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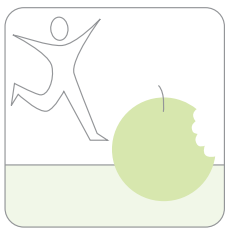
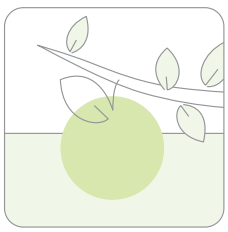
Action for Mental Health

Activities co-funded from European Community Public Health Programmes 1997-2004






Action for Mental Health

Activities co-funded from European Community Public Health Programmes 1997-2004

**Report prepared for the European Commission,
Health and Consumer Protection Directorate-General,
by Professor Ville Lehtinen**

December 2004

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Foreword

Today, the relevance of mental health as an indivisible part of health is widely accepted within the health sector and beyond.

The positive echo to the WHO's announcement of its intention to organise the Ministerial Conference on Mental Health "Facing the Challenges, Building Solutions" (Helsinki, 12-15 January 2005), reflects the recognition of mental health as a public health issue. The European Commission was pleased to accept the invitation to contribute to the organisation of this major conference with the status of a collaborating partner.

This recognition of the importance of mental health is the result of many efforts by individuals, organisations and Governments. The European Commission is proud that it could make its contribution to this work. Mainly this happened through a significant number of projects which have been co-funded from Public Health Programmes of the European Community. Details about these programmes and the reports resulting from all the projects presented in this brochure can be found on the European Commission's Public Health web site[1].

This brochure aims to provide an overview of the projects and other activities, which the Commission supported during the years from 1997 to 2004.

The projects described in this brochure show: a high level of good mental health in the population needs to be actively fostered. Like many other intangible assets it needs to be built pro-actively. In doing so, it is useful to look at what we can learn from each other.

These projects have produced a great stock of knowledge about mental health, the state of mental health in the EU-population and evidence-based practices to promote mental health. In future, the European Commission will increase its efforts to further valorise the results from this work, together with Member State Governments and stakeholders, such as schools and employers.

The Ministerial Conference on Mental Health comes at the right time: In the present profound transformation process into a knowledge society, in which the European Union finds itself, mental health has become ever more important. Under the conditions of global competition, the success of the European Union depends on its ability to fully mobilise its human, economic and social resources. Health in general and mental health in particular have become key resources for a European Union, which seeks to ensure the quality of life of its citizens, to spur innovation and economic growth and to promote social progress.

Finland has rendered great services to developing mental health on the European policy agenda: in 1997 it brought mental health for the first time on the agenda of an EU Council of Health Ministers. In 2005, it is hosting the WHO Ministerial conference on Mental Health.

It was therefore with great pleasure that the European Commission accepted the offer of the Finnish National Research and Development Centre for Welfare and Health (STAKES) to publish this joint brochure.

John F. Ryan
Head of Unit
Health Information
European Commission

[1] http://europa.eu.int/comm/dgs/health_consumer/publichealth.htm

Contents

1. Mental health is an indivisible part of public health

Mental health can be approached and defined in many ways. The most essential in grasping the concept 'Mental Health' is that it should be seen as a broad issue, not only as something relating to mental disorders or being the matter of psychiatrists and psychologists only.

There is no health without mental health. Thus, mental health :

- is everybody's business
- is an issue of everyday life originating in families, schools, workplaces, leisure time activities etc.
- is an indivisible part of general health
- is an important resource for both society and individual
- is much more than mental disorder
- has two dimensions, positive and negative

In the box below, the definition of mental health, formulated by the EU funded 'Key Concepts' project, is given in a modified form.

Mental health as an indivisible component of general health, reflects the equilibrium between the individual and the environment. It is influenced by a) individual biological and psychological factors; b) social interactions; c) societal structures and resources; and d) cultural values. In this context, mental health can be seen also (see figure 1) as a process that comprises predisposing factors (e.g. childhood experiences), actual precipitating factors (e.g. stressful life events) and supporting factors(e.g. social network) as well as various consequences and outcomes (e.g. creativity or health behaviour). Mental health has two dimensions: 1) *Positive mental health* can be conceptualised as a value in itself (feeling well) or as a capacity to perceive, comprehend and interpret our surroundings, to adapt to them and to change them if necessary; to think and to communicate with each other; 2) *Negative mental health* (or mental ill-health) is concerned with mental disorders, symptoms and problems.

Before 1996, mental health was not in any visible way on the agenda of the European Communities. One of the first steps to approach mental health issues on the high political level was a discussion initiative by the Finnish Health Minister in the Council of Health Ministers in 1997. It gave impetus to a extending process, materialised through several projects and other activities. Many good reasons why actions in the field of mental health and its promotion should be taken by the European Commission were presented during this process :

- Positive mental health contributes to the social, human and economic capital of the societies
- The burden of mental ill-health is so extensive that care alone can never solve the problem
- Effective interventions and programmes are available to enhance positive mental health and to prevent mental ill-health
- Trans-national collaboration in the field holds great potential for providing Community added value.

The burden caused by mental disorders is, of course, the most urgent reason to direct attention to issues of mental health. Several facts depict the burden:

1. **Mental disorders are common.** It has been estimated that at any time, up to 20% of the adult population in the EU suffers from some form of mental ill-health. In adolescence the occurrence is estimated to be at same level. Already in 8-9 year old children the prevalence of any mental disorder has shown to be as high as 15% in some European studies.

2. **Mental ill-health imposes a heavy economic burden.** This is due to the high prevalence, and the onset in young ages combined with the often chronic course of mental disorders. The total costs of these disorders are estimated to be up to 3-4% of the GNP. The major part of these costs is indirect, mainly caused by disability and lost productivity, and thus incur outside the health sector. Mental disorders are the major reason for granting of disability pension in most EU Member States.

3. **Mental disorders are associated with increased mortality.** The risk of death among patients with a mental disorder is several times higher than in the population as a whole. The main causes are suicides or other violent deaths. Suicide rates, which clearly exceed the number of deaths from traffic accidents, are especially high in many of the new Member States of the EU. Besides suicides, the increase in mortality is based on co-morbidity: poor mental health may deteriorate physical health and vice versa.

