Mental Health in the EU
Key Facts, Figures, and Activities

A Background Paper
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Content

Directorate-General for
Health & Consumers

1. Introduction

This background paper has been prepared to support the activities of the European Commission and its partners in preparing and implementing a European Pact for Mental Health. As a follow-up to the Green Paper on Improving the Mental Health of the Population in 2005, the Commission indicated its intention to launch a Pact on Mental Health at a high-level conference in June 2008. The purpose of the Pact is to highlight the relevance of mental health for public health, productivity, learning, and social cohesion in the EU. It signals a willingness to work together on mental health, based on a common set of principles for action. Implementation of the Pact will be taken forward through a series of thematic conferences in 2008 – 09 in order to develop further plans for action and a Commission Proposal for a Council Recommendation on Mental Health in 2009.

The Pact will focus on five themes:

- Prevention of Suicide and Depression
- Mental Health in Youth and Education
- Mental Health in Workplace Settings
- Mental Health and Older People
- Addressing Stigma and Combating Social Exclusion

The Pact will also emphasise the importance of action on four 'horizontal' levels: the promotion of mental wellbeing; the prevention of mental disorders; support for people experiencing mental health problems; and improvement of the knowledge base.

The background paper presents information and evidence to illustrate why improving the mental health of the EU population is important as a public health objective. The promotion of mental health, the prevention of mental disorders and improving the situation of people with mental health problems can make a substantial contribution towards achieving current EU social and economic policy objectives.

Mental health is therefore a matter that concerns EU citizens and policy makers; it is also of direct relevance to health, education, and social sectors as well as to the workplace and to communities.

Knowledge, experience, and expertise are now accumulating on actions that can be taken to promote mental health, prevent mental disorder, and improve the quality of life of those affected by mental health problems.

The paper aims to increase awareness of the part that different sectors and a range of actors can play in addressing mental health issues. It draws on scientific research and on policy and practice, with examples of actions that can be taken in a range of settings with different age groups to promote mental health and wellbeing. It is intended as an introduction to some of the many different activities that can be undertaken and to serve as a resource. It is not a systematic review of good practice.

2. Why Mental Health Matters

2.1 MENTAL HEALTH AND THE EU

The mental health of its citizens is a vital but under-valued resource within the EU. There is a close interrelationship between the EU's policy objectives of prosperity, social inclusion, and security and public health on the one hand, and mental health on the other. A better understanding of mental health and of actions that can be taken to achieve improved mental health can be of considerable benefit in addressing a range of social and economic priorities that are of direct concern to the EU and its Member States.

Mental health is affected by policies and practices across many different sectors, notably policy that influences early years and family life, education, employment, working conditions, migration, household income, housing, and the built and natural environment (see Table 1 in the Appendix). Many existing EU policy priorities will themselves help to improve mental health and will in turn be enhanced by a stronger focus on mental health.

2.2 CONCEPTS OF MENTAL HEALTH

Mental health and mental health problems

The World Health Organisation describes **mental health** as:

"*a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*".

Mental health encompasses the abilities to develop emotionally, psychologically, intellectually, socially and spiritually (Barry and Jenkins, 2007). It includes concepts such as resilience, a sense of mastery and control, optimism and hope as well as our ability to initiate and sustain relationships and to play a part in our social world.

Mental health is therefore a measure of how people, organisations, and communities think, feel, and function, individually and collectively. Communities, organisations, and societies benefit socially and economically where people have good mental health and this is therefore a desirable condition to foster (Keyes, 2007).

Mental disorders - cover a continuum of diagnosable conditions that affect cognitive and emotional functioning, including mood disorders (e.g. depression) and psychotic disorders (e.g. schizophrenia).

Mental health problems - denote emotional and psychological difficulties, which cause distress and interfere with how people go about their everyday lives.

Mental health promotion - aims to protect and support emotional and social well being and create the conditions that enable optimal functioning of individuals, families, communities, and societies.

Mental disorder prevention - aims to reduce risk factors associated with mental health problems in order to reduce the incidence, prevalence, and recurrence of mental disorders, and to diminish the impact of illness on individuals and their families.

