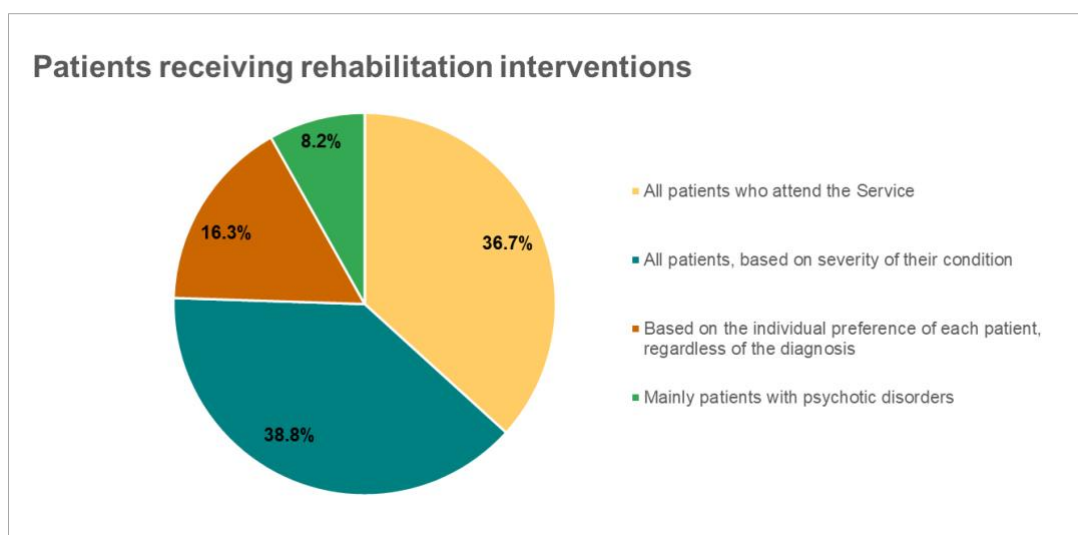


Figure 7. Patients receiving rehabilitation interventions. Data are shown as % of units. No units reported providing interventions “mainly to” patients with eating disorders or affective disorders, or anxiety spectrum disorders.

INFORMATION ON INTERVENTIONS INVOLVING STRUCTURED PHYSICAL ACTIVITY/EXERCISE AND/OR SPORT

Provision of interventions involving structured physical exercise and/or sports

Participants were asked to report as to whether rehabilitation interventions involving structured physical exercise and/or sports are (or were) carried out in their services. Data are available for n=48 respondents (98%). The vast majority of services (n=39) reported that one or more programs are currently active (n=27; 56.3%) or have been provided in the past (n=12; 25.0%), while only nine units (18.8%) stated such interventions have never been provided. This is not consistent with the answer to question 1 (see **Table 3**); in question 1, only 3 units (6.1%) reported offering interventions involving structured physical activity/exercise and/or sport. Of the 39 units reported to provide such interventions, only 41% reported collaboration with Sports clubs/Associations/Organizations.

Patients receiving interventions involving structured physical exercise and/or sports (n=39)

All the following analyses were carried considering the sample of 39 units that reported providing interventions involving structured physical exercise and/or sports. These units were asked for which patients these programs were available. Data are available for 38 respondents (97.4%). Most units (n=29) reported offering these interventions to all patients based on the severity of their condition (n=14; 36.8%) or their preference (n=15; 39.5%), while six units (15.8%) to all patients attending the service. Except for two units that reported providing these interventions mainly to patients with psychotic disorders (n=1; 2.6%) and eating disorders (n=1; 2.6%), these rehabilitation programs do not appear to be offered to specific clinical populations (patients with affective disorders, or anxiety spectrum disorders) (**Figure 8**).

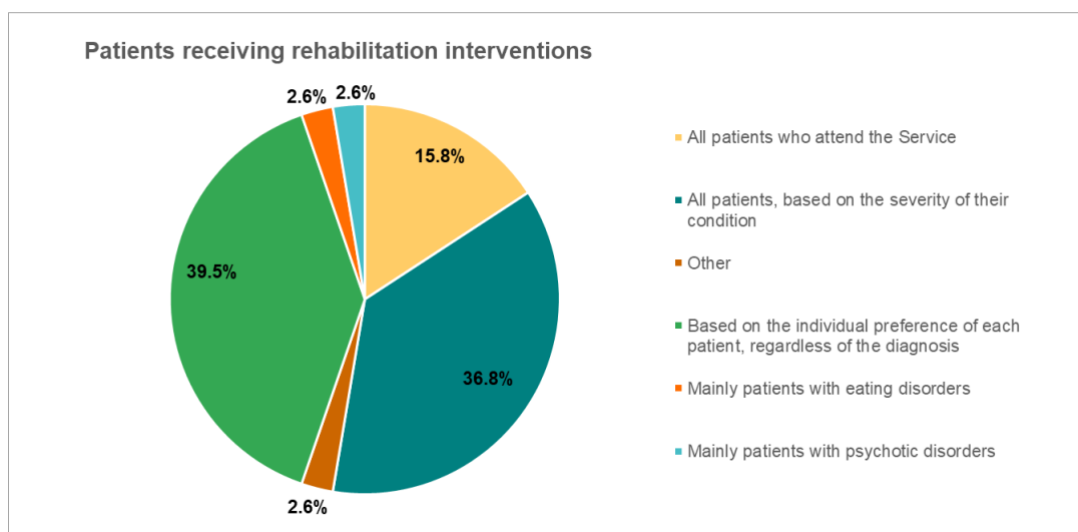


Figure 8. Patients receiving rehabilitation interventions involving structured physical exercise and/or sports. Data are shown as % of units. No units reported providing interventions “mainly to” patients with affective disorders or anxiety spectrum disorders.

Funds for interventions involving structured physical exercise and/or sports (n=39)

Participants were asked to indicate whether their unit uses dedicated funds for carrying out rehabilitation interventions involving structured physical exercise and/or sports. Data are available for 38 respondents (97.4%). The majority of the units (n=26, 68.4%) reported not using dedicated funds to carry out these interventions. Seven units (18.4%) use public health funds, while only two (5.3%) use public social funds. Only one unit (2.6%) use private funds, while two units (5.3%) reported using more than one type of fund (health, social and private) (Figure 9).

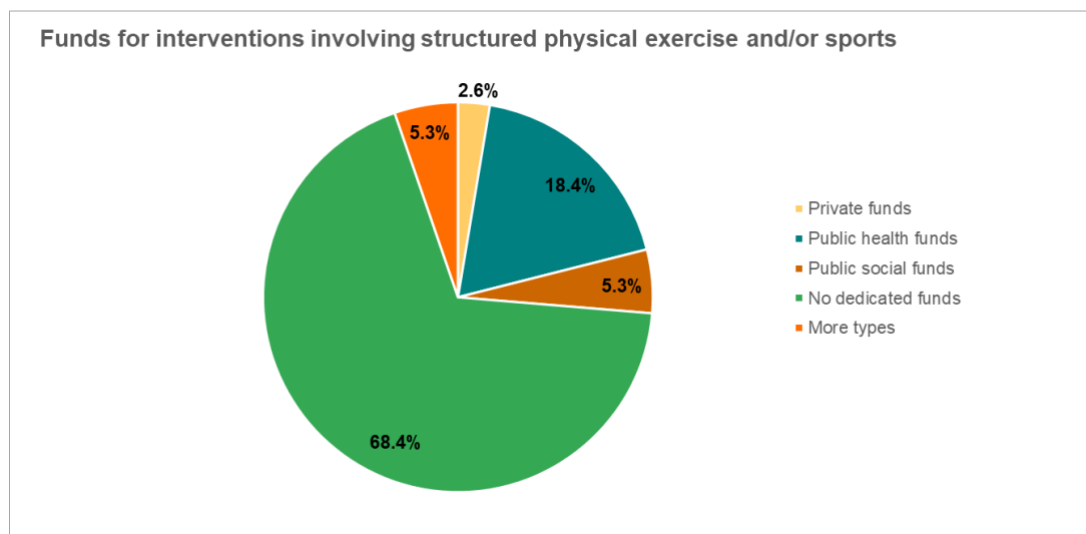


Figure 9. Funds for carrying out rehabilitation interventions involving structured physical exercise and/or sports. Data are shown as % of units reporting the provision of intervention.

Aim of the interventions involving structured physical exercise and/or sports (n=39)

Participants were asked to indicate the aim(s) of rehabilitation interventions involving structured physical exercise and/or sports. Data are available for 38 respondents (97.4%). **Table 6** shows the aims of rehabilitation interventions involving structured physical exercise and/or sports offered in the sample of participants, expressed as the number (n) and the % of services offering the interventions. Since services could list more than one aim (multiple answers could be selected), percentages are computed out of the number of services (n=39) instead of the number of aims listed (n=152); hence, the sum of individual percentages exceeds 100%.

Table 6. Aims of Rehabilitation interventions	n	%*
Promotion of social integration	35	92.1%
Promotion of healthy lifestyles (e.g. weight reduction, smoking)	32	84.2%
Improvement of social skills	26	68.4%
Recreational/Occupational activity	19	50.0%
Reduction of clinical symptoms	19	50.0%
Cognitive rehabilitation	17	44.7%
Other	4	10.5%

* % is computed out of the number of services (n=39)

Type of sport included in the rehabilitation program (n=39)

Participants were asked to indicate the type of sport included in the rehabilitation interventions involving structured physical exercise and/or sports. Data are available for 37 respondents (94.9%). **Table 7** shows the type of sport included in the interventions, expressed as the number (n) and the % of services offering the interventions based on that sport.

Table 7. Type of sport/exercise included in the program	n	%*
Walking	27	73.0%
(Gentle) gymnastics [#]	21	56.8%
Football/Five-a-side football	16	43.2%
Swimming	10	27.0%
Running	7	18.9%
Volleyball	5	13.5%
Horse riding	3	8.1%
Sailing	2	5.4%
Other	4	10.8%

* % is computed out of the number of services (n=37). [#] includes coordination, breathing, postural, joint mobility, muscle awakening, stretching

Monitoring, assessment of effectiveness (n=39)

Participants were asked to indicate whether the rehabilitation interventions involving structured physical exercise and/or sports are monitored. Data are available for 38 respondents (97.4%). The majority of units (n=28) reported evaluation/monitoring of these interventions (“sometimes”: n=11, 28.9%; “always”: n=17, 44.7%), while 10 units reported to never assess the effectiveness of rehabilitation interventions involving structured physical exercise and/or sports (**Figure 10**).

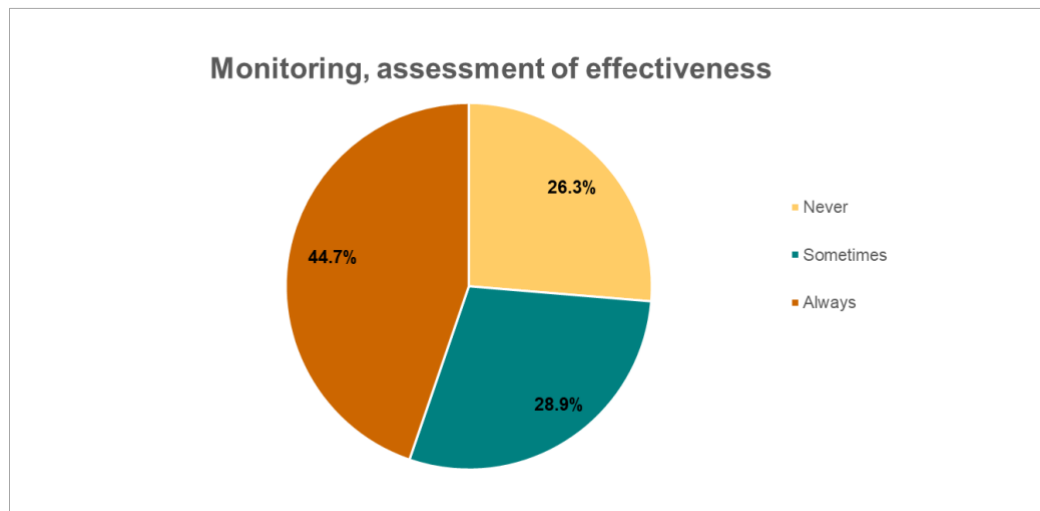


Figure 10. Monitoring, assessment of effectiveness. The graph shows the % of units reporting monitoring/assessment of effectiveness “always”, “sometimes” and “never”.

Tools used for monitoring (standard/validated scale or other monitoring tools) (n=28)

Of the 28 units reporting the monitoring of rehabilitation interventions involving structured physical exercise and/or sports, only 23 indicated specific tools. Nine units reported the use of non-validated tools (39.1%), while only six units (26.1%) reported the use of validated tools (e.g., CBCL, BPRS, MMSE). Eight units (34.8%) reported the assessment of effectiveness using physiological/health/metabolic parameters such as weight and BMI.



UNITED KINGDOM

2.2 UK

Methods

Public mental health care services. In the United Kingdom, the National Health Service (NHS) is the health organization responsible for specialist mental health care in the community. The NHS includes primary care facilities such as community mental health centers, general hospitals, university clinics as well as secondary acute care in psychiatric units and residential facilities. In addition to this, there is a large percentage of mental health care that is provided by private care providers. **Figure 1** shows the network of mental health services in the UK.

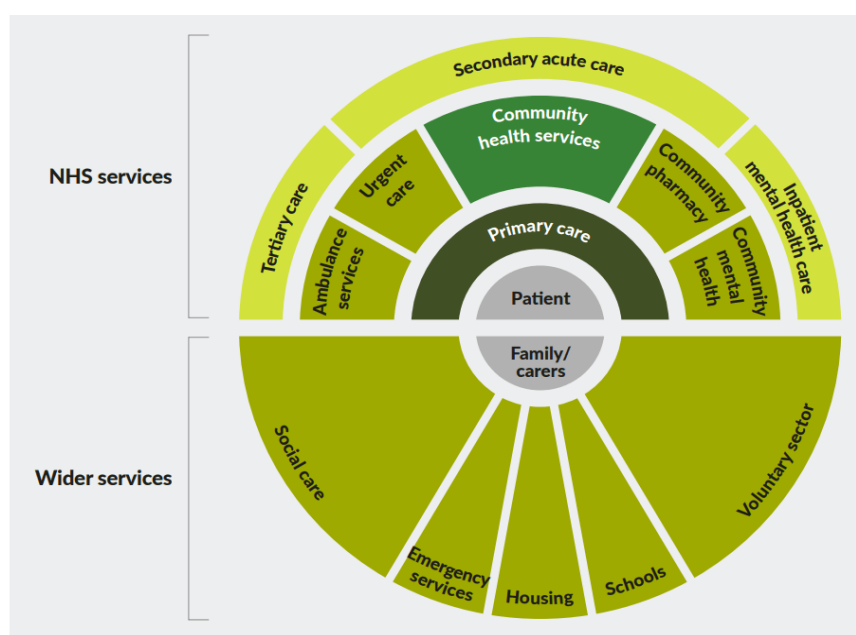


Figure 1. Network of mental health services in the UK. The NHS is the health organization responsible for specialist mental health care in the community.