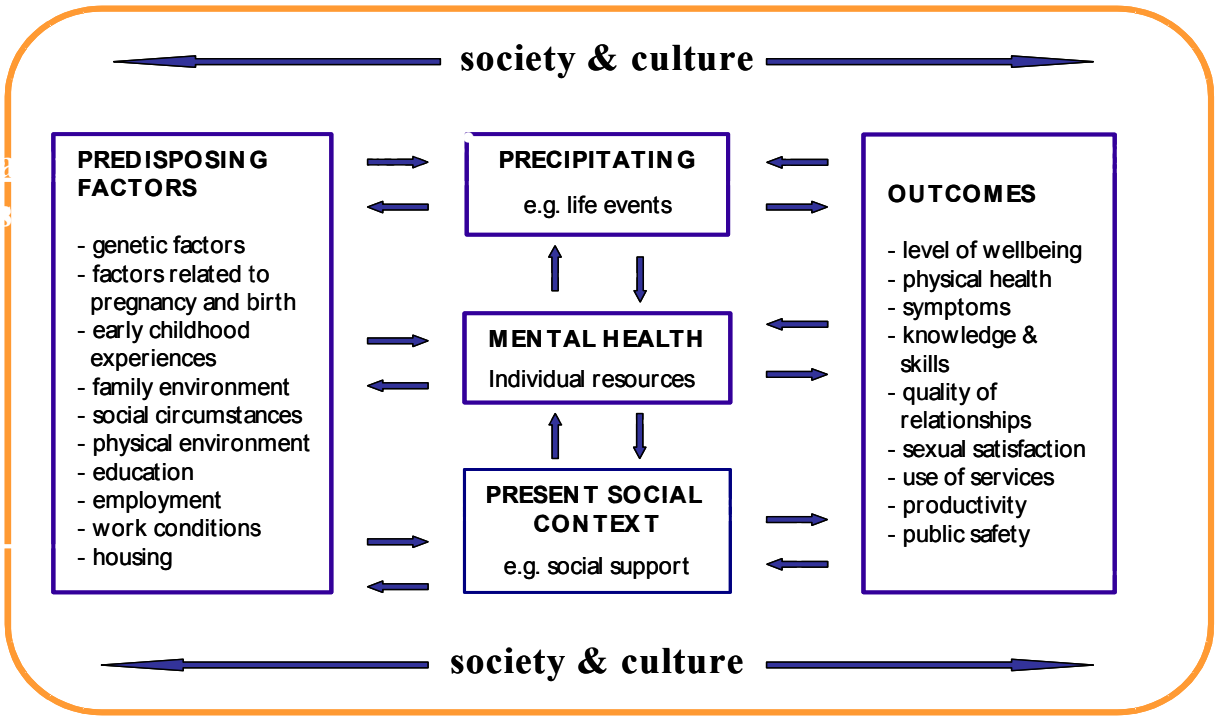
4. **Mental disorders generate enormous amounts of human suffering.** The anxiety, fear, despair and depression, and the consequent guilt and shame can subjectively be as incapacitating as the most severe physical pain. This burden affects both the person suffering from the disorder as well as the family that often encounters the extra burden of taken care of the ill family member.

5. **Mental disorders lead easily to marginalisation.** Mental disorders are associated with exclusion, stigma and other negative attitudes, and can lead to discrimination. In many Member States the mental health services are in a secondary position when distributing the health service resources. People suffering from mental disorders are among the most marginalised in our societies. Associated problems such as poverty, homelessness, criminality, alcohol addiction and drug abuse often lead to a very low quality of life.

6. **Mental disorders affect negatively the subsequent generations.** Mental ill-health is not only a burden for the individual in question, but affects in many ways also the social environment. Especially the children of mentally ill parents are in a clearly increased risk of developing a severe mental disorder later in their life.

The European Commission has been active in the field of mental health mainly through co-funding from the Public Health Programmes several action projects. On the one hand, the Commission has funded projects in the field of mental health information and monitoring, on the other hand several projects have dealt with mental health promotion and the prevention of mental ill-health. The Commission has also sponsored several EU-Presidency conferences and other important events and meetings related to these themes. Additionally, the Commission itself has organised important meetings and established taskforces to put forward the mental health agenda.

Figure 1. The functional model of mental health



2. Legal basis for action

The European Community received its first mandate to act in the area of health in 1993 through adoption of the Maastricht Treaty. The current mandate of the European Community to act in the area of health is defined in the article 152 of the Amsterdam Treaty which replaced the earlier treaty in 1999. The mandate is restricted to health promotion, prevention of ill-health and health information, but does not cover health services or medical care which falls fully under the responsibility of the Member States.

Extract of the Article 152 of the Amsterdam Treaty:

- A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and disease, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.
- The Community shall encourage co-operation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action.
- The Community and the Member States shall foster co-operation with third countries and the competent international organisations in the sphere of public health.
- Community action in the field of public health shall fully respect the responsibility of the Member States for the organisation and delivery of health services and medical care.

The first Public Health Programme (Framework for Action in the Field of Public Health 1994-2000) was adopted in November 1993. Its duration was extended until 2002. The implementation of this programme was based on eight separate Action Programmes, six of which were 'vertical' and focused only on a specific health problem: AIDS and other communicable diseases, cancer, drug dependence, injury prevention (including suicide, however), rare diseases and pollution-related diseases. Thus, the two horizontal Action Programmes (Health Promotion, Information, Education and Training, and Health Monitoring) were the most feasible in co-funding mental health projects, although some activities in suicide prevention have been co-funded from the Action Programme on Injury Prevention.

The mental health projects and other activities, supported by the Commission, have been funded mainly from this first Public Health Programme. A more detailed description of these activities is given in the chapters that follow.

The new Public Health Programme (Programme of Community Action in the Field of Public Health 2003-2008)[2], was adopted in September 2002. The general objectives of the programme are to:

- improve information and knowledge for the development of public health (Strand 1)
- enhance the capacity of responding rapidly and in a co-ordinated fashion to health threats (Strand 2)
- promote health and prevent disease through addressing health determinants across all policies and activities (Strand 3).

[2] Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008) - Commission Statements, published in: *Official Journal L 271 , 09/10/2002 P. 0001 - 0012*

3. Promotion of mental health by action projects

3.1. INTRODUCTION

The first mental health project, co-funded from the Public Health Programme was the so-called *Key Concepts Project* which was conducted in 1997-1998. The main aims of this project were to define and evaluate the central concepts - mental health and mental health promotion - and to propose priorities in the field of mental health promotion for the European Community (the definition of mental health, launched by this project, is presented in Chapter 1).

Title of the project	**Action programme**	**Years**	**Co-ordinator**
Mental Health Promotion for Children up to 6 years	Health Promotion	1997-1999	Mental Health Europe
Putting Mental Health on the European Agenda	Health Promotion	1998-2000	Ministry of Social Affairs and Health, Finland
Establishment of a Set of Mental Health Indicators for EU	Health Monitoring	1999-2001	STAKES, Finland
Unemployment and Mental Health	Health Promotion	1999-2001	University of Deusto, Spain
European Review of Suicide and Violence Epidemiology, phases 1&2	Injury Prevention	1999-2003	University of Glasgow, UK
Mental Health Promotion of Adolescents and Young People	Health Promotion	2000-2001	Mental Health Europe
Involuntary Placement and Treatment of Mentally Ill	Health Promotion	2000-2002	Central Institute of Mental Health, Germany
Mental Health Promotion and Prevention Strategies for Coping with Anxiety, Depression and Stress Related Disorders in Europe	Health Promotion	2001-2003	Consortium co-ordinated by University of Deusto, Spain
Supporting Children in Substance Abuse Families	Health Promotion	2002-2003	Katholische Fachhoch-schule, Germany
Report on the State of Mental Health in Europe	Health Monitoring	2002-2004	MGEN, France
Placement and Treatment of Mentally Ill Offenders	Health Promotion	2002-2004	Central Institute of Mental Health, Germany
Mental Health Economics	Health Promotion	2002-2004	Mental Health Europe
Integrating Mental Health Promotion Interventions into Countries' Policies, Practice and Health Care System	Health Promotion	2002-2004	University of Nijmegen, the Netherlands

Table 1. Mental health projects co-funded from the old EU Public Health Programme

The following nine priority areas of action in the field of mental health were suggested for the European Community by the *Key Concepts Project*:

- Enhancing the value and visibility of mental health
- Empowerment, participation and information society
- Towards mental health promoting working life
- Unemployment, underemployment and re-employment
- Support and protection of children, young people and families with children
- Enhancing quality of life of older people
- Promoting mental health of alcohol and drug abusers
- Supporting research and development in the field
- Development of information and dissemination systems concerning mental health.