Stigma, discrimination, and social exclusion are terms that are often used interchangeably in the mental health field. For the purposes of this paper, stigma is used to describe the attitudes adopted by society or individuals towards those with mental health problems or mental disorders. Discrimination is used to describe the actions that arise from stigmatising attitudes. Social exclusion is described in this context as a consequence of stigma and discrimination. (Myers et al 2008, WHO)

3. Mental Health in the European Union

3.1 CURRENT STATE OF MENTAL HEALTH IN THE EU

3.1.1 Mental Health and Wellbeing

Good mental health is increasingly important for economic growth and social development in Europe. Thus, monitoring of population mental health is crucial. At present, most health information systems are better developed to measure mental ill health than mental health. However, from a public health perspective, monitoring population mental health is vital, as it concerns the whole population not only the proportion affected by mental ill health.

General Population

Reliable and comparable surveys on mental wellbeing[1] are few. A Special Eurobarometer Survey on Mental Wellbeing was undertaken in December 2005 and January 2006. This covered the population aged 15 or over in all current 27 EU member states and the Candidate countries Croatia and Turkey (European Commission 2006).

During the 4 weeks preceding the interview, a substantial majority of EU citizens experienced positive and balanced feelings rather than negative emotions such as feeling depressed. 64% felt full of life all the time or most of the time, 55% had a lot of energy, 65% reported they were happy and some 63% felt calm and peaceful.

The results indicate significant discrepancies between countries. In relation to positive feelings related to mental health, the proportion reporting they felt happy all or most of the time ranged from 83% in the Netherlands to 42% in Latvia and Bulgaria. Over a quarter of respondents in Belgium (27%), the Netherlands and Luxembourg (26% each) indicated that they were happy all the time while 7% of Bulgarians and 6% of Latvians reported that they had not felt happy any of the time. Finland had the highest number of respondents who felt calm and peaceful almost all the time (83%). Italy by contrast had the lowest proportion of respondents reporting these feelings (46%).

In relation to the energy/vitality dimension, 90% of Finnish respondents felt full of life all or most of the time whereas only 30% of Hungarians experienced the same. Respondents from Finland were considerably more likely to report feeling 'full of life all the time' (45%), whereas 16% of Hungarians and 14% of Estonians indicate that they have not felt this way in the month prior to the survey.

Finally, 72% of respondents from Netherlands indicated that they had a great deal of energy all or most of the time during the past month. By contrast, only 37% of German respondents reported the same.

Overall, the Special Eurobarometer indicates a higher level of mental health in the old Member States, especially in the Nordic and Benelux countries, than in the new Member States. It appears that citizens of the Netherlands and Finland are more likely to experience positive feelings during the 4 weeks preceding the interview. Respondents from Italy and the three Baltic States seem to experience positive emotions less frequently.

In a subgroup analysis, men, the young, those who have studied longer, students, managers, self-employed people, and those who have neither sought nor received help for mental health problems were more likely to state that they felt positive all or most of the time in the preceding 4 weeks.

The MINDFUL Project[2] mapped the availability of data on positive mental health and identified the following:

• In 1999, most European countries took part in the World Values Study Survey, which generated comparable data on level of happiness in the population. High scores were noted in Denmark, the Netherlands, and Ireland, and the lowest scores among EU25 were recorded in Latvia, Estonia, and Slovakia.
• Data on self-esteem are available from most countries for the year 2004. The highest score is reported for Estonia, Austria, and Finland, and the lowest scores are reported for Slovakia, Malta, and Lithuania.
• Data on perceived social support is available for most countries for the year 2002. Social support appears to be high in Spain, the Netherlands, Denmark and Sweden, and low in Italy and France.

In addition to specific instruments monitoring the mental health of the population, there is other useful data collected for different purposes within the EU, which illustrates the impact of wider determinants on mental health and mental health problems. For example, most Eurobarometer surveys on general health matters have relevance to mental health, in particular Eurobarometer 272e (Health in the EU)[3] .

