Boosting impact of mental health policies and services for European people, communities and economies

Joint statement to invest in mental health research and a European Implementation Partnership on Mental Health and Wellbeing

For a full list of (inter)national signatories, please see annex 1

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Version: 2.4
Date: August 7, 2017

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Mental ill health leads to huge personal and economic costs for European individuals, communities and economies. The European Commission, EU Member States, WHO, and OECD recognise the need to address this negative impact of mental ill health. A "Mental Health in all Policies" approach is required in order to ensure social inclusion and financial sustainability. However, the lack of parity of esteem and disparity of funding between mental and physical health has been a huge barrier. Mental health research and the implementation of research outcomes are disproportionally underfunded.

This Joint Statement makes a case for investing in mental health research and implementation.

Building upon systematic reviews and consensus decision making involving more than a thousand stakeholders and experts, the Framework Programme-7 project ROAMER (**Roa**dmap for **Me**ntal Health **R**esearch in Europe) published in 2015 a comprehensive agenda on mental health research priorities. Funding this agenda is a first necessary step to address this issue properly.

The lagging implementation of evidence-based interventions in many European countries is a highly costly issue. To have impact, a European Implementation Partnership needs to focus on crossing the gap between innovation and adaption in the entire range of potential interventions: promotion of mental health and wellbeing, prevention of mental ill health and delivery of cost effective services.

Therefore, signatories urge the European Commission and Member States:

- To create a (virtual) European Network or Institute for Mental Health in line with the ROAMER recommendations. Its aim would be to build and share the research and implementation findings with respect to mental health in all EU Member States and monitor and coordinate mental health research and implementation efforts at the EU level.
- To invest € 100 million every year to execute the ROAMER recommendations on mental health research, as part the 9th Framework Programme.
- To start in 2018 together with Member States and other stakeholders a European Implementation Partnership for Mental Health.
- To dedicate at least 2% of ERDF, ESF and INTERREG funds for the implementation of national programmes for mental health promotion, prevention of mental ill health and accessible, quality and cost effective community-based services from 2021.
- The impact of these investments are significant. With an annual return of investment of 37%, the payback period will be less than 3 years.

Now is the time for parity of esteem and parity of funding between mental and physical health. It is time to act.

Despite the huge personal and economic costs of mental ill health…

Mental health problems still constitute the most significant yet most neglected area of health problems. Every year, more than a third of the European population of nearly 900 million[1] are affected by mental ill health (WHO Europe, 2013:16). More specifically, major depression affects an estimated 30.3 million Europeans; psychotic episodes affect 5 million Europeans, based on 12-month prevalence rates (Wittchen et al, 2011). Mental health problems also rank first, ahead of other chronic diseases as contributing the most years lived with disability (WHO Europe, 2013:16).

The OECD has estimated that the costs of mental ill health (excluding addictions, dementia and neurological conditions) are between 2.4 – 4.4% of Member States GDP (OECD, 2015). In 2013, the European Commission stated that the total costs of work-related mental ill health in the EU27 amounted to nearly € 610 billion per year (EAHC, 2013:5). These costs were related to:

- employment due to absenteeism and presenteeism (€ 270 billion)
- the economy in terms of lost output (€ 240 billion)
- the healthcare systems due to treatment costs (€ 60 billion)
- the social welfare systems due to disability and unemployment benefits (€ 40 billion)

Increasingly, studies have shown that mental ill health constitutes a major risk factor for a wide range of physical health problems (De Hert et al, 2011). Co-morbid mental health problems have been estimated to increase health care costs by 45-75% and thus account for between 12-18% of all spending on non-communicable conditions (Naylor et al, 2012). The costs of physical health care for people with cancer and depression are significantly higher. In the UK, co-morbid mental ill health accounts for € 10 - 18 billion (Department of Health, 2010).