After the *Key Concepts Project* the Commission has co-funded several mental health projects during the years 1999-2004. Thirteen of these projects have been funded from the old Public Health Programme. The projects and their co-ordinators are presented in table 1. Most of these projects have already been completed, but some will be finished by the first months of 2005. Two of the projects have been funded from the Health Monitoring Action Programme, one from the Injury Prevention Action Programme, and all the others from the Health Promotion Action Programme.

In 2004, the Commission has made decisions of co-funding from the new Public Health Programme three new mental health projects (Table 2). Additionally, some project proposals are in the phase of negotiation between the Commission and the Applicant.

Title of the project	Strand	Years	Co-ordinator
Mental Health Information and Determinants for the European Level	Health Information and Knowledge	2004-2006	STAKES, Finland
European Alliance Against Depression	Health Determinants	2004-2005	University of Munich, Germany
Implementation of Mental Health Promotion and Prevention Policies and Strategies	Health Determinants	2004-2006	FIOSH, Germany

Table 2. Mental health projects co-funded from the new EU Public Health Programme

In the following the main aims as well as the most important outcomes and core results from these projects will be presented. The presentation of the projects is not in the chronological order but grouped under relevant sub-headings.

3.2. CONTRIBUTION TO MENTAL HEALTH POLICY

1. Public health action for mental health

Putting Mental Health on the European Agenda (1998-2000), co-ordinated by STAKES, Finland, was a project in two parts. The aim of the first part of the project was to outline a public health action framework for mental health in the European Union context. The second part resulted in the

EU Presidency conference *Promotion of Mental Health and Social Inclusion* which will be described in the next chapter.

As its main outcome the project formulated the main strategies of action on mental health. They should cover the following issues:

- Development of general policies which are favourable for people's mental health
- Systematic mental health impact assessment as part of general health impact assessment in societal planning and decision-making
- Promotion of mental health in all relevant settings
- Reduction of risk factors of mental disorders
- Improvement of the health and social functioning of people with mental disorders
- Delivery of appropriate services for early detection, care, treatment and rehabilitation
- Reduction of premature mortality of people with mental disorders
- Reduction of stigma
- Protection of human rights and dignity of all citizens, and especially people with mental health problems.

In addition, the project advocated strongly the need to shift the focus of mental health to a comprehensive population approach including mental health promotion and prevention of mental ill-health. A public health approach to mental health within the European context is important because of the vital contribution made by mental health to the well-being of populations, and to the enhancement of their human, social and economic capital. It is therefore of utmost importance that mental health and its promotion is closely integrated with all public health strategies. The value of mental health needs to be recognised throughout Europe and across all levels and all sectors of society.

2. Policy action plan for promotion and prevention in mental health

The project *Integrating Mental Health Promotion Interventions into Countries' Policies, Practice and the Health Care System (IMHPA)* (2002-2004), co-ordinated by the University of Nijmegen, the Netherlands, involves participants from 28 European countries, collaboration with several European networks, and support of the WHO Regional Office for Europe. The project has been engaged in the development of :

- an Internet database of evidence-based mental health promotion and mental disorder prevention programmes,
- a set of training initiatives including a training manual for primary health care professionals, and
- a European policy and action strategy for mental health promotion and mental disorder. prevention.

The project states that very limited resources are dedicated to the prevention of mental disorders and the promotion of mental health despite the opportunities for health, social and economic gain for society. To tackle the problem of mental illness in European countries, a public health approach of action, which encompasses and prioritises promotion and prevention alongside care and rehabilitation, is seen to be crucial. The project calls upon countries to develop comprehensive country-based action plans for prevention and promotion in mental health. Similarly, resources allocated to mental health should be proportional to the burden of mental health problems and distributed equally for prevention and promotion to support implementation, research, infrastructure and professional development.

The project suggests that in the action plan, ten action areas and five common principles for mental health promotion and mental disorder prevention (see on next page) should be approached. For each action area and common principles the project has specified the main aim of the action and the needed activities.

Action areas:	**Common principles:**
1. Support parenting and early years of life 2. Promote mental health in schools 3. Promote workplace mental health and prevent work related stress 4. Involve primary and secondary health care 5. Address groups at risk for mental disorders 6. Prevent depression and suicide 7. Prevent violence and substance use disorders 8. Reduce disadvantage and social exclusion 9. Create supportive environments linking with other policies 10. Empower community action and prevent stigma	1. Expand the knowledge base for mental health 2. Support effective implementation 3. Build capacity and train the workforce 4. Engage different actors 5. Evaluate and monitor mental health, implementation and outcomes

3. European Alliance Against Depression

The project *European Alliance Against Depression (EAAD)*, co-ordinated by the University of Munich, Germany, has started in 2004 and is expected to finish in 2005. It addresses the severe deficits regarding awareness, information, recognition and treatment concerning depression by establishing a four-level intervention programme on depression in 18 European regions. The regions represent both 'old' and 'new' Member States of the EU. The following box describes the measures that are being taken:

- **Co-operation with the general Practitioners:** General practitioners will be invited to educational workshops. They will receive videotapes about depression that can be handed out to patients, and they will have access to consultation with a specialist concerning treatment of individual cases.
- **Public relations campaign:** The general public will be addressed by posters, cinema spots, information leaflets, brochures and public events and an internet homepage. The aim is to improve the knowledge about adequate treatment of depression and to reduce the stigmatisation of the topic "depression" and of the affected individuals.
- **Co-operation with multipliers:** Community facilitators such as teachers, priests, police and professionals in geriatric care and the media will be informed about depression and trained in educational workshops.
- **Services for affected persons and their relatives:** Persons after suicide attempt will receive an "emergency card" guaranteeing direct access to professional help in a suicidal crisis. Self-help groups will be supported, and special events will be organised to initiate new self-help groups on local level.

The first step of the project consists of a comprehensive collection of available tools to defeat depression on European level, and a careful evaluation of examples of best practice. A common core set of measures will be defined, adapted by the Project Group to comply with the requirements of the participating regions.