Recruitment of services. Staff from various NHS Trusts from across the UK were contacted by email to disseminate the online survey to their services. To ensure a representative reach was established to encapsulate the broad geographical reach of the UK's National Health Service 11 key regions were selected using stratified random sampling, i.e., a random selection within geographical macro-areas.

Data analysis. Data relative to closed-ended questions (with pre-coded response options) were analyzed descriptively using frequency distribution of items. Data relative to open-ended questions were analyzed using content analysis; recurring issues were listed and described using frequency distribution.

Results

We obtained 31 responses referring to 31 different services. If multiple responses were received from the same organization but represented different interventions they were treated as single units, otherwise, they were considered the same and merged to form one unit.

INFORMATION ON THE MENTAL HEALTH SERVICE

Type of Service

Data are available for all respondents (n=31; 100%). Type of services are shown in **Table 1**. More than half of the units (61.3%) were outpatients services (**Figure 2**).

Table 1. Type of Service	n	%
Community Mental Health Centre/Outpatient unit	13	41.94%
Community based mental health support charities	12	38.70%
Community residential facilities	2	6.45%
Acute psychiatric in-patient units	2	6.45%
Stepped up care services	1	3.23%
Private clinics	1	3.23%
Total	31	100.0%

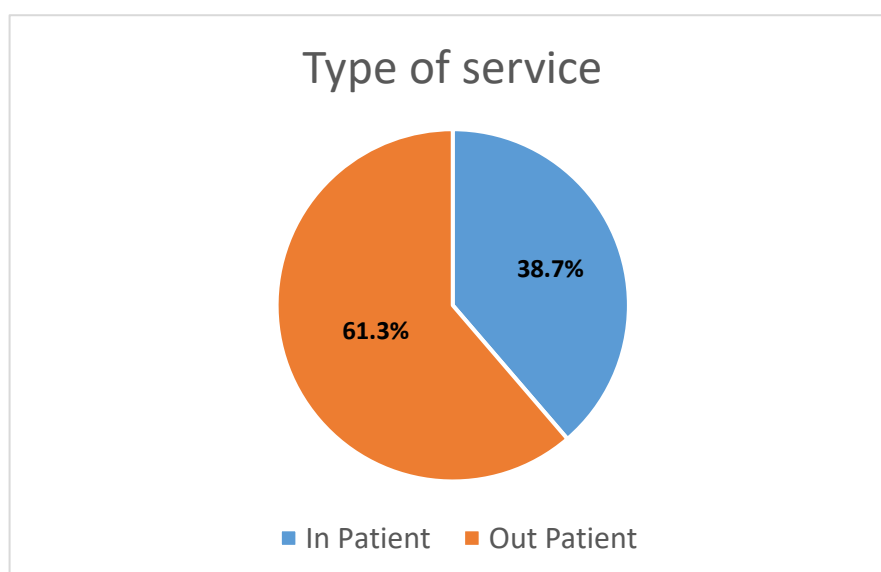


Figure 2. Type of services. The graph shows the % of Inpatients (n=16) and Outpatients units (n=33) in the sample of respondents.

Location

Data are available for all respondents (n=31; 100%). Units participating in the survey are based on 7 different UK regions (**Table 2**). Most of the respondents are based in the North West region (n=13; 41.94%).

Table 2. Locations	n	%
North West	13	41.94%
London	10	32.3%
Midlands	3	9.68%
South West	2	6.4%
North East	1	3.23%
South East	1	3.23%
Wales	1	3.23%
Scotland	0	0%
Northern Ireland	0	0%
Total	31	100.0%

The services participating in the survey were grouped according to the geographical macro-areas where the units are located (North West, London (capital), Midlands, South West, North East, South East and Wales). There was a fairly even split of the respondents from the North of the UK (15= 48.3%), compared to the South of the country (13= 41.9%) with respondents (9.68%) representing the Midlands. Although surveys were distributed to other representative parts of the UK (Scotland and Northern Ireland) no responses were obtained from these regions (**Figure 3**).

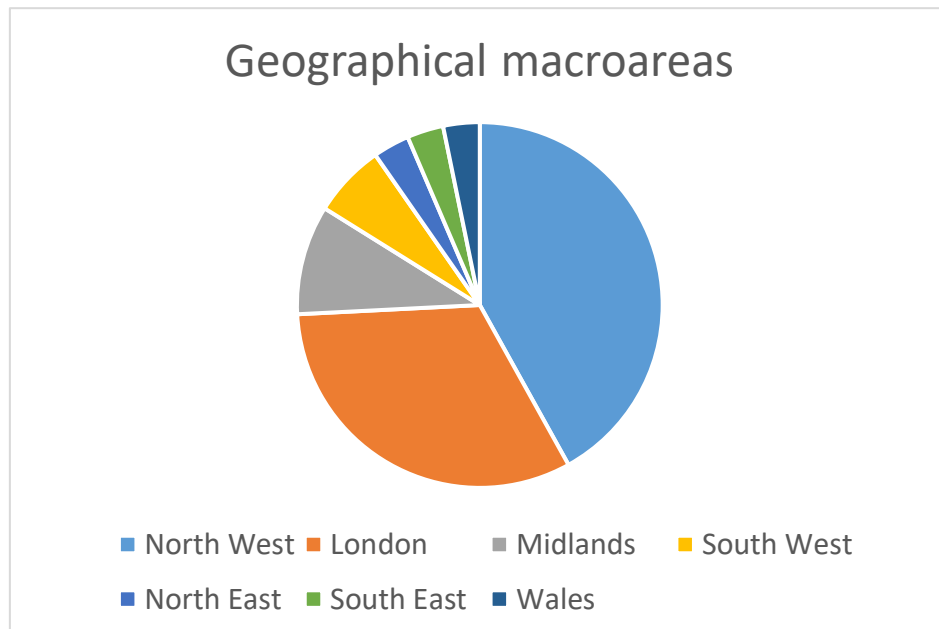


Figure 3. Location. Geographical macro-areas where the units participating in the survey are located (n=31).

INFORMATION ON REHABILITATION INTERVENTIONS

Types of rehabilitation interventions provided to patients

Participants were asked to indicate the type of rehabilitation interventions provided to their patients. Data are available for 30 out of the 31 respondents. **Table 3** shows the type of rehabilitation interventions offered in the sample of participants, expressed as the number (n) and the % of services offering the intervention. Since participants could list more than one intervention (multiple answers could be selected), percentages are computed out of the number of services (n=31) instead of the number of interventions listed; hence, the sum of individual percentages exceeds 100%.

Table 3. Rehabilitation interventions	n	%*
Interventions including structures physical activity/ exercise and/or sport	26	83.87%
Educational interventions to improve lifestyles (diet, smoking, substances of abuse)	18	58.06%
Psychoeducational interventions [#]	16	51.61%
Social Skills Training	16	51.61%
Social agriculture/Horticulture	6	19.35%
Supported employment	6	19.35%
Art therapy	5	16.13%
Assertive Community Treatment	4	12.9%
Cognitive rehabilitation (CogPack etc.)	4	12.9%
Covid-19 adjustment counselling	1	3.23%
Peer-to-peer support	1	3.23%
Token economy	1	3.23%
VADO (Skills Assessment and Definition of Goals)	1	3.23%
Wellness cafe	1	3.23%

* % is computed out of the number of services (n=31). [#]both in an individual setting and in a group or family setting.

Figure 4 shows the frequency of rehabilitation interventions provided by services, expressed as % of the total responding services (n=31). All interventions provided by less than 10 units were merged in the 'Other' category. Music therapy and Theatre therapy were merged in the 'Art therapy' and Pet therapy and Social agriculture in the 'Nature-based interventions' category.

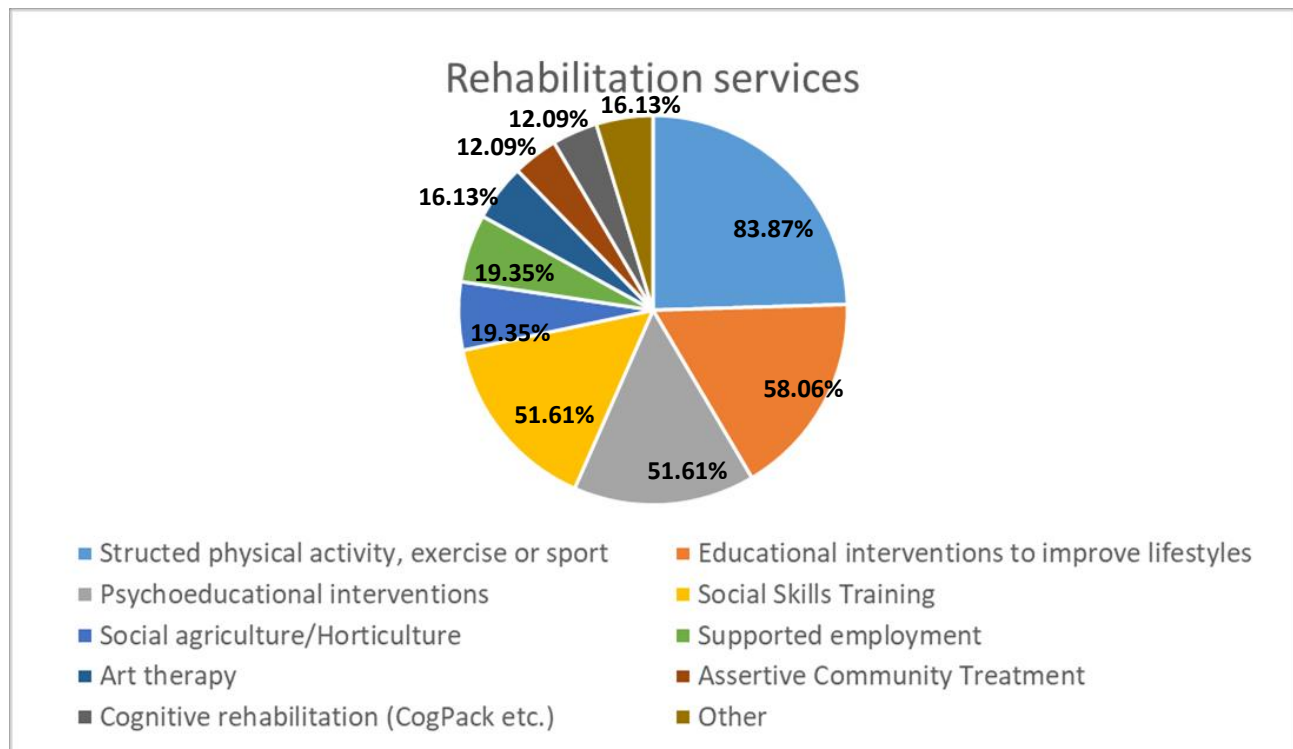


Figure 4. Types of rehabilitation interventions. Percentages are computed out of the number of services (n=49).

Professional figures involved in rehabilitation interventions

Participants were asked to indicate the professional figures involved in rehabilitation interventions in their unit. Data are available for all respondents (n=31, 100%). The over half of services reported the involvement of trained family members and volunteers (58.06%) and nurses (51.61%). With a large number of services involving social workers (48.3%), psychologists (45.1%) and Occupational Therapists (OT) (45.1%). About one-third of services reported the involvement of educators (29.0%) and Psychiatrists (29.0%) with 12.9% of services indicating involvement with sports coaches. Additional professional figures were reported by different units ("Other" option) (**Table 4; Figure 5**).

Table 4. Professional figures	n	%*
Trained family members	18	58.06%
Trained volunteers	18	58.06%
Nurses	16	51.61%
Social workers	15	48.3%
Psychologists	14	45.1%
Occupational therapists	14	45.1%
Educators	9	29.0%
Psychiatrists	9	29.0%
Psychiatric rehabilitation technicians	4	12.9%
Sports coaches (<i>Other</i>)	4	12.9%
Healthcare support workers (<i>Other</i>)	1	3.23%
Counsellors (<i>Other</i>)	1	3.23%
Physical Wellbeing Lead (<i>Other</i>)	1	3.23%
Lived experience volunteers (<i>Other</i>)	1	3.23%
Physiotherapist (<i>Other</i>)	1	3.23%
Life skills coaches (<i>Other</i>)	1	3.23%
Activity coordinator (<i>Other</i>)	1	3.23%
Students (<i>Other</i>)	1	3.23%
Other	8	25.81%

*Percentages are computed out of the number of services (n=31) instead of the number of professionals listed; hence, the sum of individual % exceeds 100%. (*Other*): answers given in the “Other” option.



Figure 5. Professional figures involved in rehabilitation interventions. Percentages are computed out of the number of services (n=31).

Training courses on rehabilitation interventions received by health care professionals

Participants were asked to indicate whether health care professionals had received *ad hoc* training courses in the last year. Data are available for all respondents (n=31, 100%). Less than half of the respondents (n= 14; 45.16%) have reported the provision of training courses and only 3 (9.68%) respondents when asked what type of training they had received indicated they had received training related to the use of physical activity and sport for mental health rehabilitation.

Involvement of family members in rehabilitation interventions

Data are available for all respondents (n=31, 100%). The vast majority of units (n=24) reported the involvement of family members in interventions (“no, never”: n=7, 22.58%, “sometimes”: n=20, 64.5%; “always”: n=4, 12.9%) (**Figure 6**).