It is also vital to understand the relation between mental health and non-communicable and chronic diseases, and of mental health and health across the lifespan. In the past twenty years, research has shown the close relationship between mental and physical health and the need to develop effective health promotion and prevention interventions. (Prados-Torres et al, 2014; Harvey & Ismail, 2008; Prince et al. 2007; Turner & Kelly, 2000; Katon & Ciechanowski, 2002; Walker et al, 2014):

- Co-morbid major depression and chronic physical illness (arthritis, heart disease, asthma, back problems, COPD and diabetes) lead to greater healthcare utilization.
- Depression and anxiety are proven risk factors for coronary heart disease and have a negative impact on the recovery after myocardial infarction.
- The risk of myocardial infarction is 4 times higher among persons with a previous history of a depressive episode than in those who have not had a depression.
- People with depression have approximately a 70% increased risk of developing heart disease. Following a heart attack, men with depression had 2.3 times greater chance of dying.
- Major depression is more common in patients with cancer than in the general population. However, 73% of patients with cancer and co-morbid depression were not receiving (potentially effective) treatment for the depression.

[1] The population of the EU at the moment is slightly over 500 million. The incidence and prevalence of mental ill health is similar though.

… mental health research is disproportionally underfunded.

The improvement of systems for prevention, treatment and management of mental ill health would not only benefit those with mental health problems, but would also support many segments of the society and economy in EU Member States. To make substantial progress, research and implementation are required as a matter of urgency. However, funding for mental health research lags far behind research for other health conditions.

Between 2007 and 2013, mental health received less than 5% of the health research budget of the European Commission's 7th Framework Programme (Wykes, 2015). On average, the UK invests approximately £8 per person affected by mental ill health; approximately 20 times more money is spent on research into cancer than on research into mental health (MQ, 2015). Looking at the burden of disease, the average funding across all health problems excluding mental health in Europe is €25 per Disability Adjusted Life Years (DALY). In contrast, funding for depression research is only €4 per DALY and only €2.9 for bipolar disorder (Catalá López et al, 2009)

Investments in mental health research deliver value for money, individuals and society. A study by the Health Economics Research Group and others showed that investment in mental health research in the UK gives a return of investment of 37% year on year, of which 7% in healthcare and 30% in GDP (Health Economics Research Group et al, 2008). A more recent Dutch study commissioned by the Netherlands Organisation for Health Research and Development (ZonMW) revealed that for every €1 they invested in mental health care research, the potentially payoff is €61 (Lokkerbol et al, 2016). Both studies illustrates the potential impact of mental health research on individuals, communities and economies in Europe.

Funding the roadmap for mental health research is a necessary first step …

The agenda for mental health research in Europe has been already developed. In October 2011, the European Commission funded a ROAdmap for MEntal health Research (ROAMER). In 2015, ROAMER published a comprehensive, coordinated mental health research agenda for Europe based on systematic reviews of published work and consensus decision making involving more than a thousand stakeholders and experts: individuals with mental health problems and their families, workers in mental healthcare, service providers, governmental policy makers and funders and payers of research and services (Wykes, 2015).

Figure 1: ROAMER research priorities

ROAMER identified 20 research priorities centred around 5 societal challenges (Figure 1 and Annex 2). These research priorities have been well received by international researchers as an important step forward, as such a transparent, evidence-based approach toward research and policy can lead to more rational and effective decisions about appropriate allocation of scarce research resources. In addition, it will give political leaders and their electorate the confidence that these resources are being appropriately stewarded and worthy of being expanded (Pincus & Rolin, 2017).