3.3. PROMOTING MENTAL HEALTH THROUGHOUT THE LIFESPAN

1. Mental health promotion for children

The project *Mental Health Promotion for Children up to 6 years* (1997-1999), co-ordinated by the non-governmental organisation Mental Health Europe, collected and evaluated altogether 195 different mental health promotion projects/programmes focused on pre-school age children from the 15 Member States and Norway. From these projects 27 were selected as particularly good examples (effective model projects) that demonstrated documented evidence of effectiveness and could be replicated across Europe. The core message from this project is presented in the box below.

There is strong evidence that the early years of life have a crucial impact on mental health throughout the life cycle. The development of strategies to promote the mental health of young children is therefore of fundamental importance. This involves raising awareness of the significance of the mental well-being of children, as well as interventions to support parenting, to facilitate positive relationships between parents and children, to improve child-rearing conditions and to protect vulnerable children.

The project revealed that the most important methods of mental health promotion for preschool age children were the following:

- counselling
- group work either with parents or with children
- home visits
- nursery school interventions
- clinical diagnosis and monitoring (early detection of risk in the child or in the family)
- educational methods.

The project *Supporting Children in Substance Abusing Families (ENCORE)* (2002-2003) was co-ordinated by an educational institute Katholische Fachhochschule Nordrhein-Westfalen, Germany. Its aim was to prevent and alleviate harm inflicted on children by problematic parental use of alcohol and other substance or related mental health problems. This was approached by building up governmental and non-governmental bodies' capacity to provide direct and indirect help and support to the children. This occurred through the exchange of information and experience and, where appropriate, joint development of materials, work, training and/or other modes of intervention.

2. Mental health promotion for young people

The succeeding project *Mental Health Promotion for Adolescents and Young People* (2000-2001) was carried out in a similar way than the project on preschool age children under the co-ordination of Mental Health Europe. The project collected altogether 52 different mental health promotion or prevention programmes from the EU Member States plus Norway and Iceland.

Among the methods used in the selected programmes around Europe to promote the positive mental health of adolescents and young people, the following intervention methods were identified by the project:

- Creation and distribution of resource packages and guidelines
- Use of group and individual counselling sessions
- Organising group work, tutoring and coaching by peers
- Arranging seminars in schools
- Organising school contests
- Use of programmes preparing for parenthood

3. Coping with anxiety, depression and stress-related disorders

The extensive project *Mental Health Promotion Strategies for Coping with Anxiety, Depression and Stress Related Disorders in Europe* (2001-2003) aimed at building a European strategy to initiate and implement actions on mental health promotion and prevention of common mental health problems in three phases of the lifespan: children and young people, working age population and the older people. A consortium of four organisations representing public bodies and non-governmental organisations competent in the fields concerned (FIOSH, Germany; Mental Health Europe; STAKES, Finland; and University of Deusto, Spain), each one encouraging multidisciplinary collaboration, carried out the project.

The project identified and evaluated promotion and primary prevention programmes, especially focused on anxiety, depression and work related stress, from the EU Member States and the three EEA countries. Those programmes that fulfilled the evaluation criteria of being relevant to the theme of the project, having been completed, and having undergone a reliable evaluation, were selected as 'models of best practice', considered to be ready for large-scale implementation in the Member States.

In addition, the project launched a policy report, including the ten key recommendations from the project. Those key recommendations that focused on the three phases of the lifespan are presented in the box below.

Mental health of **children, adolescents and young people** is a crucial issue since it has an impact not only on the current generation in this age group but also for their well-being in their future years. Mental health promotion and prevention strategies require support given to good parenting and to the development of a strong parent/child relationship. These form a basis for empowerment, self-confidence and resilience for lifetime. A holistic approach to strategies for promotion and prevention in schools, colleges, universities and establishments that provide young people with training for work shall involve a co-ordinated approach that shall involve children, students, their teachers and parents.

Mental health actions on promotion and prevention of anxiety, depression and stress related disorder have a significant place in the **world of work,** and in particular, have a positive impact to well-being at work as well as outside of work. Strategies for mental health promotion and prevention support personal development, empower individual competencies and offer a positive impact on mental health and well-being throughout lifetime employment. Thus, mental health promotion and prevention shall be included in occupational safety and health schemes as well as promotion and prevention activities in enterprises.

In **older people,** mental health promotion and prevention of anxiety, depression and stress related disorders require that supportive actions be created to ensure their social cohesion, social inclusion and their empowerment. Coping skills training and prevention of loneliness and isolation require to be taken account of in both community approaches and in care settings.

4. Implementation of mental health promotion and prevention strategies

The two-year project *Implementation of Mental Health Promotion and Prevention Policies and Strategies in EU Member States and Applicant Countries* has started in 2004 under co-ordination of FIOSH, Germany. It is a continuation of the project described above. Its main goals are to :

- improve mental health information and knowledge for the development of mental health in public health;
- promote mental health and prevent mental disease through addressing health determinants;
- address promotion and prevention specifically in stress, anxiety, depression, suicide and related disorders.

The project will be conducted by a consortium of the co-ordinator and six partnership organisations or networks. The project will develop an action programme to support the implementation of mental health promotion and prevention strategies, especially focused on stress, anxiety, depression, suicide and related disorders. During the two-year duration of the project this action programme will be introduced in altogether 12 Member States or Applicant Countries. The main methods of implementation will be networking and organising national workshops in each target country.

The project is expected to achieve considerable Community added value because of the possibility for sharing experiences and learning from each other. This is important, because previous efforts in the search for best practices in mental health promotion and prevention of mental health problems have shown diversity of approaches, the absence of sharing experiences between countries, and in many countries, lack of integrating mental health promotion and prevention practices within national health and mental health planning.

3.4. ENSURING RELEVANT INFORMATION ON MENTAL HEALTH

1. Development of mental health indicators

The project *Establishment of a Set of Mental Health Indicators for European Union* (1999-2001) was co-ordinated by STAKES, Finland. Its main aim was to propose a set of feasible and reliable indicators for monitoring mental health. A prerequisite was also that the set of indicators should be easily integrated in the general European Community Health Indicators (ECHI) system[3]. A clear starting point was also that the set should include indicators for both the positive and negative mental health. From the beginning it was also clear that, apart from statistical data, also population survey measures must be included. An important question was also the availability of data, and especially concerning the survey indicators that they were easily included in a general health survey.