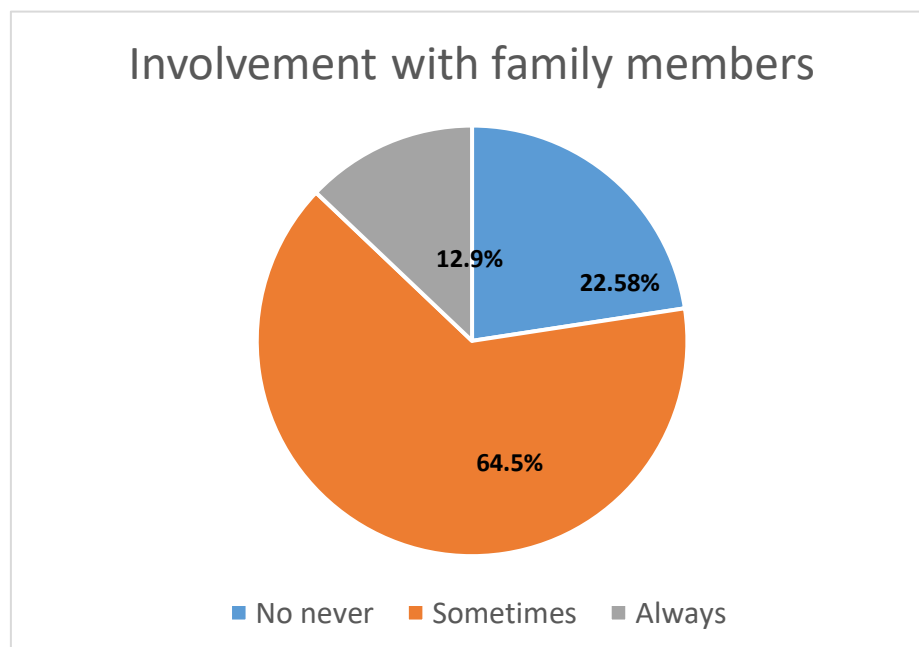


Figure 6. Involvement of family members in rehabilitation interventions. The graph shows the % of units reporting the involvement of family members “always” (n=4), “sometimes” (n=20), and “never” (n=7).

Involvement of the private social sector in rehabilitation interventions

Participants were asked to indicate whether the private social sector (i.e., Non-governmental organization-NGOs, Charities, Associations, or Foundations) is involved in rehabilitation programs. Data are available for n=30 respondents (96.8%). Thirteen units (43.3%) reported having “never” involved the private social sector in the rehabilitation programs. One-third of units (n=10) 30% reported “sometimes”, whilst 7 units, 23.3% reported “always” having involvement with the private social sector.

Monitoring

In those cases (n=30) in which the involvement of the private sector was reported, the effectiveness of the interventions is monitored with different approaches as shown in **Table 5**.

Table 5. Monitoring of the intervention with the involvement of the social private sector	n	%
Through the administration of validated assessment tools	8	25.81%
Not available	7	22.58%
Through direct contact between the service and the NGOs/association/foundation	6	19.35%
Through periodic reports of the activities	6	19.35%
Other	4	12.9%
Total	31	100.0%

INFORMATION ON INTERVENTIONS INVOLVING STRUCTURED PHYSICAL ACTIVITY/EXERCISE AND/OR SPORT

Provision of interventions involving structured physical exercise and/or sports

Participants were asked to report as to whether rehabilitation interventions involving structured physical exercise and/or sports are (or were) carried out in their services. Data are available for (n=31 100%) revealed that the vast majority of services reported that one or more programs are currently active (n=25; 80.65%) or have been provided in the past (n=5; 16.13%), while only one unit (3.23%) stated such interventions have never been provided. Participants were asked if their programmes have or currently are carried out in collaboration with Sports Clubs/Associations/Organizations. Data are available for all respondents (n=31, 100%) revealed that 83.87% of programmes were carried out in collaboration with Sports Club/Association/Organization, whereas 16.13% were not.

Patients receiving interventions involving structured physical exercise and/or sports (n=30)

Participants were asked to indicate which patients are involved in rehabilitation interventions. Data are available for respondents (n=30). Over half of the units reported offering these interventions to all patients (n=20; 66.67%); in other cases, the provision of interventions was reported to be based on the patients' preference regardless of their condition (n=9; 30%). Whilst only a respondent indicated they involve patients based on the severity of their condition (n=1; 3%).

Funds for interventions involving structured physical exercise and/or sports (n=30)

Participants were asked to indicate whether their programme uses dedicated funds for carrying out rehabilitation interventions involving structured physical exercise and/or sports. Data are available for 30 respondents. The majority of the units (n=23, 76.67%) reported using dedicated funds to carry out these interventions. 15 of these units (50%) reported

using public or social health funds, while six units (20%) use private funds, and 11 units (36.67%) reported using more than one type of fund (health, social and private) (**Figure 9**).

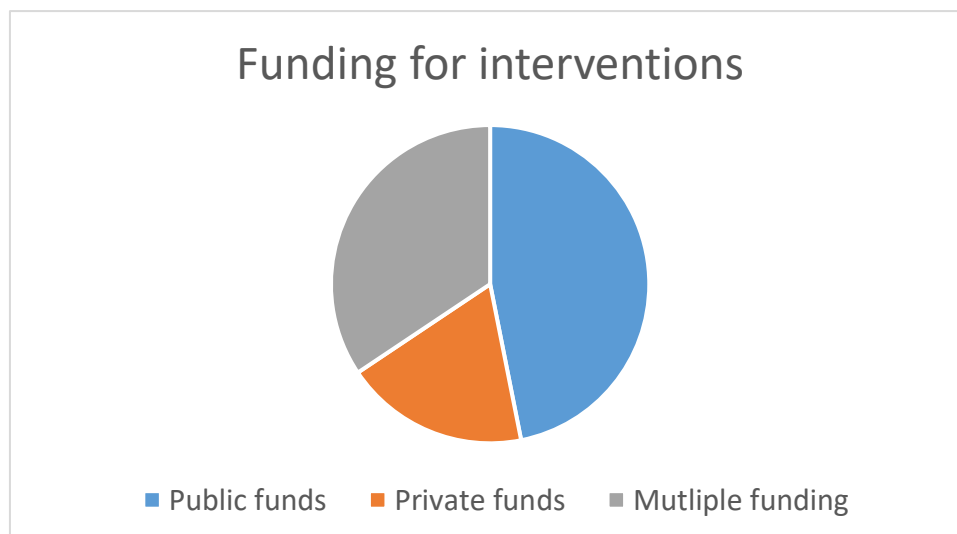


Figure 9. Funds for carrying out rehabilitation interventions involving structured physical exercise and/or sports. Data are shown as % of units reporting the provision of intervention.

Aim of the interventions involving structured physical exercise and/or sports (n=30)

Participants were asked to indicate the aim(s) of rehabilitation interventions involving structured physical exercise and/or sports. Data are available for 30 respondents. **Table 6** shows the aims of rehabilitation interventions involving structured physical exercise and/or sports offered in the sample of participants, expressed as the number (n) and the % of services offering the interventions. Since services could list more than one aim (multiple answers could be selected), percentages are computed out of the number of services (n=30) instead of the number of aims listed; hence, the sum of individual percentages exceeds 100%.

Table 6. Aims of Rehabilitation interventions	n	%*
Promotion of healthy lifestyles (e.g. weight reduction, smoking)	28	93.3%
Improvement of social skills	25	83.3%
Promotion of social integration	24	80.0%
Reduction of clinical symptoms	24	80.0%
Recreational/Occupational activity	22	73.3%
Cognitive rehabilitation	12	40.0%

* % is computed out of the number of services (n=30)

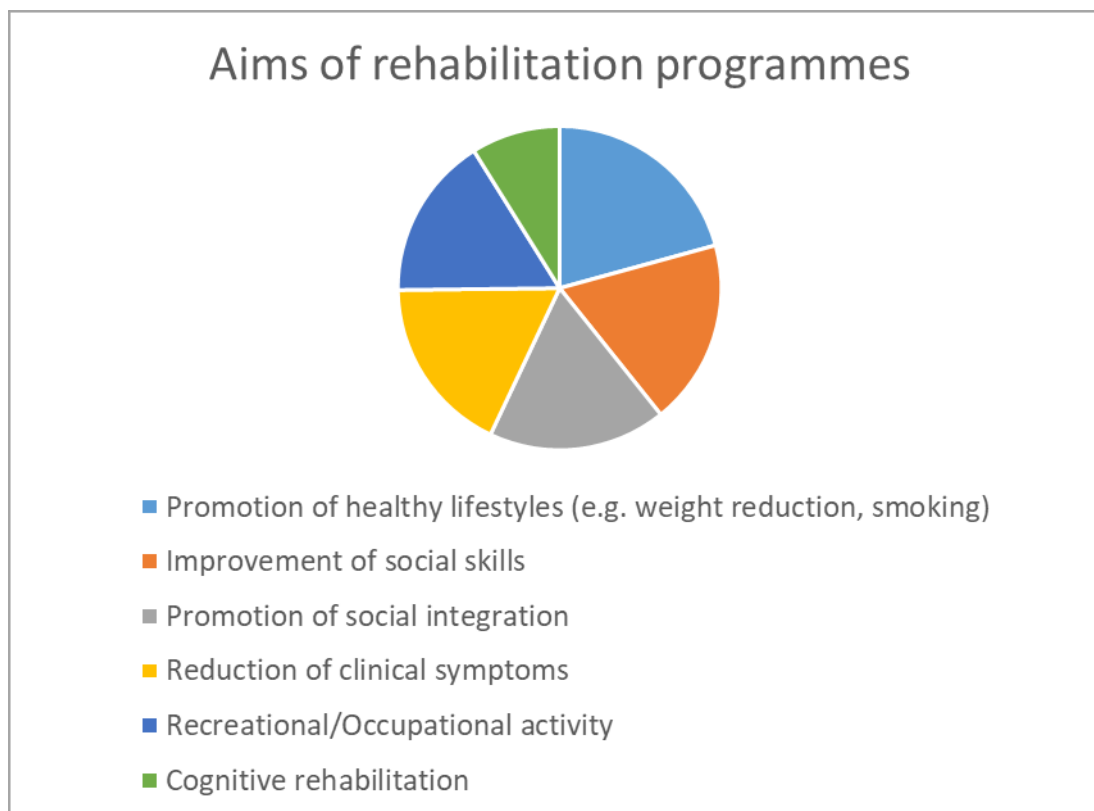


Figure 10. Aims of rehabilitation interventions involving structured physical exercise and/or sports. Data are shown as % of units reporting the provision of intervention.

Type of sport included in the rehabilitation program (n=30)

Participants were asked to indicate the type of sport included in the rehabilitation interventions involving structured physical exercise and/or sports. Data are available for 30 respondents (94.9%). **Table 7** shows the type of sport included in the interventions, expressed as the number (n) and the % of services offering the interventions based on that sport.

Table 7. Type of sport/exercise included in the program	n	%*
Football	26	86.6%
Walking	18	60.0%
Five-a-side football	16	53.3%
Running	11	36.6%
Tennis	9	30.0%
Basketball	6	20.0%
Tai Chi	5	16.7%
Table Tennis	4	1.3%
Yoga	4	1.3%
Other*	27	90.0%

* % represents other sports or exercise interventions undertaken.

Monitoring, assessment of effectiveness (n=30)

Participants were asked to indicate whether the rehabilitation interventions involving structured physical exercise and/or sports are monitored. Data are available for 30 respondents. An even split of 14 respondents reported evaluation/monitoring of these interventions as taking place “always” and “sometimes”, while 2 units reported never assessing the effectiveness of rehabilitation interventions involving structured physical exercise and/or sports (**Figure 10**).

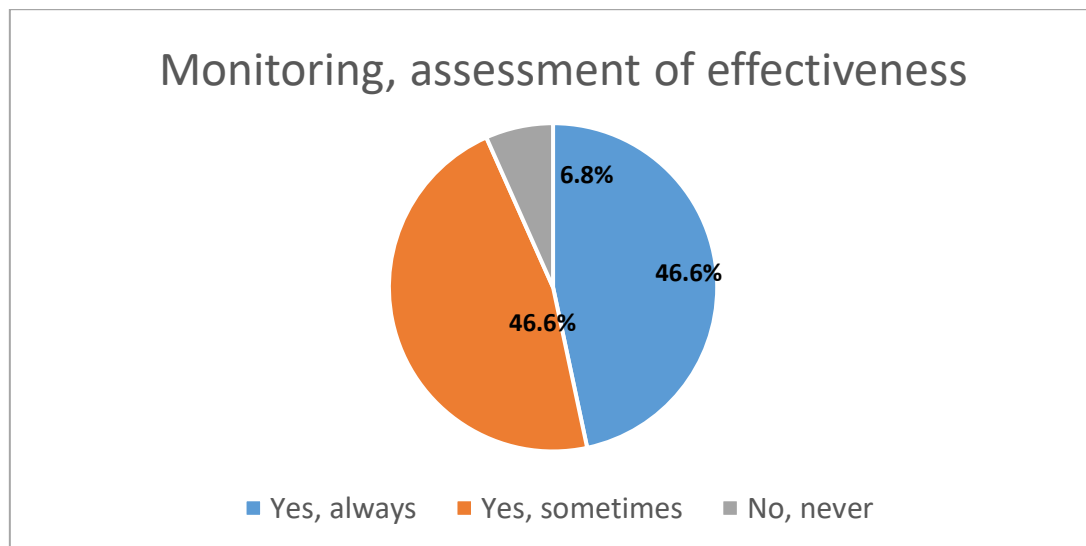
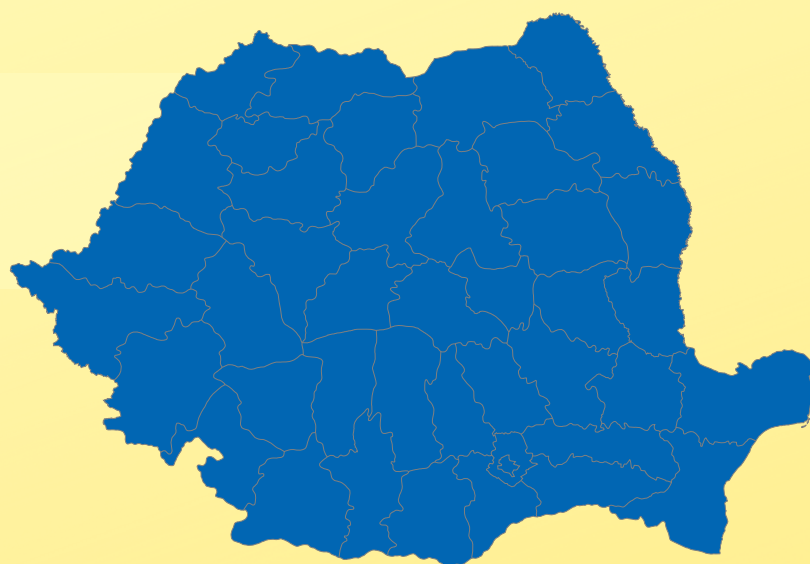


Figure 10. Monitoring, assessment of effectiveness. The graph shows the % of units reporting monitoring/assessment of effectiveness “always”, “sometimes” and “never”.