EU-SILC, the EU Survey on Income and Living Conditions, is a survey of private households. EU-SILC covers EU (25) member states. It contains information on the income and living conditions of different types of households. Data from this survey show measures of social inclusion and protection and poverty.

Further useful information is available from the EU Labour Force Surveys and the European Quality of Life Survey undertaken by the European Foundation for the Improvement of Living and Working Conditions. The Foundation has collated data on a wide range of quality of life related indicators in its EurLIFE

database, available at http://www.eurofound.europa.eu/areas/qualityoflife/eurlife/index.php

Children and Young People

Most school-aged children in Europe appear to enjoy good mental health and wellbeing. That said there is substantial variation between member states and between communities and demographic groups. No statistical instrument is yet in place at Community level to monitor mental health in this age group although multiple state data are provided from other sources.

Two main surveys provide information on the mental health and wellbeing of children and young people in Europe. The Health Behaviour in School-aged Children (HBSC)[4] study provides information on the health and behaviour of young people aged 11 to 15 years, including emotional and psychological aspects of health. HBSC is a cross-national study that covers most EU member states. The most recent available report presents international data from the year 2001/2002. The KIDSCREEN survey tool[5], developed by the 5th Research Framework project KIDSCREEN, provides cross-culturally comparable data from 13 countries in Europe on the wellbeing of children and adolescents and on the socio-economic status of their families.

The HBSC study shows that between 16 and 27% of girls and 12 and 16 % of boys aged 11-15 years rate their health fair or poor. There are large variations between countries. Those with poorer self-reported health and wellbeing include Latvia, Lithuania, Wales, and England. By comparison, self-reported health is higher in Greece, Spain, and Finland. Both self reported health and well being and life satisfaction show a marked decline for both boys and girls between the ages of 11 and 15.
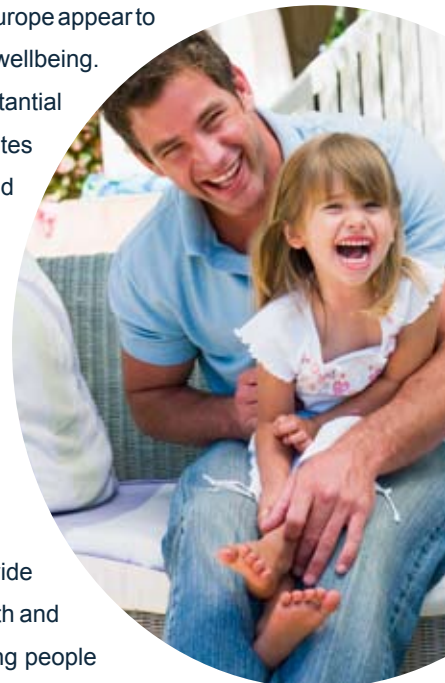
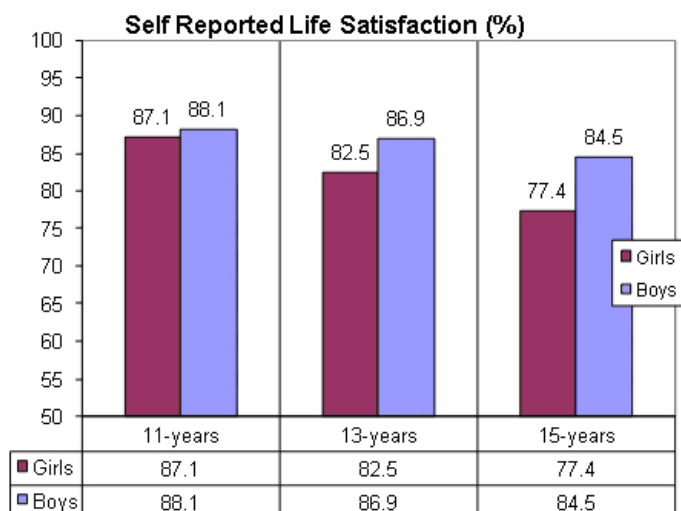1. http://ec.europa.eu/health/ph_publication/eurobarometers_en.htm
2. Co-financed by the Public Health programme 2003-8, report available from STAKES at: http://www.stakes.fi/pdf/mentalhealth/Mindful_verkkoversio.pdf
3. http://ec.europa.eu/health/ph_publication/eb_health_en.pdf
4. http://www.hbsc.org/
5. http://kidscreen.diehauptstadt.de/