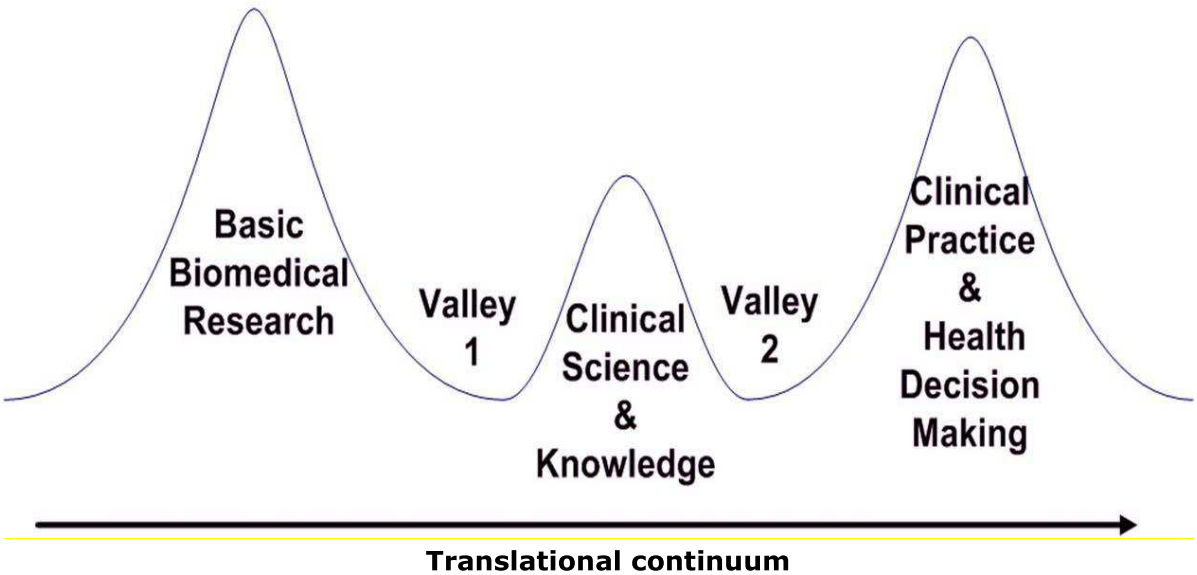
After funding and executing ROAMER, the EU and its Member States will benefit from the robust research infrastructure and the development of client-centred and integrated care, and personalised services for people with complex mental health needs.

… but to have impact, a structured implementation programme is necessary.

Funding, organising and conducting research is only half the challenge. ROAMER bridges but the first gap between fundamental and applied research. Translating existing knowledge and evidence to accessible, affordable and high quality social care, clinical practice and health decision making is a crucial step towards improving the quality of mental health care in EU Member States.

Evidence-based interventions aimed at the promotion of mental health, at the prevention of mental ill health and at early interventions generate significant economic benefits, including savings in public expenditure (Knapp et al, 2011). Other examples of cost effective measures are interventions to prevent psychosis in ultrahigh risk groups (Ising et al, 2016) and the scaling up of treatment of depression (Chisholm et al. 2016).

From clinical and translational research to policies and practice: 2 valleys of death



On average, it takes 17 years between innovation and adaptation (Blas and Boren, 2000). The EU cannot afford to wait this long anymore. To have an impact on people, communities and economies, all stakeholders need to accelerate the implementation of evidence-based interventions and evidence-informed policies. For health in general, the European Commission's Scientific Panel for Health (2016) calls for a coordination body to assure intensified cooperation and value at the European level.

For mental health, a European Implementation Partnership would be an appropriate approach to bridge the gap between innovation and adaptation and to deliver valuable services to the public in a shorter time span. This Partnership would bring together relevant stakeholders at the EU, national and regional levels across different policy areas to address this specific societal challenge. It would be a structured implementation effort facilitated by the European Commission and executed by the Member States within their own specific health systems and competencies.

The Partnership will build upon and use existing instruments for collaboration, e.g. the European Compass on Mental Health and Well-being, the Joint Action(s) on Mental Health and Well-being, Chronic Diseases and Health Technology Assessment, the EU Steering Group on Promotion and Prevention, the European Research Area, Erasmus+, the European Observatories on Health Systems and Social Polices and the European Innovation Partnerships. For its agenda and priorities, the Partnership could build upon the work of 20 European expert organisations in their Joint Statement on Mental Health for the EU Health Policy Platform (2016).