Tools used for monitoring (standard/validated scale or other monitoring tools) (n=30)

Of the 30 units reporting the monitoring of rehabilitation interventions involving structured physical exercise and/or sports, only 19 indicated specific tools. 5 units reported the use of non-validated tools, while 14 units reported the use of validated tools (e.g., Warwick Edinburgh Mental Well Being Scale (WEMWBS, ReQuol, HOOS/KOOS). 1 unit reported the assessment of effectiveness by means of physiological/health/metabolic parameters such as Rate of Perceived Exertion (RPE).



ROMANIA

2.3 Romania

Methods

Public mental health care services. In Romania, the Ministry of Health is the health organization responsible for specialist mental health care in the community. The Ministry includes different facilities such as community mental health centers, daycare facilities, general hospital psychiatric units, residential facilities, university clinics, and private nursing homes. **Figure 1** shows the network of mental health services in Romania according to Law no. 487 of July 11, 2002 on mental health and protection of persons with mental disorders. Although the law provides for these types of institutions, the Ministry of Health includes in the list published on the site only psychiatric hospitals, sections of these hospitals, and sanatoriums.

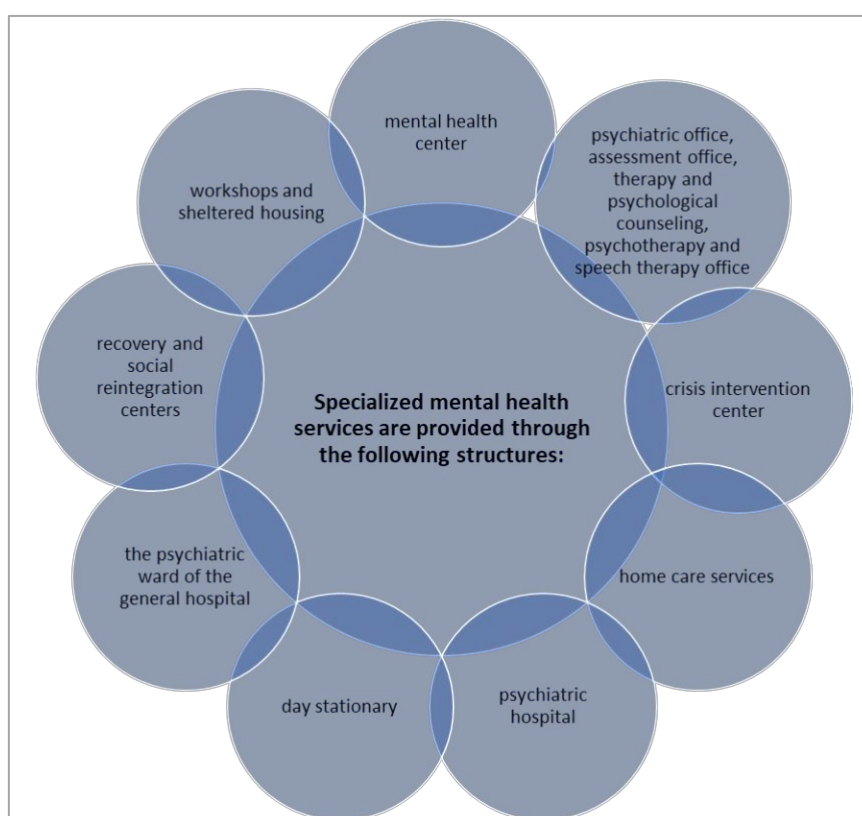


Figure 1. Network of mental health services in Romania according to the law no. 487 of July 11, 2002

Recruitment of services. We sent an email and called the 88 units on the list of psychiatric institutions and organizations in Romania which is regularly published and updated by Health Ministry. The questionnaire was also sent to the psychological offices in Constanta and to some foundations which carry out various activities for people with mental health problems.

Data analysis. Data relative to closed-ended questions (with pre-coded response options) were analyzed descriptively using frequency distribution of items. Data relative to open-ended questions were analyzed using content analysis; recurring issues were listed and described using frequency distribution.

Results

We obtained 12 responses referring to 3 different services.

INFORMATION ON THE MENTAL HEALTH SERVICE

Type of Service

Data are available for all respondents (n=12; 100%). Most of the participants were Community mental health centers (CSMs), Community residential facilities, Hospital psychiatric wards (**Table 1**).

Table 1. Type of Service	n	%
Community mental health centers (CSM)	1	8.3%
Hospital-psychiatric ward	5	41.7%
Individual psychological offices	6	50%
Total	12	100.0%

Services were split into Outpatient units (Community mental health centers, Daycare centers, Individual psychological offices) and Inpatient units (Hospitals psychiatric wards). More than half of the units (58.3%) were Outpatients services (**Figure 2**).

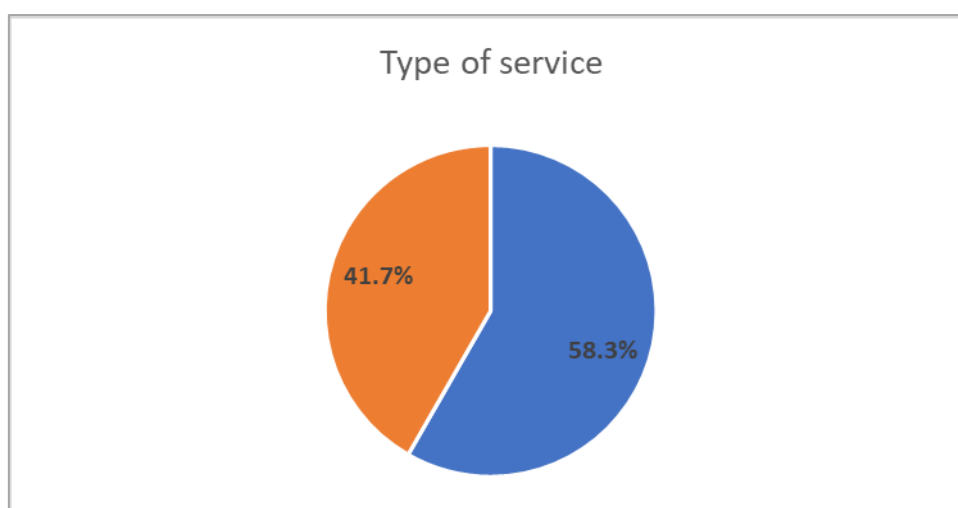


Figure 2. Type of services. The graph shows the % of Inpatients (n=5; 41.7%) and Outpatients units (n=7; 58.3%) in the sample of respondents.

Location

Data are available for all respondents (n=12; 100%). Units participating in the survey are based on the different Romanian regions (**Table 2**). Most of the respondents are based in the East region of the country (n=7; 58.3%). (**Figure 3**).

Table 2. Locations		n	%
Constanta	east	7	58.3%
București	south	1	8.3(3)%
Argeș		1	8.3(3)%
Gorj		1	8.3(3)%
Dolj		1	8.3(3)%
Maramureș	north	1	8.3(3)%
Total		12	100.0%



Figure 3. Distribution of answers by county

The services participating in the survey were grouped according to the geographical macro-areas where the units are located (Northern, Southern, and Eastern Romania). Most of the respondents (more than half; 58.3%) are based in the South-East of Romania, 33.34% of units are located in the South, and 8.3% are in Northern Romania. No information was obtained from services located in Center Romania or from West Romania (**Figure 3**).

INFORMATION ON REHABILITATION INTERVENTIONS

Types of rehabilitation interventions provided to patients

Participants were asked to indicate the type of rehabilitation interventions provided to patients in their unit. Data are available for all respondents (n=12; 100%). **Table 3** shows the type of rehabilitation interventions offered in the sample of participants, expressed as the number (n) and the % of services offering the intervention. Since participants could list more than one intervention (multiple answers could be selected), percentages are computed out of the number of services (n=12) instead of the number of interventions listed (n=188); hence, the sum of individual percentages exceeds 100%. Only three units (which represent 6.1% of the total sample) indicated offering interventions including structured physical activity/exercise and/or sport.

Table 3. Rehabilitation interventions	n	%*
Social Skills Training	7	58.3%
Psychoeducational interventions [#]	6	50%
Cognitive rehabilitation (CogPack etc.)	5	41.7%
Educational interventions to improve lifestyles (diet, smoking, substances of abuse)	5	41.7%
VADO (Skills Assessment and Definition of Goals)	4	33.4%
Art-Therapy	4	33.4%
Interventions including structured physical activity/exercise and/or sport	4	33.4%
Wellness Self-Management	3	25%
Theatre therapy	2	16.7%
Assertive Community Treatment	2	16.7%
Occupational Therapy	1	8.3%
Virtual Reality Therapy	1	8.3%
Supported employment	1	8.3%

* % is computed out of the number of services (n=12). [#]both in an individual setting and in a group or family setting.

Figure 4 shows the frequency of rehabilitation interventions provided by services, expressed as % of the total responding services (n=12).

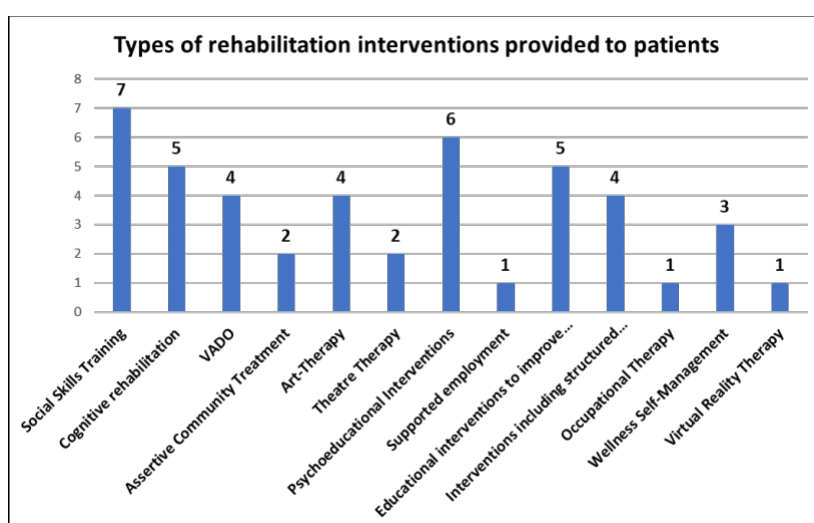


Figure 4. Types of rehabilitation interventions. Percentages are computed out of the number of services (n=12)

Professional figures involved in rehabilitation interventions

Participants were asked to indicate the professional figures involved in rehabilitation interventions in their unit. Data are available for all respondents (n=49, 100%). The vast majority of services reported the involvement of psychiatrists, psychiatric rehabilitation technicians (85.7%), nurses (79.6%), and psychologists (71.4%). About half of them reported the involvement of social workers and educators (53.1%) and healthcare social workers (44.9%). Twenty-two units reported the involvement of trained volunteers/family members (22.4%). All the other professional figures listed in the survey were reported by less than five units. Additional professional figures were reported by different units ("Other" option) (Table 4; Figure 5).

Table 4. Professional figures	n	%*
Psychologists	11	91.7%
Psychiatrists	6	50%
Occupational therapists	6	50%
Nurses	5	41.7%
Social workers	3	25%
Trained volunteers / Trained family members	2	16.7%

*Percentages are computed out of the number of services (n=12) instead of the number of professionals listed; hence, the sum of individual % exceeds 100%.



Figure 5. Professional figures involved in rehabilitation interventions. Percentages are computed out of the number of services (n=49). 'Other': professionals present in less than 10 Services.

Family members

Family members are involved in 11 cases out of 12 (91.66%) in rehabilitation interventions. For 3.1 we received 7 answers from 11 and there were multiple answers for one respondent. So, the interventions in which family members are involved were:

- support groups – n=3
- psychoeducation groups – n=3
- palliative care – n=1
- social assistance – n=1
- skills to work from home with the person being cared for - n=1

Training courses on rehabilitation interventions received by health care professionals

Participants were asked to indicate whether health care professionals had received *ad hoc* training courses in the last year. Data are available for all respondents (n=12, 100%). **None** of the respondents **have taken training courses in the last year**.

Patients receiving rehabilitation interventions

Participants were asked to indicate which patients are involved in rehabilitation interventions. Data are available for all respondents (n=12, 100%). More than half of the units reported offering these interventions based on the individual preference of each patient, regardless of the diagnosis (n=7; 58.3%); in other cases, the provision of interventions was reported to be based on the severity of the patients' condition (n=2; 16.7%). Fewer units reported providing these interventions mainly to patients with anxiety spectrum disorder, psychotic disorders. Also, 1 unit reported offering these interventions to all patients who attend the service. (**Figure 6**).

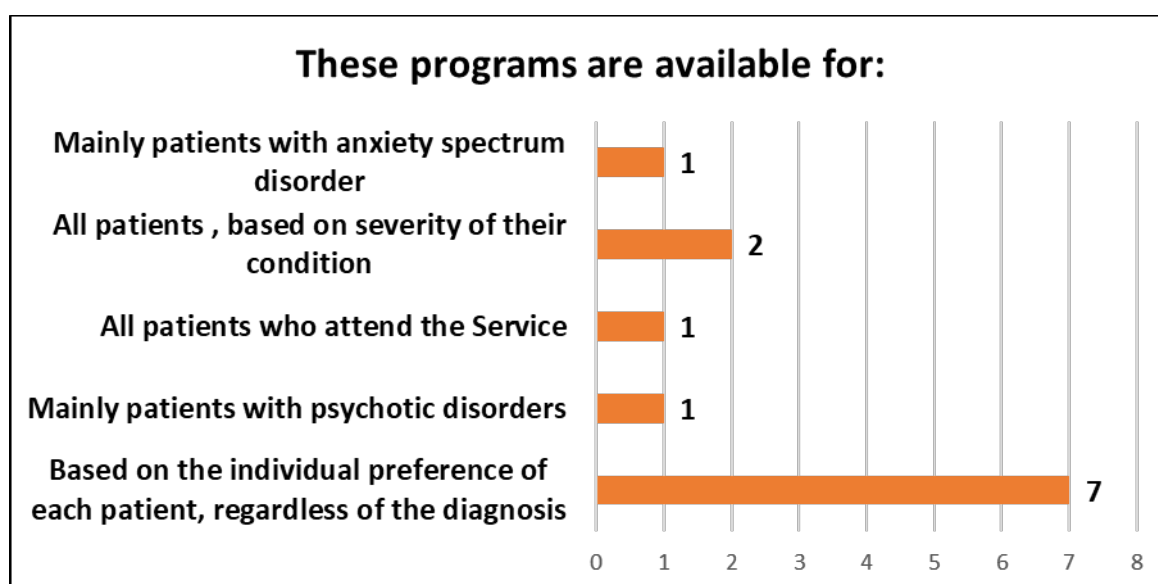


Figure 6. Patients receiving rehabilitation interventions. Data are shown as % of units.