Table 3 presents the 36 indicators which were proposed by the project, grouped in the categories of the ECHI system. Most of these indicators should be collected as statistical data in the Member States, but 13 of the proposed indicators need a population survey to collect the needed data. The project also conducted a pilot survey in five European countries to test the feasibility of the proposed survey indicators. The results showed that they are feasible and easily applicable. Thus, an

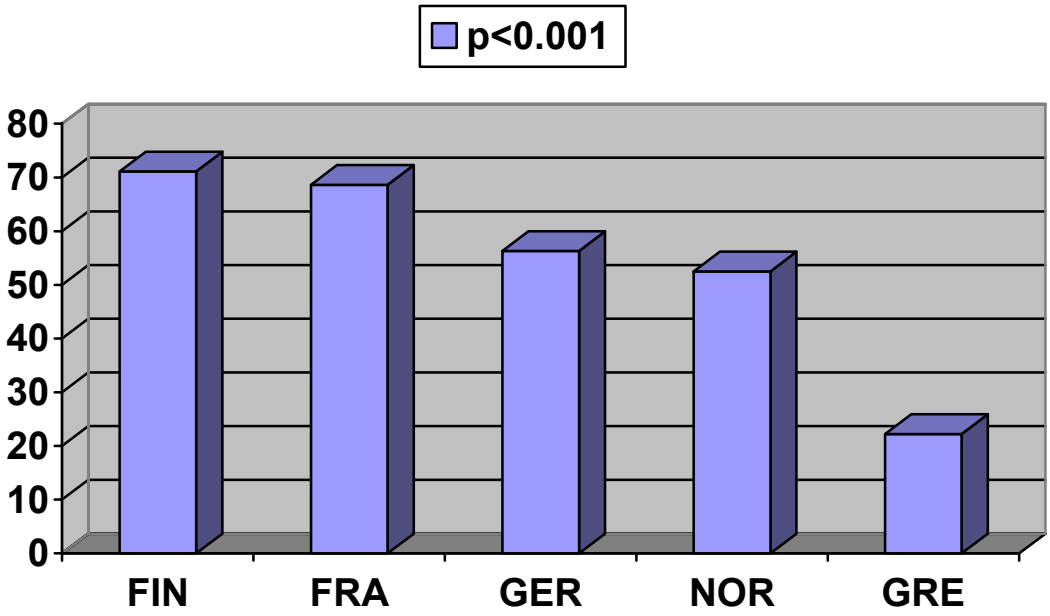
[3] ECHI is a specific action project, funded from the Health Monitoring Action Programme, that has worked for establishing a comprehensive list of indicators covering all relevant aspects of health.

urgent future challenge for the European Union is to organise a permanent system of repeated health surveys in all Member States.

Table 3. List of the set of indicators proposed by the Mental Health Indicators Project

DEMOGRAPHIC AND SOCIO-ECONOMIC FACTORS *(included in the full ECHI list)*
HEALTH STATUS • **Cause-specific mortality** (Suicide; Harmful events, intention unclear; Drug related deaths; Alcohol related deaths) • **Morbidity, disease-specific** (Generalised anxiety disorder; Major depression; Alcohol dependence; Suicide attempts) • **Morbidity, generic** (Psychological distress; Psychological well-being; Role limitations due to emotional problems)
DETERMINANTS OF HEALTH • **Personal conditions** (Sense of mastery; Optimism) • **Social and cultural environment** (Social support; Social isolation; Social network; Life events)
HEALTH SYSTEMS • **Prevention, health protection and promotion** (Suicide prevention projects; Projects to support parenting skills) • **Health resources** (Psychiatric beds; psychiatrists; Child psychiatrists; Other professionals in the field of mental health) • **Health care utilisation** (Inpatient episodes for mental disorders; Inpatient episodes for mental disorders for minors; Long-stay patients; Use of out-patient services; Self-reported use of mental health services; Consumption of psychotropic drugs; Disability pensions due to mental disorders; Money spent on disability pensions due to mental disorders; Sickness compensation periods due to mental disorder) • **Expenditures** (Total national expenditure on psychiatric services; Proportionate national expenditure on psychiatric services; Proportionate national expenditure on psychiatric services for minors) • **Health care quality indicators** (National quality accreditation for mental health services)

Figure 2. Occurrence of suicidal ideation by persons with major depression (%)



According to the pilot survey the prevalence of depression was about the same level (7.9-10.5%) in all the five countries (Finland, France, Germany, Greece and Norway). But what is interesting is that the occurrence of suicidal ideation among persons diagnosed as depressed varied extensively across countries, as in shown in Figure 2. The difference between Finland and Greece was more than threefold. This result is especially important because it reflects directly the differences in suicide rates between these countries.

2. Suicide epidemiology

The aim of the project *European Review of Suicide and Violence Epidemiology (EUROSAVE)* (1999-2003), co-ordinated by the University of Glasgow, was to pool expertise in epidemiology and injury research from across the EU in order to strengthen and support the Community epidemiological network for monitoring suicide. The project:

- conducted a systematic review of the literature on suicide and parasuicide (suicide attempts);
- identified and evaluated the quality of existing European data sources for suicide and parasuicide;
- investigated recent epidemiological trends in suicide and parasuicide; and
- made explicit recommendations on information quality, highlighting especially the deficiencies in routine data.

Conclusions from the EUROSAVE:
Suicide mortality rates vary markedly between countries, for reasons that are unclear. Deficiencies in routine data need to be addressed. We recommend that methods of suicide and exposure to risks along with standard demographic variables be included when recording data. This may be achievable via a European-wide code of practice employed by each Member State. In the absence of adequate EU-wide data, the effective prevention of suicide is likely to remain elusive for the foreseeable future.

3. Report on mental health

The project *Report on the State of Mental Health in the European Union* (2002-2004) has been co-ordinated by the MGEN Foundation, France. It continued the series of health reports published by the European Commission[4]. This report, which aims to describe and compare the state of mental health in the European Union and Norway in the context of the longstanding efforts of EU Public Health Programmes to promote good mental health and to prevent mental ill-health, was published in 2004.

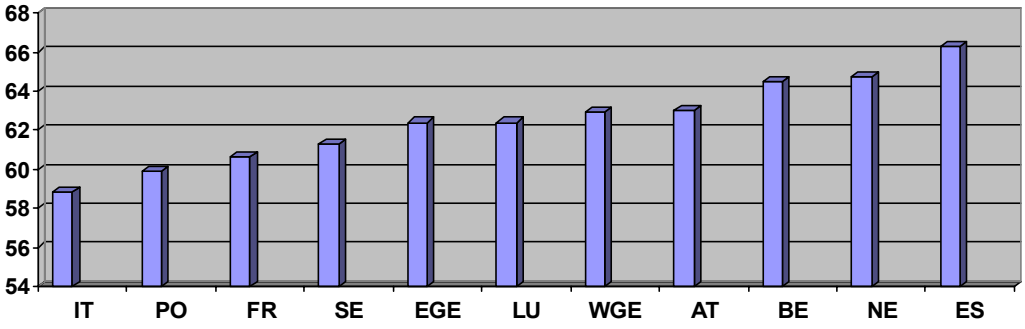
In describing the state of mental health report combines three main kinds of data:

- routinely collected statistics on deaths from suicide, the use of drugs and alcohol, and psychotropic drug consumption
- results from national populations surveys
- results from available studies covering a number of Member States (ODIN, ESEMeD, Eurobarometer).

Regarding population surveys, one important experience from the project was that, although many surveys which include mental health measures were identified, the differences in survey techniques and research methods make real comparisons almost impossible. This highlights the importance of collecting data in a comparable manner across the EU.