ROAMER has provided ample examples of the added value of a European infrastructure dedicated to research on mental health and well-being. Other potential areas of collaboration that could increase impact for Europeans include: integrating basic neurosciences and social sciences with clinical knowledge and peer expertise, joint work on the development of multidisciplinary clinical guidelines and care pathways, shared curricula development for peer experts and mental health workers, standardization of key indicators (PROMs and PREMs) and certification of digital mental health solutions.

At Member State level, dedicated EU funding will leverage national funding to address the implementation needs in every country or region. Implementation is a community effort. Within their own health and social systems, Member States can work with clients, families, health care and social care professionals, NGO's, service providers, health and disability insurers, schools, employers and police to implement their own mental health agenda and bring their mental health system to the desired level. This will encompass effective mental health promotion, prevention of mental ill health and if needed client centred, cost effective services in the community. The link to national funding mechanisms will guarantee that all 28 Members States will benefit from these efforts.

Investing in mental health and wellbeing contributes to other EU commitments

The funding of ROAMER mental health research agenda and the European Implementation Partnership for Mental Health is connected to many other European policies and commitments. With these investments, the European Commission and Member States will contribute to:

- the UN Sustainable Development Goals on health (UN, 2015)
- the UN Convention on the Rights of Persons with Disabilities (UN, 2006)
- the WHO Mental Health Action Plan (WHO, 2013)
- the ambitions of the OECD Ministers of Health on the next generation of health reforms (OECD, 2017).

ANNEX 1: Signatories of the Call to Action

European organisations	
European Association of Paritarian Institutions (AEIP)	Stephan Neetens, AEIP Permanent Representative
European Brain Council	Frédéric Destrebecq, Executive Director
European College of Neuropharmacology	Alexander Schubert, Executive Director
European Community Mental health Service providers Network (EuCoMS)	Dr. Rene Keet, Chair
European Federation of Associations of Families of People with Mental Illness (EUFAMI)	Miia Männikkö, President Aagje Ievens, Secretary General
European Psychiatric Association (EPA)	Professor Silvana Galderisi MD, PhD, President Professor Tamás Kurimay, Chair of the EPA Council of National Psychiatric Associations.
GAMIAN-Europe	Hilkka Karkkainen, President
Horatio, European Psychiatric Nurses	Aisling Culhane, Secretary General
International Association of Mutual Benefit Societies (AIM)	Menno Aarnout, Executive Director
Mental Health Europe	Nigel Henderson, President
ROAMER Consortium	Professor Josep Maria Haro Abad Professor Dame Til Wykes
International organisations	
World Federation of Mental Health (WFMH)	Gabriel Ivbijaro, MBE, President Filipa Palha, Vice-President Europe
Austria	
Austrian Society of Psychiatry	Dr Christa Rados, President
Belarus	
Belarusian Psychiatric Association	Dr Oleg Skugarevsky, President
Belgium	
Belgian Brain Council	Professor Jean Schoenen, PhD MD, President
Bulgaria	
Bulgarian Brain Council	Nikolay Gabrovsky, MD, PhD, President
Croatia	
Croatian Brain Council	Dinko Mitrecic, MD PhD, General Secretary
Croatian Psychiatric Association	Professor Vlado Jukic, President
Czech Republic	
Czech Brain Council	Professor Pavel Mohr, President
National Institute of Mental Health, Clinical Division	Professor Pavel Mohr, Head
Denmark	
Danish Psychiatric Association	Torsten Bjørn Jacobsen, President

Finland	
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Finnish Brain Council	Perttu Lindsberg, President
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French Brain Council	Francois Mauguiere, MD President
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German Association for Psychiatry, Psychotherapy and Psychosomatics (DGPPN)	Professor Dr Arno Deister, President
Hungary	
Hungarian Psychiatric Association	Dr György Purebl, President
Pszichiátriai Érdekvédelmi Fórum (Mental Health Interest Forum 1999)	Iván Radó, President
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Israeli Brain Council	Professor Illana Gozes, PhD. President
Israel Psychiatric Association	Professor R.H. Belmaker, President
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Italian Psychiatric Association	Professor Bernardo Carpiniello, President
University of Naples SUN	Professor Mario Maj, Chair department of Psychiatry
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Latvian Psychiatric Association	Dr Elmars Terauds, President
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Luxembourg Brain Council	Alexandre Bisdorff MD, PhD, President
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Maltese Association of Psychiatry	Dr Beppe Micallef Trigona, Liaison Office
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Trimbos Institute (Netherlands Institute for Mental Health and Addiction)	Professor Rutger Engels, Chief Executive
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Norwegian Brain Council	Aud Kvalbein, Chief Executive
Norwegian Psychiatric Association	Dr Ulrik Fredrik Malt, President