Involvement of the private social sector in rehabilitation interventions

As for the involvement of the private social sector in rehabilitation interventions, the 12 respondents answered as we see in **Figure 7**.

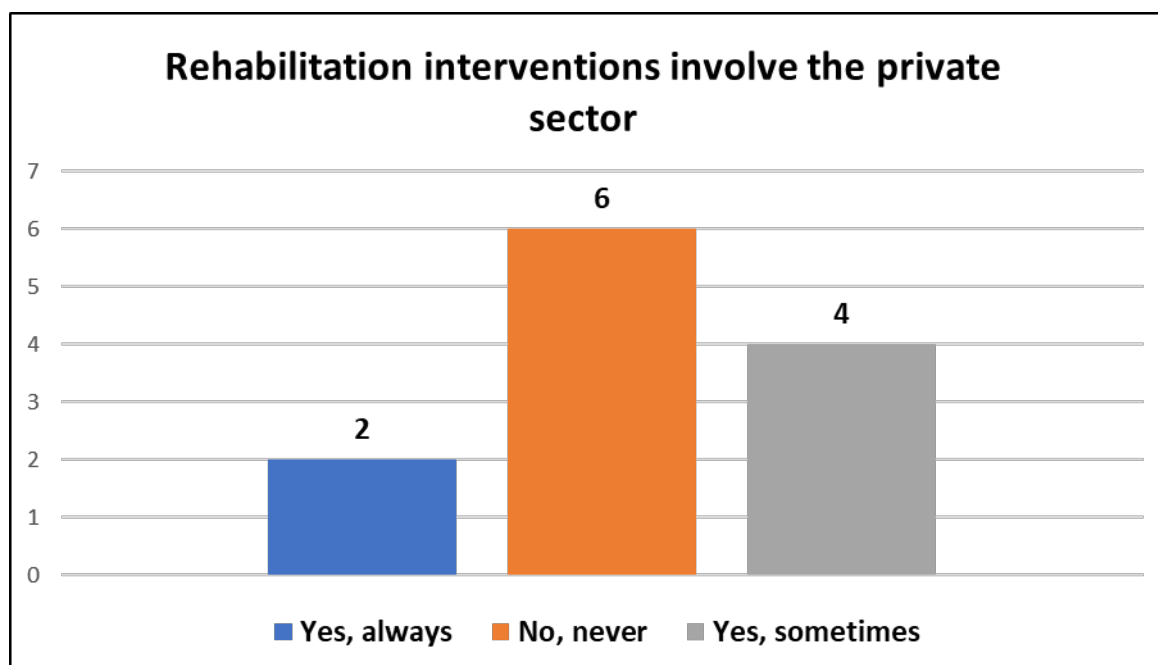


Figure 7. The involvement of the private sector in the rehabilitation interventions

Monitoring the rehabilitation interventions

As for the monitoring of the interventions, the 12 respondents answered as we see in **Table 5**.

Table 5. Monitoring of the intervention with the involvement of the social private sector	n	%
No never	6	50%
Yes, sometimes	4	33.3%
Yes, always	2	16.7%
Total	12	100.0%

There were 10 answers to this question (n=10; 83.3%). The effectiveness of the interventions is monitored with different approaches as shown in **Table 6**.

Table 6. Monitoring of the intervention with the involvement of the social private sector	n	%
Through direct contact between the service and the NGOs/association/foundation	3	30%
Through the involvement of a <i>case manager</i> in rehabilitation intervention	2	20%
Through periodic reports of the activities	2	20%
Through the administration of validated assessment tools	0	0%
Other	0	0%
Not available	3	30%
Total	10	100.0%

INFORMATION ON INTERVENTIONS INVOLVING STRUCTURED PHYSICAL ACTIVITY/EXERCISE AND/OR SPORT

Provision of interventions involving structured physical exercise and/or sports

Participants were asked to report as to whether rehabilitation interventions involving structured physical exercise and/or sports are (or were) carried out in their services. Data are available for n=10 respondents (83.3%). Four of the 10 respondents said that such an intervention was never provided (40%). Three of the respondents (30%) reported that one or more programs are currently active (n=3; 30%), while two units (20%) did not respond (**Figure 8**). This corresponds somehow with the answer to question 1 (see **Table 3**); in question 1, 4 units reported offering interventions involving structured physical activity/exercise and/or sport. Of the 10 units reported to provide such interventions, only 7 had responded and only 1% reported collaboration with Sports clubs/Associations/Organizations (**Figure 9**).

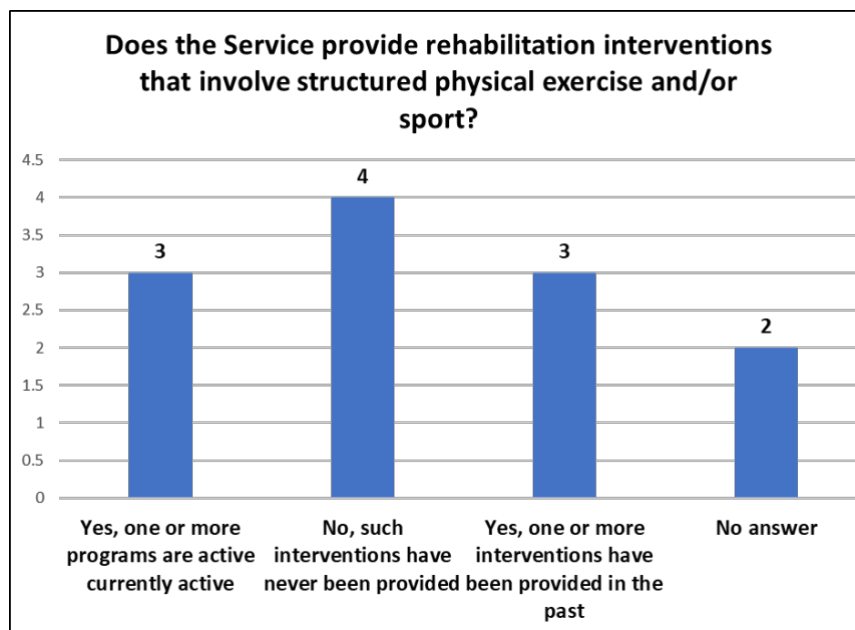


Figure 8. Provision of rehabilitation interventions involving structured physical exercise and/or sports

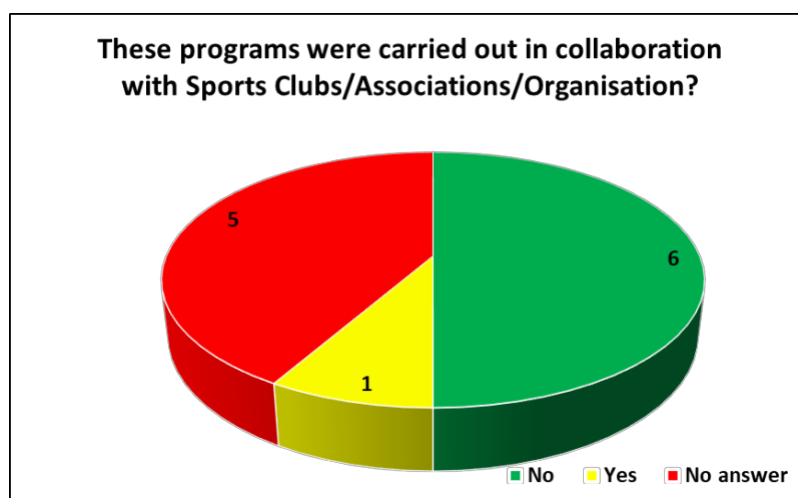


Figure 9. Collaboration with Sports Clubs/Associations/Organisations

Patients receiving interventions involving structured physical exercise and/or sports

All the following analyses were carried considering the sample of 6 units that reported providing interventions involving structured physical exercise and/or sports. These units were asked for which patients these programs were available. Data are available for 6 respondents (50%). One unit reported offering these interventions to all patients based on the severity of their condition (n=1; 16.7%), one unit (16.7%) to all patients attending the service, while four units reported offering the interventions based on the individual preferences, regardless the diagnosis (66.6%). (**Table 7**).

Table 7. Patients receiving interventions involving structured physical exercise and/or sports	n	%
Based on the individual preferences of each patient, regardless of the diagnosis	4	66.6%
All patients who attend the service	1	16.7%
All patients, based on the severity of their condition	1	16.7%
Mainly patients with psychotic disorders	0	0%
Mainly patients with eating disorders	0	0%
Mainly patients with affective disorders (bipolar disorder or depressive disorder)	0	0%
Mainly patients with anxiety spectrum disorders	0	0%
Other	0	0%
Total	6	100.0%

Funds for interventions involving structured physical exercise and/or sports

Participants were asked to indicate whether their unit uses dedicated funds for carrying out rehabilitation interventions involving structured physical exercise and/or sports. Data are available for 7 respondents (58.3%). The majority of the units (n=5; 71.4%) reported not using dedicated funds to carry out these interventions. One unit (14.3%) uses public health funds, and one (14.3%) uses private funds. (**Figure 10**).

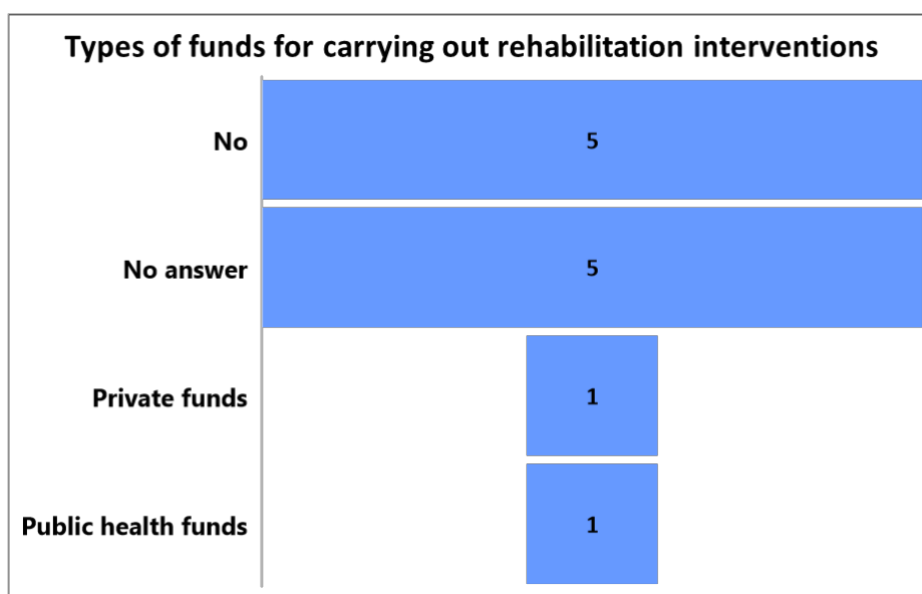


Figure 10. Funds for carrying out rehabilitation interventions involving structured physical exercise and/or sports. Data are shown as % of units reporting the provision of intervention.

Aim of the interventions involving structured physical exercise and/or sports

Participants were asked to indicate the aim(s) of rehabilitation interventions involving structured physical exercise and/or sports. Data are available for 7 respondents (58,3%). **Table 8** shows the aims of rehabilitation interventions involving structured physical exercise and/or sports offered in the sample of participants, expressed as the number (n) and the % of services offering the interventions. Since services could list more than one aim (multiple answers could be selected), percentages are computed out of the number of services (n=7) instead of the number of aims listed; hence, the sum of individual percentages exceeds 100%.

Table 8. Aims of Rehabilitation interventions	n	%*
Recreational/Occupational activity	6	85.7%
Promotion of healthy lifestyles (e.g. weight reduction, smoking)	6	85.7%
Reduction of clinical symptoms	5	71.4%
Improvement of social skills	3	42.9%
Promotion of social integration	3	42.9%
Cognitive rehabilitation	3	42.9%
Other	0	0%

* % is computed out of the number of services (n=7)

Type of sport included in the rehabilitation program

Participants were asked to indicate the type of sport included in the rehabilitation interventions involving structured physical exercise and/or sports. Data are available for 6 respondents (50%). **Table 9** shows the type of sport included in the interventions, expressed as the number (n) and the % of services offering the interventions based on that sport.

Table 9. Type of sport/exercise included in the program	n	%
Walking	3	50%
(Gentle) gymnastics [#]	1	16.7%
Football/Five-a-side football	2	33.3%
Running	2	33.3%
Volleyball	1	16.7%
Basketball	1	16.7%
Tennis	3	50%
Other	2	33.3%

* % is computed out of the number of services (n=6). [#] includes coordination, breathing, postural, joint mobility, muscle awakening, stretching

Monitoring, assessment of the effectiveness

Participants were asked to indicate whether the rehabilitation interventions involving structured physical exercise and/or sports are monitored. Data are available for 7 respondents (58.3%). Three of the units (n=7) reported evaluation/monitoring of these interventions ("sometimes": n=3, 42.9%), one unit reported "always": n=1, 14.3%), while 3

units reported to never assess the effectiveness of rehabilitation interventions involving structured physical exercise and/or sports (42.9%). (**Figure 11**).