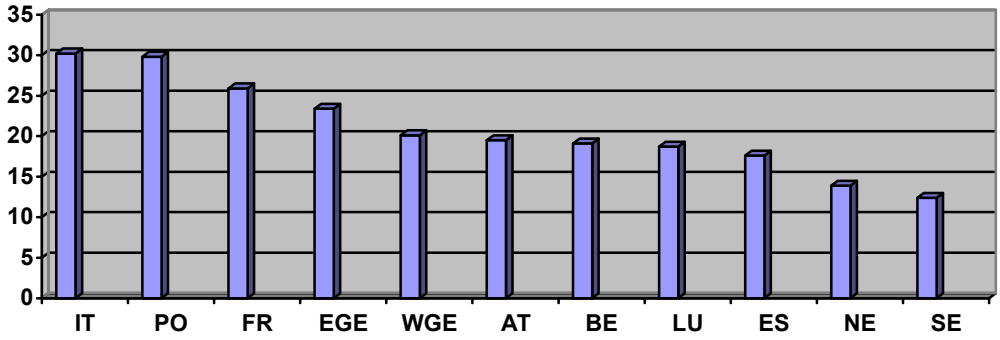
Very few EU designed surveys on mental health have been conducted so far. The only one covering all the 15 'old' Member States was the Eurobarometer survey that took place in autumn 2002. This specific survey included few items also on mental health: the Energy and Vitality scale (EVI) and the Mental Health Index (MHI-5) of the SF-36 questionnaire. These measures have been widely used to describe positive and negative mental health respectively. Because of poor response rate in some countries, cross-country comparisons (figures 3 and 4) could be made only between 11 countries or regions (East and West Germany were treated separately).

Figure 3. Mean score of positive mental health (SF-36 EVI) by country



[4] Previous reports: The State of Health in the European Community, 1996; The State of Women's Health in the European Community, 1997; Report on the State of Young People's Health in the European Union, 2000; The Health Status of the European Union, 2003.

Figure 4. Prevalence (%) of psychiatric cases (MHI-5 < 53) by country



One has to be careful in interpreting these figures, especially when comparing the prevalence rates between the countries, because methodological biases cannot be ruled out. First of all, the response rate in many countries was still rather low (50 - 60%), although those countries where the response rate was below 50% were excluded. It is also evident that there are cultural differences in how people experience or express their inner feelings or are willing to report about them. This will most likely mean that the criteria for defining a case should be at least somewhat different in different countries and cultural environments.

However, we can also see some consistencies in the results presented. For example Italy, Portugal and France show low scores in positive mental health and high prevalence of psychiatric cases, whereas the reverse is true especially for Spain and The Netherlands. Sweden, on the other hand show clear inconsistency: its positive mental health score is rather low but, despite that, its prevalence of psychiatric cases is the lowest.

4. Towards a comprehensive mental health information system

The previous projects, funded from the Health Monitoring programme, have shown that the available data on most of the mental health indicators are insufficient. Very few indicators are available from all Member States, and data for many of the indicators exist only in few countries. This is especially true for those indicators that are based on population survey data. The project *Mental Health Information and Determinants for the European Level (MINDFUL)*, that started in 2004 under co-ordination of STAKES, Finland, and will finish in 2006, was established to tackle this shortage.

MINDFUL will :

- analyse the data needs in the EU and the Member States
- define the final set of mental health indicators based on the proposal of the earlier project
- provide technical support for national efforts
- pool together the available data at the EU level
- propose a system of analysing and reporting the information
- disseminate the results.

The project is conducted by a consortium consisting of the co-ordinator and six sub-contractors, focusing on different aspects of the main task. MINDFUL consists of the following sub-projects:

1. Refining the system of mental health indicators and analysing their availability
2. Determinants of Mental Health and Mental Disorders
3. Monitoring Positive Mental Health
4. Survey Indicators of Mental Health: Development and Use
5. Establishing a System to Monitor Service Utilisation Data
6. Examining Mental Health Monitoring Systems in the New EU Member States
7. Training on indicators for Effective Mental Health Promotion and Mental Disorder Prevention

The main outcome of the project will be a joint report from the whole consortium, describing the suggested mental health information system in its wholeness: the indicators, their definition and availability, methods of collecting and analysing the data as well as the reporting system. In addition to this, each partnership project will publish its own report.

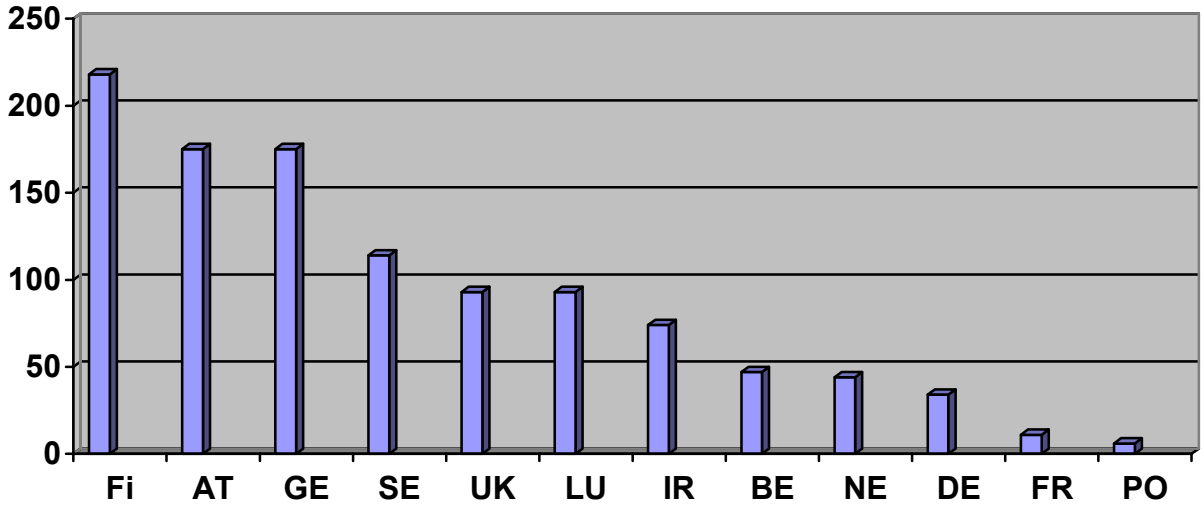
3.5. MENTAL HEALTH LEGISLATION

1. Involuntary placement and treatment of mentally ill

The project *Involuntary Placement and Treatment of Mentally Ill - Legislation and Practice in European Union Member States* (2000-2002) was co-ordinated by the Institute of Mental Health, Germany. It aimed at gathering, describing and analysing information on the differences or similarities of legal frameworks for involuntary placement or treatment of mentally ill patients across the European Union Member States.

The most evident outcome of the project was that the legal regulations on the practice of involuntary placement or treatment of mentally ill patients are very heterogeneous across the 15 old Member States of the European Union. Furthermore, besides legal regulations there are far more factors that determine actual practice or outcome. Different cultural or legal traditions, general attitudes towards mentally ill people, and the structure and quality of mental health care systems or administrative procedures must be considered along with other factors when analysing or comparing the outcome from the legal frameworks of the Member States. This diversity is also reflected in the prevalence of involuntary placements, as seen in Figure 5. The difference between Portugal and Finland is almost 40-fold. For some countries the rate was not available.