Poland	
Polish Psychiatric Association	Professor Agata Szulc, President
Fundacji NeuroPozytywni (Polish Brain Council)	Izabela Czarnecka-Walicka, President
Portugal	
ENCONTRAR+SE - Association for the Promotion of Mental Health	Filipa Palha, President
Portuguese Brain Council	Antonio Freire, M.D., President
Serbia	
Serbian Brain Council	Professor Pavle Andjus, PhD, President
Serbian Psychiatric Association	Professor Dusica Lecic-Tosevski, President
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Turkey	
Turkish Brain Council	Professor Rana Karabudak M.D., President
Turkish Neurological Society	Professor Rana Karabudak M.D., President
Ukraine	
Scientific Society of Neurologists, Psychiatrists and Narcologists of Ukraine	Professor Petro V. Voloshyn, President Professor Natalia O. Maruta, Vice-President
United Kingdom	
King's College London, Institute of Psychiatry, Psychology & Neuroscience	Professor Dame Til Wykes, Vice Dean Psychology and Systems Sciences
The McPin Foundation	Vanessa Pinfold, Research Director
Mental Health Foundation	Jenny Edwards CBE, Chief Executive
MIND	Paul Farmer, Chief Executive
MQ: Transforming Mental Health	Cynthia Joyce, Chief Executive
Royal College of Psychiatrists	Professor Sir Simon Wessely, President

ANNEX 2: The ROAMER priorities for mental health research
(source: ROAMER Press Release September 23, 2015)

1. Preventing mental disorders, promoting mental health and focusing on young people
   Example: Long-term cohort studies looking at determinants of mental health and well-being will identify risk and protective factors for mental ill health and mental health across the lifespan – especially in young people as many mental health problems develop early in life. Its outcome is an estimated returns of € 1 investment could be as high as € 10.27 (for early screening), € 17.97 (for prevention of mental ill health) or € 83.73 (mental health promotion).

2. Causal mechanisms of mental disorders
   Example: Identification of factors underlying co- and multi-morbidity. Co-morbidity is currently one of the largest hidden costs in healthcare – e.g. depression co-occurring with asthma currently increases healthcare costs by 140%. The outcome would be a reduction (or elimination) of substantial healthcare costs associated with co-morbidity (e.g. average extra cost of depression with another disorder is currently 17%-46%).

3. Setting up international collaborations and networks for mental health research
   Example: European mental health databases across different countries and studies with standardised mental health outcomes. Similar studies are being conducted across Europe at any given time – but the lack of coordination of measures prevents us from pooling or sharing these data sets. By sharing, the datasets become more powerful and research becomes more and more cost-effective over time.

4. Developing new and better interventions for mental health and well-being
   Example: Testing the value of internet-based treatments as automated versions of standard psychological treatments in different settings and countries. The internet offers straightforward and extremely cost-effective ways of providing additional treatment that would make many interventions greatly more effective, increase treatment options opportunities for self-management of conditions at low cost.

5. Reducing stigma and empowering service users and carers
   Example: Studying the role of stigma in the wider context of inequalities (health inequalities, etc.) and assessing the place of stigma in public services. Stigma and socio-economic inequalities are large contributors to disability burden for both individuals with mental health problems and carers but are typically not addressed by mental health care interventions. Negative effects of stigma and informal care currently places higher burdens on individuals and groups who are already disadvantaged (namely women). Reducing stigma would decrease a substantial source of disability and healthcare costs that currently impede effective implementations at present

6. Research into health and social systems
   Example: Investigating the impact of differences in the organisation and delivery of national healthcare systems on well-being of individuals with mental disorders and carers will allow different political decisions about health and social care across Europe have affected the health of individuals with mental health problems and their carers. Outcome: Evidence-based policy on how health policies can be most effectively implemented.