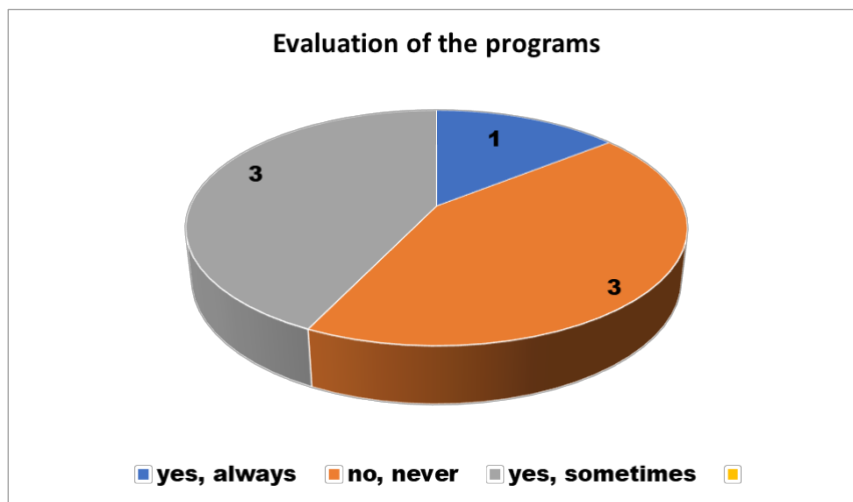


Figure 11. Monitoring, assessment of effectiveness. The graph shows the % of units reporting monitoring/assessment of effectiveness “always”, “sometimes” and “never”.

Tools used for monitoring (standard/validated scale or other monitoring tools) (n=3)

Of the 4 units reporting the monitoring of rehabilitation interventions involving structured physical exercise and/or sports, only 3 indicated specific tools. One unit reported the use of non-validated tools (33.3%), one unit (33.3%) reported the use of validated tools (Unconditional Self Acceptance Questionnaire - USAQ) and one unit (33.3%) reported that the monitoring is performed but without saying the concrete specification of the tools.



FINLAND

2.3 Finland

Methods

Public mental health care services. In Finland, the Ministry of Social Affairs and Health is responsible for the legislation concerning mental health services¹, the regulations for admission to treatment, and other official governance. Statistics show that the greatest volume of mental health services is provided by health centres and specialist medical care facilities. Social services and parishes also undertake certain activities that may be considered mental health services. Furthermore, a wide range of mental health services is provided by NGOs, i.e. the third sector. Private-sector services are of significant importance particularly in the area of psychotherapy.

The majority of the clients of mental health services receive outpatient care; only a small percentage require hospitalization. Today, Finland's psychiatric hospitals have about 3,500 beds altogether, compared with about 20,000 at their peak. The number of beds will continue to decrease as the number of outpatient visits increases. Today, hospitals treat fewer than 30,000 people annually, about one-third of them subjected to involuntary treatment under the Mental Health Act.

In Finland, when people experience symptoms of anxiety or depression or more severe mental health symptoms, they first contact their local health centre. Many health centre facilities have psychiatric nurses who work with health centre physicians to examine such cases and to offer help. Health centres also have psychologists, and in some places there are psychiatrists.

In certain communities, psychiatric specialist medical care provides on-call services that can be directly contacted. Otherwise, you will need a specialist medical care referral from a physician. There are great differences in how mental health services are organised in different communities. To find out about the situation in the local community, it is possible to consult the instructions issued by the local authority or visit the [Mental Hub](#) website. This online service contains lots of information besides first-aid and self-help instructions. Specialist medical care facilities provide psychiatric services in outpatient care and in hospitals. In addition to the general psychiatric outpatient clinics, there are also specialised services addressing specific issues such as eating disorders.

Moreover, there are dedicated crisis teams to help people in a crisis, for instance in the aftermath of an accident, in order to prevent later mental health issues. Information on crisis teams is available at emergency clinics and also from the rescue services and the police.

In case of a personal crisis, you may turn to the crisis centres maintained by the Finnish Association for Mental Health and the family counselling centres run by parishes. Various NGOs also offer more specialised services for this purpose.

¹'Mental health services' refers to services that aim to prevent, alleviate and treat mental health problems and their consequences. Promoting mental health may also be considered a mental health service. Such services include providing guidance, advice, needs-based psychosocial support, psychosocial support in crisis situations, and the study, treatment and rehabilitation of mental health problems.

[Finnish Institute for Health and Welfare <https://thl.fi/en/web/mental-health/mental-health-services>]

Recruitment of services. We seek to recruit the main public and private Mental Health actors and associations which might already have some physical activity rehabilitation programs, or which might be interested in piloting such programs especially here in our region. We already had connections to some mental health associations because of the previous Erasmus project SPHERE, so we decided to approach our local SPHERE partners first and ask if they could help us to extend the survey in their networks. We also contacted our region's Health Care District to reach out public mental health care units. We asked The Finnish Central Association for Mental Health, the local Health Care District, and The Finnish Paralympic Committee to forward the EASMH survey in their networks to their member organizations and associations and public mental health units.

Data analysis. Data relative to closed-ended questions (with pre-coded response options) were analyzed descriptively using frequency distribution of items. Data relative to open-ended questions were analyzed using content analysis; recurring issues were listed and described using frequency distribution.

Results

We obtained 17 responses from different Services (see Methods for the list of Services)

INFORMATION ON THE MENTAL HEALTH SERVICE

Type of Service

Data are available for all respondents (n=17; 100%). Data are shown in **Table 1**.

Table 1. Type of Service	n	%
Community mental health centers (CSM)	8	47%
Community residential facilities	2	12%
Daycare centers	1	6%
Mental health Organization (NGO)	3	18%
Private mental health association	2	12%
Municipality Sport Services	1	6%
Total	17	100.0%

Services were split into Outpatient units and Inpatient units as shown in **Figure 1**. More than half of the units (53%) were Outpatients services.

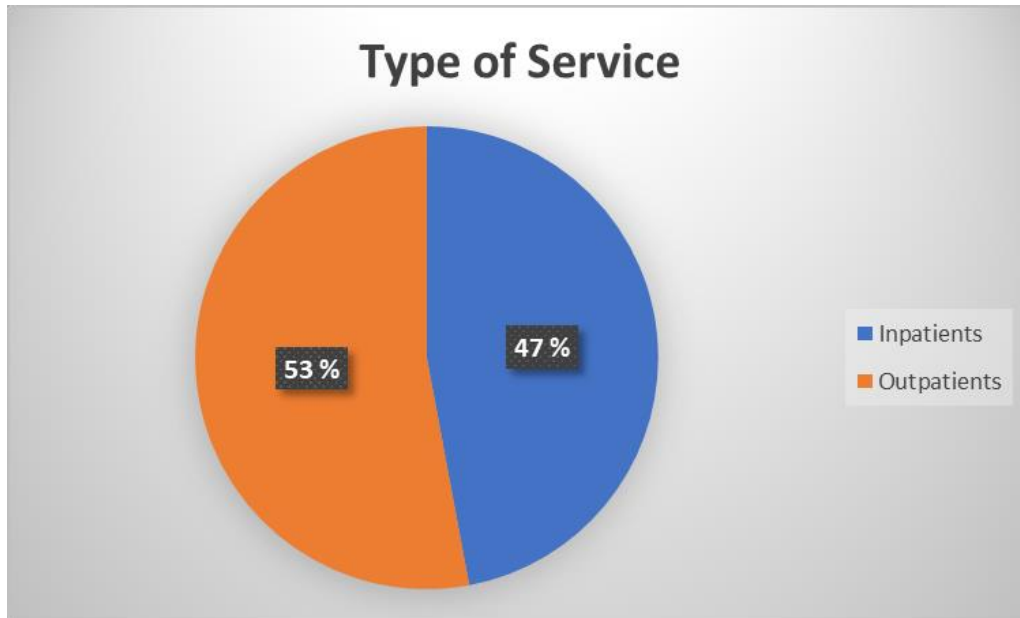


Figure 1. Type of services. The graph shows the % of Inpatients and Outpatients units in the sample of respondents.

INFORMATION ON REHABILITATION INTERVENTIONS

Types of rehabilitation interventions provided to patients

Participants were asked to indicate the type of rehabilitation interventions provided to patients in their unit. Data are available for all respondents (n=17; 100%). **Table 2** shows the type of rehabilitation interventions offered in the sample of participants, expressed as the number (n) and the % of services offering the intervention. Since participants could list more than one intervention (multiple answers could be selected), percentages are computed out of the number of services (n=17) instead of the number of interventions listed (n=70); hence, the sum of individual percentages exceeds 100%. Fourteen units (which represent 82% of the total sample) indicated offering interventions including structured physical activity/exercise and/or sport.

Table 2. Rehabilitation interventions	n	%*
Social Skills Training	10	59%
VADO (Skills Assessment and Definition of Goals)	4	24%
Cognitive rehabilitation (CogPack etc.)	8	47%
Psychoeducational interventions#	9	53%
Educational interventions to improve lifestyles (diet, smoking, substances of abuse)	9	53%
Wellness Self-Management	10	59%
Assertive Community Treatment	1	6%
Animal-assisted therapy (Pet therapy)	1	6%
Supported employment	4	24%
Interventions including structured physical activity/exercise and/or sport	14	82%

* % is computed out of the number of services (n=17). #both in an individual setting and in a group or family setting.

Figure 2 shows the frequency of rehabilitation interventions provided by services, expressed as % of the total responding services (n=17). All interventions provided by less than 5 units were merged in the 'Other' category. Music therapy and Theatre therapy were merged in the 'Art therapy'. Pet therapy and Social agriculture in the 'Nature-based interventions' category.

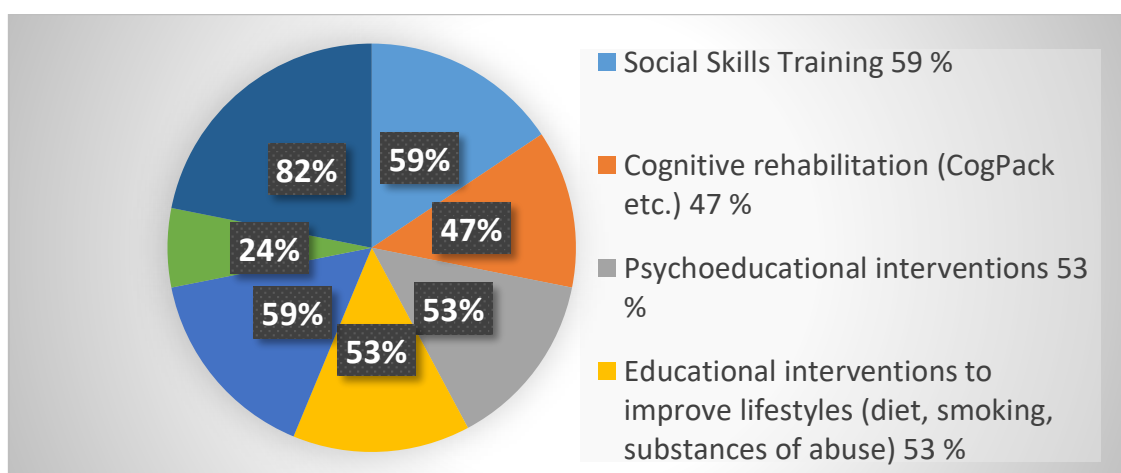


Figure 2. Types of rehabilitation interventions. Percentages are computed out of the number of services (n=17)

Professional figures involved in rehabilitation interventions

Participants were asked to indicate the professional figures involved in rehabilitation interventions in their unit. Data are available for all respondents (n=17, 100%). Data are shown in **Table 3** and **Figure 3**.

Table 3. Professional figures	n	%*
Psychiatrists	7	41%
Psychiatric rehabilitation technicians	6	35%
Nurses	11	65%
Psychologists	6	35%
Social workers	6	35%
Healthcare social workers (OSS)	5	29%
Trained volunteers / Trained family members	4	24%
Occupational therapists	3	18%
Sport instructor	2	12%
Other	1	6%

*Percentages are computed out of the number of services (n=17) instead of the number of professionals listed (n=51); hence, the sum of individual % exceeds 100%.

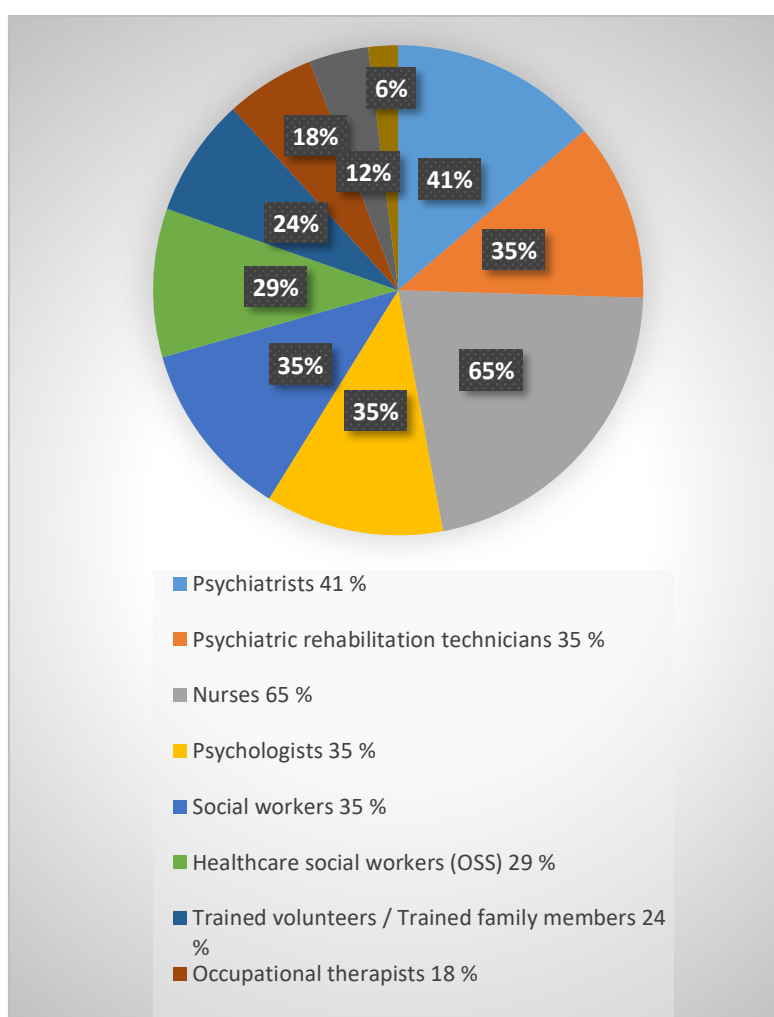


Figure 3. Professional figures involved in rehabilitation interventions. Percentages are computed out of the number of services (n=17).