Figure 5. Prevalence (%) of involuntary placements per 100,000 population by country in 1998, 1999 or 2000



2. Mentally ill offenders

The aims of the project *Placement and Treatment of Mentally Ill Offenders - Legislation and Practice in European Union Member States* (2002-2004), also co-ordinated by the Institute of Mental Health, Germany, are:

- to provide a standardised description of :
    - legal framework of action
    - (forensic assessment, court trial, decision procedures, re-assessment, discharge, patient rights)
    - service provision
    - epidemiology
- to describe similarities of differences between Member States
- to draw conclusions for potential harmonisation on an European level (see box below).

Preliminary conclusions:

- Legal traditions and frameworks, routine procedures or key concepts of forensic care vary remarkably across the EU, so do the pathways to the two major sanction systems: prison or specialised forensic care.
- Forensic service provision is heterogeneous (in quality or quantity), although hard to evaluate and compare; under-provision with specialised services is common.
- Clear definitions for forensic cases or capacities are lacking and standardised European indicators are not provided, which is a serious obstacle for international comparison of efficacy of forensic practices
- Available data suggest a slight increase of prevalence of forensic cases during the last decade
- Harmonisation of legal frameworks, or agreement on basic standards of forensic care at EU level, seem hard to achieve in the near future.

3.6. APPROACHING SOME SPECIFIC ISSUES

1. Unemployment and mental health

The project *Unemployment and Mental Health* (1999-2001), co-ordinated by the University of Deusto, showed clearly that these two issues are interlinked, but in a rather complicated manner. Employment is usually supportive to mental health, but sometimes work may mean overwhelming stress and a threat to employee's mental health. Unemployment, on the other hand, is usually associated with poor mental health, but again sometimes unemployment may mean a relief from unbearable work conditions.

Key findings from the project Unemployment and Mental Health

1. Unemployment has a negative effect on the mental health of most affected people and their family members.
2. Effective means to counteract the negative impact exist, but they have to be disseminated more effectively. Unemployment means different things to different groups of people, e.g. young persons, the elderly, women and immigrants; the measures have to be applied accordingly.
3. More solidarity with unemployed people is needed. It is most important that the unemployed are not treated as responsible for or guilty of their situation.
4. Co-operation between the different actors (the unemployed person and his/her family, employers, trade unions, service providers, professionals, political decision makers, and NGOs) is of utmost importance in reducing the negative impact of unemployment on mental health.

2. Mental health economics

The project *Mental Health Economics* (2002-2004), co-ordinated by Mental Health Europe, aims to:

- describe the role of mental health economics in Europe,
- make a detailed review of the health financing systems across the participating 17 EU and EEA countries by a structured questionnaire,
- collect information on the relationship between employment and mental health problems, as well as on legislation and policies that may be used to overcame the problems encountered, especially the barriers to employment,
- support capacity building in mental health economics across Europe,
- provide recommendations for future development (see the box below).

Key points and policy recommendations:

1. The health and socio-economic consequences of mental health problems are profound, being at least 3-4% of European GNP.
2. The majority of these costs are incurred outside the health care sector. Lost productivity through absenteeism, sick leave and early retirement can account for between 60% and 80% of all the costs of mental health problems.
3. Effective and cost-effective interventions are available; but much less is known about the cost-effectiveness of mental health promoting interventions.
4. Funding for mental health in many countries appears low, being under 10% while the contribution to overall European disease burden of mental disorders is in excess of 20%.
5. Many mental health promotion and care services are provided outside health sector, e.g. in social care sector. Access and entitlements to services outside the health care sector may be variable across and within countries, and substantial out of pocket payments may be incurred.
6. Capacity for mental health economic evaluation is growing, but remains highly limited in some parts of Europe.

4. Presidency conferences and other important events

Important milestones among the Commission's activities in the field of mental health were the several European mental health conferences, co-funded from the Public Health Programme. Some of them have been organised as official EU Presidency conferences. A summary of these conferences is presented below.

YEAR	TITLE OF THE EVENT	LEVEL	COUNCIL RESOLUTIONS/ CONCLUSIONS
04/1999	Balancing Mental Health Promotion and Mental Health Care	Joint WHO/EC meeting	
10/1999	European Conference on Promotion of Mental Health and Social Inclusion	Finnish EU Presidency	Council resolution on the promotion of mental health
03/2000	Health Determinants in the EU	Portuguese EU Presidency	Council resolution on action on health determinants
06/2000	Violence and Promotion of Mental Health of Children and Young People	Portuguese EU Presidency	
09/2000	Prevention of Youth Suicide	French EU Presidency	
11/2000	Unemployment and Mental Health	French Ministry of Health	
01/2001	Young People and Alcohol	Joint Swedish EU Presidency/ WHO	Council conclusions on Community strategy to reduce alcohol-related harm
09/2001	Future Mental Health Challenges in Europe: Impact of Other Policies on Mental Health	Joint EC/WHO meeting	
10/2001	Coping with Stress and Depression-Related Problems in Europe	Joint Belgian EU Presidency/ WHO	Council conclusions on combating stress and depression-related problems
12/2002	Future Mental Health Challenges in Europe: Strengthening Co-operation between EU and WHO	Joint EC/WHO seminar	
03/2003	Mental Illness and Stigma in Europe: Facing up to the Challenges of Social Inclusion and Equity	Joint Greek EU Presidency/ WHO/ Council of Europe	Council conclusions on combating stigma and discrimination in relation to mental health
10/2003	Mental Health in Europe: New Challenges, New Opportunities	EC-funded /co-sponsored by WHO	

Table 4. Summary of selected EC events relating to mental health between 1999 and 2003

In April 1999 a joint World Health Organization / European Commission meeting on *Balancing Mental Health Promotion and Mental Health Care* was held in Brussels. This meeting reached a consensus on the need to ensure a balance between providing mental health care and undertaking mental health promotion activities in Europe in the years to come.

As part of the official programme of the Finnish EU Presidency the *European Conference on Promotion of Mental Health and Social Inclusio*n was held in Tampere, Finland in October 1999. The Conference marked an important step in the process to put mental health on the European Agenda. In November 1999 the Health Council of the European Union adopted a *Resolution on the Promotion of Mental Health*. The resolution stated the need for enhancing the value and visibility of mental health and for promoting good mental health in particular among children, young people, older people, and at work. The Resolution invites the Member States and the Commission to take specific actions in mental health promotion, good quality data collection, support to research, the incorporation of mental health in future programmes of public health action and stated the need to consider a proposal for a Council Recommendation on the promotion of mental health.