Figure 1: Self Reported Life Satisfaction among Adolescents (HBSC)

Self Reported Life Satisfaction (%)	11-years	13-years	15-years
Girls	87.1	82.5	77.4
Boys	88.1	86.9	84.5

Older People

SHARE, The Survey of Health, Ageing and Retirement in Europe, is a multidisciplinary and cross-national database of data on holistic health of people aged 50 or over. At present, the SHARE database contains data on the individual life circumstances in nine European countries (Sweden, Denmark, Germany, Netherlands, France, Austria, Italy, Spain, and Greece.) Data collection is still going on and the database is growing all the time.

SHARE predicts that demographic change and the rising proportion of older people will be one of the greatest challenges of the 21st century for the European societies. Europe has the highest proportion of population aged 65 or over of the world regions. According to Eurostat in year 2007 16.9% of the EU (27) population will be aged 65 or over and 35.2% will be 50 or over. Further discussions about the challenges of the ageing population of Europe are discussed in "Healthy ageing: keystone for a sustainable Europe"[6], produced by DG-SANCO.

In sum, although there are limitations to the availability of data on population mental health, what is known about the mental health of Europeans indicates significant variations between countries and within populations, which can inform policy development.

3.1.2 Mental Health Problems, Mental Disorders, and Suicide

Mental health problems are common. Although different studies suggest different rates, one recent European study suggested that 11 per cent of the population experience mental disorders every year (Alonso and Lepine, 2007). In adolescence, the occurrence is estimated to be at the same level. Among, 8-9 year old children the prevalence of any mental disorder has shown to be as high as 15% in some European studies (Hackauf and Wunzen, 1999).

Mental Ill Health, Disability, and Long-Term Illness in the EU

In 2002, neuropsychiatric conditions accounted for a quarter of all European ill health and premature death and depression was the second leading cause of disability after ischaemic heart disease. The World Health Organisation has predicted that, in high income countries, mental disorders will continue to account for close to a third of the disease burden associated with non-communicable diseases (Prince et al, 2007). It is estimated that mental ill health costs developed countries 3-4% of GDP per annum (Gabriel and Liimatainen, 2000). This is equivalent to double the GDP of a country the size of Austria.

According to the September 2007 Eurobarometer 272e (European Commission, 2007), around 3 out of every 10 (29%) Europeans have a longstanding illness or health problem. This is a 5% increase from the level of ill health reported in the 2003 survey. Exactly a quarter of the surveyed population were currently undergoing medical treatment. This is very much in line with the 26% who gave the same answer in a 2003 survey.

It is possible to compare the reported experience of common mental disorders with the experience of other long-term health problems.

Disability and Degree of Restriction

A recent study of data on disability in the EU was commissioned by DG-Employment and Social Affairs. "Men and Women with Disabilities in the EU: Statistical Analysis of the LFS Ad Hoc Module and the EU-SILC[7]" is a quantitative study of people in the EU with long-standing health problems or disability (LSHPD). This study addresses a series of issues concerning the extent of people's ability to participate in employment and to access education, as well as their income and wage levels. The analyses in the study are based on two data sources; these were a special ad hoc module of the EU Labour Force Survey (LFS) on people with disabilities and long-term health problems (2002) and EU-SILC (EU Statistics on Incomes and Living Conditions 2004).

Approximately 10% of LSHPD were shown to be related to mental, nervous, or emotional problems, a figure that supports the Eurobarometer results (Figure 2). EU-SILC and the Labour Force survey also give information on the degree of restriction caused by the experience of illness or disability.