Involvement of family members in rehabilitation interventions

Data are available for all respondents (n=17, 100%). The vast majority of units (76%) reported the involvement of family members in interventions (“sometimes”: 76%; “always”: 0%) (**Figure 4**).

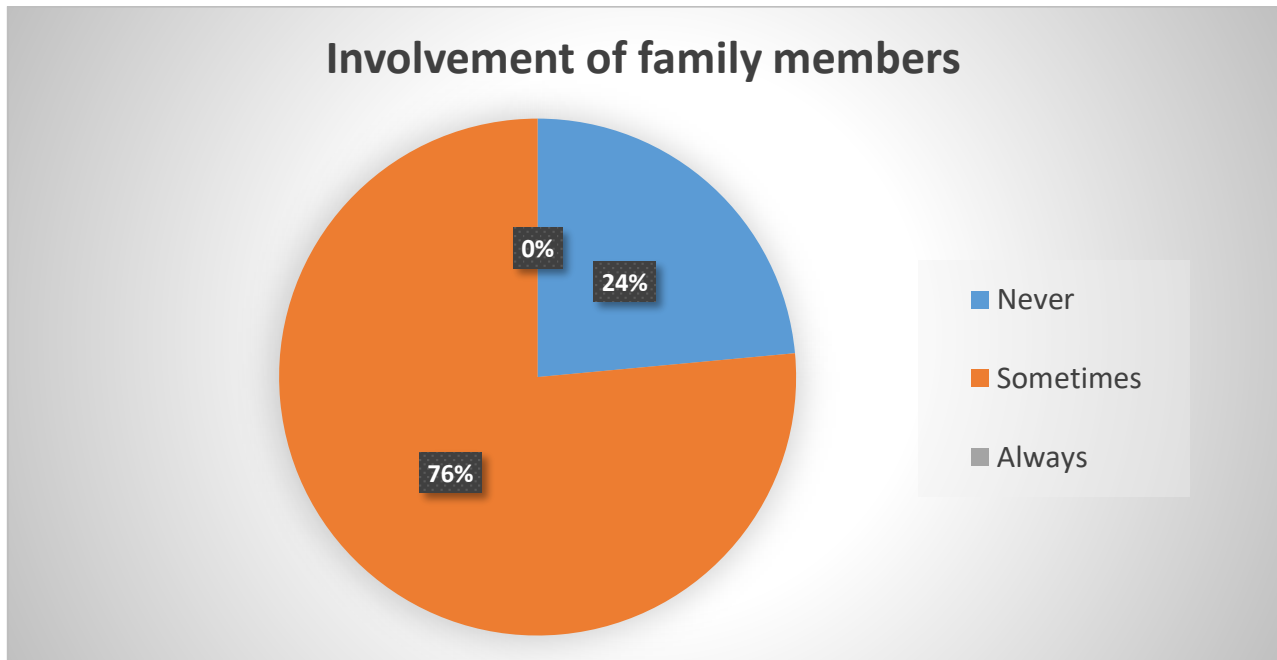


Figure 4. Involvement of family members in rehabilitation interventions. The graph shows the % of units reporting the involvement of family members “always”, “sometimes”, and “never”.

Involvement of the private social sector in rehabilitation interventions

Participants were asked to indicate whether the private social sector (i.e., Non-governmental organization-NGOs, Charities, Associations, or Foundations) is involved in rehabilitation programs. Data are available for n=17 respondents (100%). Only one unit (6 %) reported having “never” involved the private social sector in the rehabilitation programs. The vast majority of units (n=16) reported the involvement of the private social sector (“sometimes”: n=13, 76%; “always” n=3, 18%).

Patients receiving rehabilitation interventions

Participants were asked to indicate which patients are involved in rehabilitation interventions. Data are available for all respondents (n=17, 100%). Data are shown in **Figure 5**.

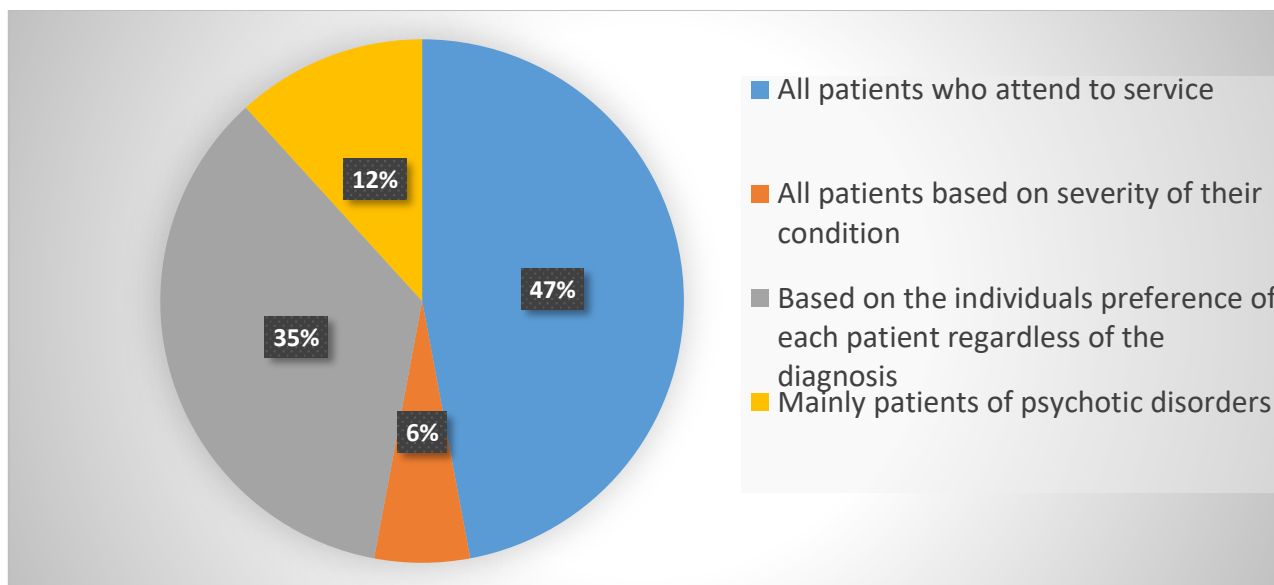


Figure 5. Patients receiving rehabilitation interventions. Data are shown as % of units. No units reported providing interventions “mainly to” patients with eating disorders or affective disorders, or anxiety spectrum disorders.

INFORMATION ON INTERVENTIONS INVOLVING STRUCTURED PHYSICAL ACTIVITY/EXERCISE AND/OR SPORT

Provision of interventions involving structured physical exercise and/or sports

Participants were asked to report as to whether rehabilitation interventions involving structured physical exercise and/or sports are (or were) carried out in their services. Data are available for n=16 respondents (94%). All but one of the services reported one or more programs are currently active, while only one unit (6.7%) stated such interventions have never been provided. Of the 16 units reported to provide such interventions, only 35% (n = 6) reported collaboration with Sports clubs/Associations/Organizations.

Patients receiving interventions involving structured physical exercise and/or sports (n=16)

All the following analyses were carried considering the sample of 16 units that reported providing interventions involving structured physical exercise and/or sports. These units were asked for which patients these programs were available. Data are shown in **Figure 6**.

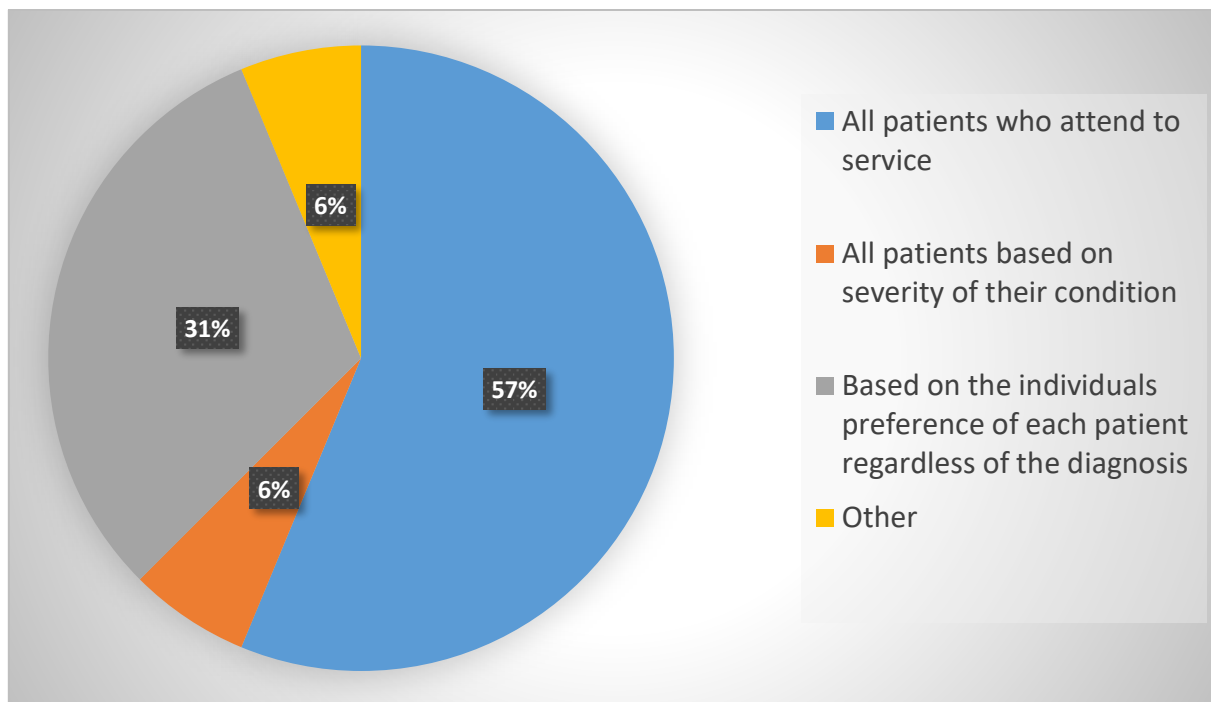


Figure 6. Patients receiving rehabilitation interventions involving structured physical exercise and/or sports. Data are shown as % of units.

Funds for interventions involving structured physical exercise and/or sports (n=16)

Five units (31 %) use public health funds, while only one (6 %) uses public social funds. Three units (19 %) use private funds, while also three units (19 %) reported using more than one type of fund (health, social and private). Only three units (n=3, 19 %) reported not using dedicated funds to carry out these interventions.

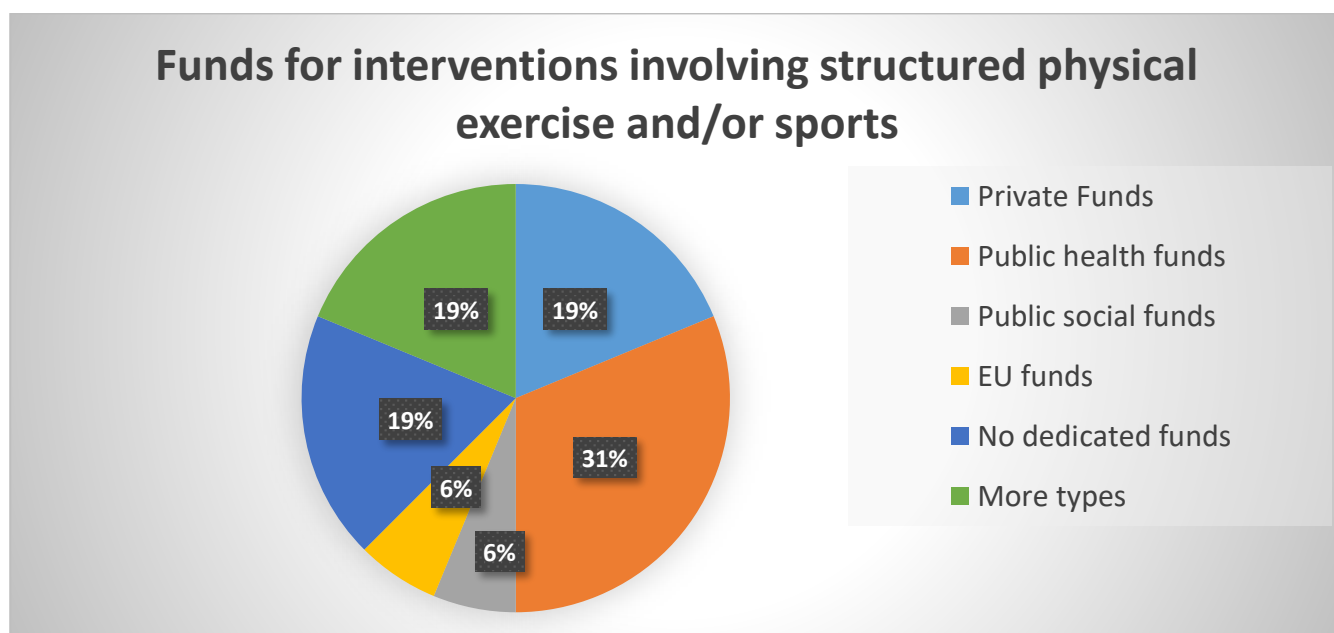


Figure 7. Funds for carrying out rehabilitation interventions involving structured physical exercise and/or sports. Data are shown as % of units reporting the provision of intervention.

Aim of the interventions involving structured physical exercise and/or sports (n=16)

Participants were asked to indicate the aim(s) of rehabilitation interventions involving structured physical exercise and/or sports. **Table 6** shows the aims of rehabilitation interventions involving structured physical exercise and/or sports offered in the sample of participants, expressed as the number (n) and the % of services offering the interventions. Since services could list more than one aim (multiple answers could be selected), percentages are computed out of the number of services (n=16) instead of the number of aims listed (n=77); hence, the sum of individual percentages exceeds 100%.

Table 4. Aims of Rehabilitation interventions	n	%*
Promotion of social integration	8	50%
Promotion of healthy lifestyles (e.g. weight reduction, smoking)	14	88%
Improvement of social skills	13	81%
Recreational/Occupational activity	9	56%
Reduction of clinical symptoms	14	88%
Cognitive rehabilitation	4	25%
Elintapaohjaus	15	94%

* % is computed out of the number of services (n=16)

Type of sport included in the rehabilitation program (n=16)

Participants were asked to indicate the type of sport included in the rehabilitation interventions involving structured physical exercise and/or sports. **Table 5** shows the type of sport included in the interventions, expressed as the number (n) and the % of services offering the interventions based on that sport.