Initiatives on the European Mental Health Agenda have been preserved and continued by several Presidencies. In March 2000 a conference on *Health Determinants in the EU* and later in June 2000 *Violence and Promotion of Mental Health of Children and Young People* were held in Portugal. In September 2000 a conference on *Prevention of Youth Suicide* was held in France. In Sweden February 2001 a conference was held on *Young People and Alcohol*. All of these activities have helped to underline the importance of taking actions in the field of mental health promotion and prevention of mental ill-health, including suicide and substance abuse.

The Belgian Federal Ministry of Social Affairs, Public Health and Environment, Belgium, together with the European Commission and the World Health Organization organised in Brussels in October 2001 Presidency conference *Coping with Stress and Depression Related problems in Europe*. In November 2001 the Health Council of the European Union adopted the conclusions of the Conference, which invited the Member States to give due attention to the impact of stress and depression related problems in all age groups, giving special attention to the problems of work-related stress and depression. The conclusions invited the Commission to facilitate the collection of comparable data, to consider undertaking activities recognising best practices concerning the promotion of mental health, as well as the recognition, prevention and monitoring of stress and depression related problems and to consider developing strategies for their prevention.

During the Greek Presidency of the European Union in March 2003, a Conference was held in Athens on *Mental Illness and Stigma in Europe: facing up to the challenges of social inclusion and equity*. In June 2003 the Council of Ministers of Employment, Social Policy, Health and Consumer Affairs, adopted the Conclusions of the Conference. Member States were invited to give specific attention to the impact of stigma and discrimination due to mental illness in all age groups, and to give special attention to reduction of the consequential risks of social exclusion. The Commission was invited to give attention to active collaboration in all relevant Community policies and actions, in particular on employment, social protection, education and health in order to reduce discrimination in relation to mental illness. The Commission was invited to facilitate exchange of information in the context of national policies to ensure protection for people with mental health problems and to promote their inclusion in society.

In Brussels in September 2001 the European Commission and WHO Euro organised a consultative meeting "Future Mental Health Challenges in Europe: Impact of other policies on mental health." This meeting focused on discussing the impact of environmental policies, social welfare policies and education policies on mental health and addressed the importance of the need for future work on the social and economic burden of illness in the mental health field.

In Luxembourg in December 2002 the European Commission and WHO Euro organised a seminar "Future Mental Health Challenges in Europe: Strengthening co-operation between EU and WHO". This seminar put emphasis on issues of premature mortality and suicide prevention, experiences of mental health promotion actions and prevention strategies during the life cycle and the crucial transitions in life, enhancing implementation of coping and prevention strategies of stress and depression-related problems at European Member State, regional and local levels.

In October 2003 a conference *Mental Health in Europe: New Challenges, New Opportunities*, jointly organised by The European Commission, the Finnish National Research and Development Centre for Welfare and Health (STAKES), the Department of Health of the Basque Government and the University of Deusto, and co-sponsored by the WHO Euro and Mental Health Europe, was held in Bilbao, Spain. A special focus of this conference was to tackle the challenges for mental health produced by the enlargement of the EU in the beginning of 2004. The conference launched several conclusions and recommendations for the four themes of the conference: Economic and social impact of mental ill-health; Impact of transitions on mental health; Needed infrastructure for mental health promotion and prevention, and Prevention of premature mortality and abuse problems.

5. Policy impact of activities

It is justified to say that mental health rose within the European Union policy agenda from 1997 to 2004. 'Mental health' was not even mentioned in the first Public Health Programme which was approved in 1994, and many Member States regarded mental health mainly as a 'vertical', disease-specific issue which was a national business, not within the mandate of the European Community. The change, however, took place during the second half of the 90's, and 1997 can be seen as the breaking through year in this respect. In that year, the Council of Health Ministers had for the first time a discussion about promotion of mental health, and the first mental health project, co-funded by the European Commission, started. Since then, as has been described in the above chapters, an increasing number of projects, conferences and other activities have taken place from 1999 onwards. Today, mental health has to be seen as a natural and essential component in the European Union's public health policy.

The most important impact, without doubt, is the fact the mental health is explicitly mentioned in the current EU Public Health Programme (2003-2008) under its strands on health information (Strand 1) and health determinants (Strand 3). In the Public Health Programme mental health is defined as a priority together with other important public health issues like tobacco, nutrition or accidents and injuries.

In order to support the implementation of Strand 1 (Operating the health information and knowledge system), the Commission has established six specific working parties, consisting of experts from different Member States, one of them being the Working Party of Mental Health.

Additionally, the Commission has published recently the report *Actions Against Depression. Improving mental health and well-being by combating the adverse health, social and economic consequences of depression*[5]. The report builds on many activities, described in this brochure. The report offers a description of depression and highlights its economic and social consequences. The report also presents the evidence base for effective interventions, identifies some of the challenges in developing promotion and prevention strategies, as well as offers evidence for solutions to these challenges and presents some conclusions with suggestions for the way forward for Europe.

A clear impact of the activities has also been the increased visibility and valuation of mental health issues in the Member States. This is best seen in the series of several EU Presidency conferences on a topic related to mental health. Since the first such conference in 1999, almost every Presidency has taken such a conference in their official programme, as described in chapter 4. It is also a fact that during these years several Member States have directed specific attention to mental health by launching specific national mental health policies or strategies, or by including mental health as a natural and indivisible part of their general health policies.

As also already mentioned, several Presidency conferences have been followed by a corresponding Council Resolution or Conclusion. Their importance lies especially in the high-level political commitment by all Member States, and the influence they have on the health policy of individual countries.

Concern has also been expressed by the European Parliament concerning aspects of human rights relating to treatment of mentally ill persons, and as regards pharmaceutical treatments. These concerns have also been expressed by non-governmental organisations at the European level.

[5] http://europa.eu.int/comm/health/ph determinants/life style/mental/depression en.htm

6. Conclusion

There exists now a certain momentum for mental health in Europe, and it is important to keep it active. A very important issue is constructive co-operation between the different actors and stakeholders, including intergovernmental and national organisations, politicians and decision makers, mental health professionals, scientists as well as user and carer organisations and other NGOs.

The projects and other events, funded by the European Commission, have contributed greatly in building this momentum and in lifting mental health on the European agenda. Mental health is not any more such a mysterious and taboo-related matter as it was in the past. The knowledge about mental health and its promotion has increased rapidly, and the attitudes towards mental health issues have become more positive. Mental health is becoming an essential and indivisible part of general health.

The *Ministerial Conference on Mental Health: Facing the Challenges, Building Solutions*, on 12-15 January 2005, will contribute to translating the momentum into action by policymakers and other stakeholders. The European Commission, together with WHO Regional Office for Europe, Council of Europe and the Ministry of Social Affairs and Health, is one of the co-organisers of this important event.

However, there is need for further consolidating the mental health action by the European Commission. It is also necessary to disseminate the experiences and lessons from previous activities, and to valorise results achieved so far.

All these activities are expected to further reduce the prejudices prevailing among the general public and also among the health professionals and decision makers, and thus, reduce the stigma connected with mental health issues. This, for its part, will improve the human rights of and services for people suffering from mental health problems.

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