Research into mental disorder prevention, mental health promotion, and interventions in children, adolescents, and young adults

- Perform and sustain long-term prospective cohort studies on the determinants of mental health and wellbeing to study risk and protective factors of mental disorders
- Develop pharmacological and psychological treatments for children and adolescents
- Improve mental health promotion and social exclusion prevention in schools
- Investigate whether prevention of depression in pregnant women protects against later mental disorder or dysfunction (eg, depression) in children, and the cost benefits of doing so
- Perform longitudinal observational studies to analyse the effects of intense use of new forms of media (eg, the internet, gaming, and social media) in early age and adolescence on later emotional and cognitive competence

Focus on the development and causal mechanisms of mental health symptoms, syndromes, and wellbeing across the lifespan (including older populations)

- Identify factors underlying comorbidity and multimorbidity, extending aetiopathogenic research on single disorders to typical comorbid constellations
- Define the functional characteristics of neurobehavioural mechanisms across the lifespan
- Identify social and biological factors that underlie risk or resilience factors for mental disorders across the lifespan
- Study the effects of financial crises on mental health
- Understand how vulnerabilities and stress affect critical developmental trajectories for poor health and specific mental disorders across the lifespan (but particularly in childhood and adolescence)
- Study what brain abnormalities predict future mental disorder using longitudinal structural and functional neuroimaging

Develop and maintain international and interdisciplinary research networks and shared databases

- Increase the number, quality, and efficiency of international and interdisciplinary networks
- Develop multidisciplinary training programmes for mental health research across different countries
- Implement standardised European research outcomes, databases, and terminology for mental health and wellbeing research
- Establish access to European mental health databases across different studies with standardised mental health outcomes

Develop and implement better interventions using new scientific and technological advances

- Strengthen research into new approaches and technology for mental health promotion, disorder prevention, mental health care, and social service delivery
- Test the value of internet-based treatments as automated versions of standard psychological treatments in specialised mental health care, in so-called indicated prevention, and particularly for use in primary care settings
- Test real-time psychometric feedback over the course of treatment (supported by modern software) to adapt dosage and intensity of treatment to service users' complexity and problem profile to promote better outcomes
- Examine acceptability and adherence of eHealth treatments (eg, for depression), the clinical improvement at 1-year follow-up, and the cost-effectiveness of the intervention in comparison with conventional psychological therapies
- Understand why some individuals do not respond to treatment by identification of relevant, and potentially developmental-phase-specific, mediating and moderating variables of evidence-based psychotherapies for youths with mental disorders

Reduce stigma and empower service users and carers in decisions about mental health research

- Study how carers and family members of people with mental health problems might perceive and experience stigma by association
- Identify the best methods to measure and value unpaid care
- Pinpoint the most cost-effective elements of anti-stigma interventions
- Study the role of stigma in the wider context of inequalities (eg, health inequalities) and implement interventions to assess and change the role of stigma in access to public services
- Establish better national or local interventions to address stigma, social exclusion, and discrimination by a careful definition of the essential questions (ie, who should be targeted; how, by whom, and when should targeting be done) and to determine how and by whom they can be assessed

Establish health-systems and social-systems research that addresses quality of care and takes into account sociocultural and socioeconomic contexts and approaches

- Investigate the effect of differences in the organisation and delivery of national health-care systems on wellbeing of individuals with mental disorders and their carers
- Study, at the health-systems level, the cost-effectiveness of different ways to finance, regulate, organise, and provide services that promote and protect mental health
- Design and investigate methods to assess outcomes from mental health services that can be easily and reliably implemented

* The order of priorities does not represent any ranking

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