Table 7. Type of sport/exercise included in the program	n	%*
Walking	15	94%
Gym	7	44%
Football/Five-a-side football	9	56%
Swimming and other activity in water	10	63%
Running	12	75%
Volleyball	2	13%
Horse riding	2	13%
Games with rackets / clubs	11	69%
Other	1	6%

* % is computed out of the number of services (n=16).

Monitoring, assessment of effectiveness (n=16)

Participants were asked to indicate whether the rehabilitation interventions involving structured physical exercise and/or sports are monitored. The majority of units (n=15) reported evaluation/monitoring of these interventions ("sometimes": n=7, 44 %; "always": n=8, 50%), while only 1 unit reported to never assess the effectiveness of rehabilitation interventions involving structured physical exercise and/or sports (**Figure 8**).

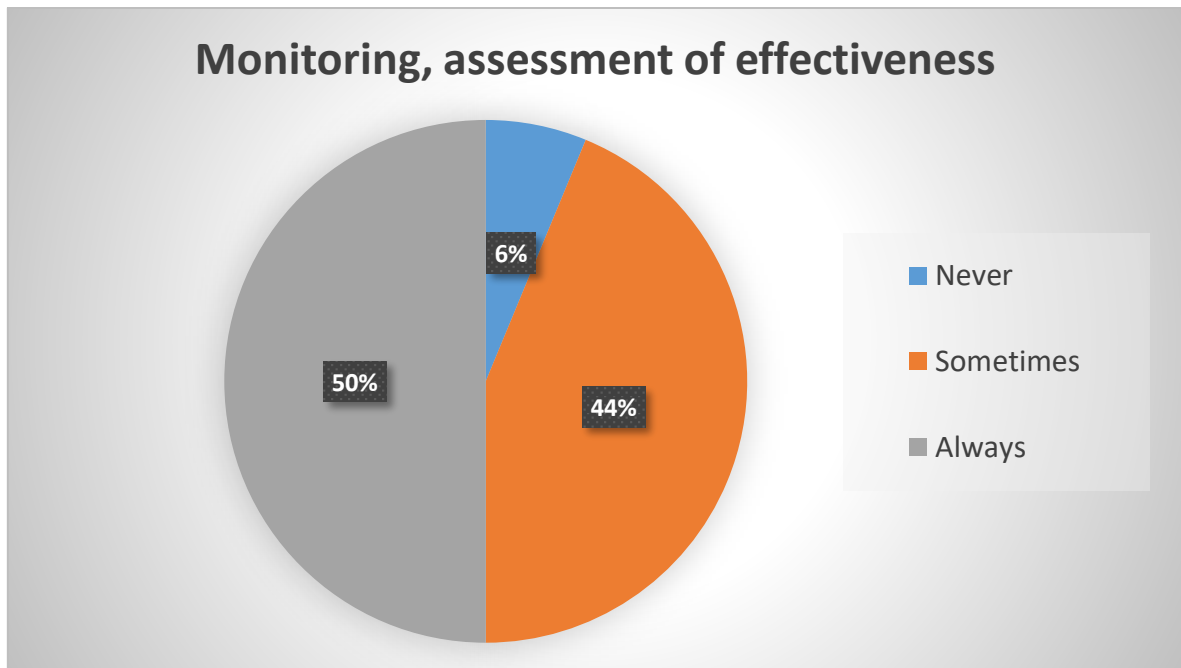


Figure 8. Monitoring, assessment of effectiveness. The graph shows the % of units reporting monitoring/assessment of effectiveness “always”, “sometimes” and “never”.

Tools used for monitoring (standard/validated scale or other monitoring tools) (n=12)

Of the 15 units reporting the monitoring of rehabilitation interventions involving structured physical exercise and/or sports, only 12 indicated specific tools. Four units reported the use of validated tools to assess the improvement of the participants (25 %). Six units reported that they collect feedback by direct groups discussions and questionnaires from participants.

3. Overview: comparison among EU countries

We obtained responses from 49 different services in Italy, 31 in UK, 12 in Romania, and 17 in Finland. The **first section** of the questionnaire was aimed at collecting information on the mental health units participating in the survey. Data show that most of the participants were community mental health centers (all countries except for Romania which reported a prevalence of individual psychological offices). Additional data were collected from community residential facilities and daycare centers in Italy, community-based mental health support charities in UK, and hospital–psychiatric wards in Romania. Mental health organizations, community residential facilities, and private mental health associations were prevalent in Finland. In all countries more than half of the services were outpatient units.

In the **second section** of the questionnaire, we aimed at collecting information on the provision of rehabilitation interventions in the participating units. Social skill training and psychoeducational interventions are among the most frequent rehabilitation interventions provided to patients in all countries. Interventions including structured physical activity/exercise and/or sport are prevalent only in UK and Finland. Educational interventions to improve lifestyle were frequently cited by respondents based UK and Finland. Interventions as V.A.D.O. or wellness self-management appear to be frequently offered only in specific countries (in this case Italy and Finland respectively).

As for the professional figures involved in the interventions, data analysis reveals substantial differences among countries. More specifically, while the vast majority of services in Italy reported the involvement of psychiatrists, psychiatric rehabilitation technicians, nurses, and psychologists, in UK there is a prevalence of trained volunteers, nurses, and social workers (with few units reporting the involvement of psychiatrists and psychiatric rehabilitation technicians). Also in Romania and Finland, there is a relatively low proportion of units reporting the involvement of psychiatrists, while psychologists and nurses respectively were reported being more frequently involved. Most of the participating units (all countries) reported the involvement of family members in rehabilitation interventions. As resulted from the survey, these interventions may be offered to all patients (mainly in UK and Finland), or the offer may be based on the severity of the patients' condition (mainly in Italy) or according to the individual preference of each patient (mainly in Romania).

Although the health field is knowledge-driven and for professionals involved staying up-to-date is crucial, in the case of our sample a scarce number of units reported the provision of training courses on rehabilitation interventions to health care professionals (less than half of the respondents in Italy and UK, none of the respondents in Romania).

Another aspect we investigated in our sample of participants was their reliance on public-private relationships to deliver health and social services, a well-known trend in many EU countries, emerged in response to the financial and organizational crisis of the National Health Systems. In our sample of services, the involvement of the private social sector in the provision of rehabilitation interventions appears to be substantial only in two countries (Italy and Finland), while only less than half of the respondents in UK and the vast majority in Romania reported having never involved the private social sector in rehabilitation activities. When the private sector is involved, the effectiveness of the interventions is mainly monitored through direct contact between the service and the NGOs/association/foundation

in Italy and Romania. Only in UK, there is a prevalent use of validated assessment tools for monitoring the interventions.

In the **third section** of the questionnaire, we collected information on the provision of rehabilitation interventions involving **structured physical exercise and/or sports**. These interventions appear to be frequently offered by mental health services, especially in Italy, UK and Finland. While in UK and Finland interventions including physical activity are commonly offered to all patients attending the service, in the other countries the provision of these interventions is based on were offered to all patients based on the severity of the patient's condition or their preference. Other differences emerged from the data: while in Italy most of the units appear to have no access to dedicated funds to carry out these interventions, in UK and Finland respondents reported using mainly public or social health funds.

Rehabilitation interventions involving structured physical exercise and/or sports can have different aims, as set by the health care teams, the most frequently being in all countries the promotion of social integration and healthy lifestyle. In some countries other aims were reported, in particular improved social skills (Italy and Finland), and reduction of clinical symptoms (Romania and Finland).

These interventions may be also based on different sports, the most frequently being walking (in Italy, Romania, and Finland), football (UK). Other very cited sports were: running (all countries), gentle gymnastics and volleyball (Italy), tennis and table tennis (UK and Finland), basketball, tai chi and yoga (UK), horse riding and swimming (Italy and Finland), sailing (Italy). The majority of services in our sample reported evaluating/monitoring these interventions by specific tools.

4. Conclusions

The current survey, although providing many interesting data on the psychiatric rehabilitation tools offered, it clearly emphasizes the great differences in the approaches taken on by psychiatric services in the management of psychiatric rehabilitation in different European countries involved in the EASMH project (i.e., UK, Romania, Finland, Italy).

Psychiatric rehabilitation programs started in Italy before and after the law 180/78 (Basaglia Law) and the final closure of Psychiatric Hospital. In Italy, the Mental Health Services has no longer Psychiatric and Forensic Hospitals and the assistance is based on community-based services. General Hospitals provide beds for psychiatric assessment and acute treatment. There are also many structures reserved for psychiatric inpatients where they can access many rehabilitation activities.

Differently from Italy, UK has a very long history in the field of Psychiatric Rehabilitation using sport and social inclusion and, not by chance, according to the present survey, it is the country where sport-based activities for mental disorders are most prevalent. In the UK, the National Health Service includes primary care facilities, community mental health centers, general hospitals, university clinics, and also secondary acute care in psychiatric units and residential facilities. Even in UK there is a large percentage of mental health care that comes from private care providers.

In Romania the Mental Health Service has begun a new program to tackle mental health, setting as target date the end of 2021 for the de-institutionalization of more than 1300 people with disabilities, including psychiatric patients. At present Romania still has a predominantly institutional mental health and social care system, although deinstitutionalization has been on the agenda and is now underway. Most care for people with mental illnesses has been generally provided in institutional settings, but the number of people being supported in small-scale community settings is increasing. In general, Mental Health services include: community mental health centers, daycare facilities, general hospital psychiatric units, residential facilities, university clinics, and private nursing homes, based on Law no. 487 of July 11, 2002 on mental health and protection of persons with mental disorders. Pharmacological treatment is the main care provided.

As for Finland, the Governmental policy has been oriented towards closing all institutions by 2020. Several programs have been developed to offer community-based support and prevent social exclusion. At present these programs are focused on the transition from group homes to community living, more in line with Article 19 of the UN CRPD, where people can exert a choice over where and with whom they live and are active participants in the community. Patients' treatment in Psychiatric Hospitals is on average no longer than 90 days. There are also patients in Psychiatric rehabilitation group homes with 24-hour assistance and others in Psychiatric rehabilitation homes with day-time only assistance. Furthermore, a wide range of mental health services is provided by NGOs, i.e. the third sector. Private-sector services are of significant importance particularly in the area of psychotherapy. There are also on-call specific services and dedicated crises teams.

This short outline indicates how in all the examined countries, the general Mental Health policy is oriented toward de-institutionalization and more and more over community-based assistance and care. The only country which has definitively closed Psychiatric Hospitals is Italy, but in UK and Finland the number of inpatients is constantly decreasing, while Romania has yet a long way to go to reach de-institutionalization.

These considerations clarify why the response to the survey has not been uniform and some countries have not been able to contact a large sample of mental health services.

However, from the surveys received, it emerges that in every country there are several psychiatric rehabilitation programs, offering many activities. Among these, structured physical activity is not the most prominent, except for UK: sport-based activities are mainly walking and football. This is likely due to the fact that walking is the cheapest and easier activity to organize, while football (i.e. five-a-side football) being very popular both among patients and psychiatric operators, is more readily taken on.

In terms of the methodology used in these programs, patients who have access to sports activities are not chosen with clear rehabilitation objectives. Physical activity appears to be carried out more to facilitate general wellbeing and social inclusion, rather than to tackle specific psychopathological aspects.

For an effective rehabilitation program, it is advisable to evaluate patients using a dimensional model in which there is a continuum within a set of pathological dimensions, that are combined to derive the specific clinical features of the patient. Using this model one can take into consideration a whole set of intermediate qualitative variables behind clinical and sub-clinical presentations – allowing to capture the gradual passage from a normo-typical presentation to a confirmed psychopathological one.

Using a dimensional approach it is possible to find the right match between the patient psychological features and the specific physical activities that can be proposed. This will allow taking advantage of the specific features of every sport and to provide a real “rehabilitative” context.

Another important aspect of the rehabilitation programs is their potential to be funded. According to the survey, most of the funds used in the different countries are not provided by public health care. Support mostly comes from the third sector, from private funds, from charities and organizations. The National Health Services, in general, is not very active in funding sport and other rehabilitation programs for mental health.

Only in the UK, where there is a long-standing tradition of “charities”, sport-based programs are funded by these and are largely employed in psychiatric rehabilitation.

The last consideration is about the shortage of sports professionals involved in physical activity with psychiatric patients. Usually, the operators who handle the sport rehabilitation programs are nurses, psychologists, relatives, and volunteers. Only to a small extent psychiatrists are present.

Implementing and including the presence of sports professionals too, could have a positive fallout on some psychopathological aspects of the patients, which could be “treated” with a precise structured physical activity, not only in a playful perspective.

As a summary, the main points coming out from the survey can be summarized as follows:

1. In mental health structures, there is a wide offer of rehabilitation activities, but physical structured activity is not the most practiced (except for UK)

2. Structured physical activity has the final aim of improving wellbeing and social inclusion. It is not considered as a specific psychiatric rehabilitation tool (such as Social skills training)
3. Access to a structured physical activity program has no specific clinical indications and is provided always in a categorical diagnostic perspective
4. The presence of specifically trained coaches is very poor
5. There is an important presence of family members, social workers, volunteers
6. Psychiatrists are involved only in a few cases
7. Specific training for sports coaches should be developed

To effectively integrate exercise practitioners within the multidisciplinary mental health team, sport and exercise practitioners must receive training in basic mental health literacy and illness-specific exercise prescription considerations. Opportunities for upskilling and continuing professional development should be provided to keep the highest level of evidence-based exercise prescription to people with MD. Enhancing the training of professionals, facilitating a cultural change within mental health services, and advocating for the provision of required infrastructure have been considered the cornerstones of achieving this goal [14].

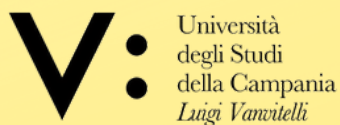
The **EASMH project will provide specific training modules** for sports professionals to follow and manage people with mental health problems and psychiatric patients in sports facilities. The EASMH project team is committed to promoting the role of exercise interventions as a key component of a comprehensive health care strategy for people with MD, also considering the need of reducing the life expectancy gap of this population.

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