Figure 2. Comparison of Chronic Anxiety or Depression with three other reasons for currently receiving medical treatment for a long-term condition, EU25 compared with highest/lowest MS (Sourced Eurostat 272e September 2007)

* more than one condition could be reported
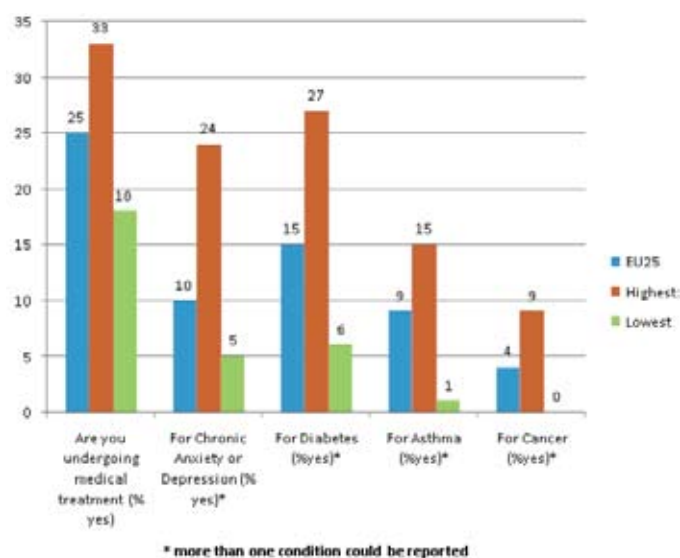
People suffering from mental, nervous, or emotional problems and those suffering from epilepsy tend to have lower levels of education than those affected by other problems. Mental health problems were a significant cause of people being considerably restricted rather than only being restricted to some extent. Some 60% of people suffering from mental health problems or epilepsy stated that they were considerably restricted in at least one aspect of work, with 18% of people suffering from mental health problems or epilepsy stating that they were restricted to some extent. These figures vary considerable by member state and by age and gender.

The relative frequency of different type of problems varies with age. Mental, nervous, and emotional problems are more common among those aged 16-24 years than other age groups. In Romania, almost half (48%) of the people in age group 16-24 reporting an LSHPD suffered from mental health problems. By

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6. http://ec.europa.eu/health/ph_information/indicators/docs/healthy_ageing_en.pdf
7. http://ec.europa.eu/employment_social/index/lfs_silc_analysis_on_disabilities_en.pdf

contrast, in Finland and Sweden mental health problems were reported only by 6-7% of young people declaring an LSHPD, with Belgium reporting the lowest incidence at only 4%.

More young people aged 16-24 in the EU with considerable restrictions on working cite mental health problems and epilepsy as the cause than any other groups of problems - almost 38% in total. Twenty-one per cent of people with LSHPD in the age group 25-54 cited mental health problems as the cause of being considerably restricted. Only 8% of people having LSHPD in the age group 55-64 cited mental health problems as the cause of being considerably restricted.

Mental, nervous, or emotional problems have an especially significant effect in reducing the amount of work that can be done, leading to an effect on participation in the labour market. Of those people in employment, approximately one fifth (18%) of people (aged 25-64) with mental health problems were working in sheltered work.

Mental Disorders in Children and Young People

Young people are increasingly exposed to circumstances that challenge their mental health and may contribute to the development of mental disorders. The incidence of mental disorders in children appears to be similar to that in adults. Data are hard to compare as the methods, criteria and samples vary, and there is a lack of data comparing multiple states. A number of individual member state studies estimate incidence at between 10 and 20 percent, with the lowest estimates at around 9.5% (UK) (Ford, Goodman, and Meltzer 2003) and the highest incidence of the order of 22.5% (Switzerland) (Steinhausen et al 1999). Ihle & Esser (2002) reviewed 19 longitudinal studies for a

thirty-year period to 2000, and found a mean prevalence rate of 18%. Prevalence estimates ranged from 6.8% to 37.4% with three quarters of studies finding prevalence rates in the range 15-22 % (Ihle and Esser, 2002).

Mental Disorders in Later Life
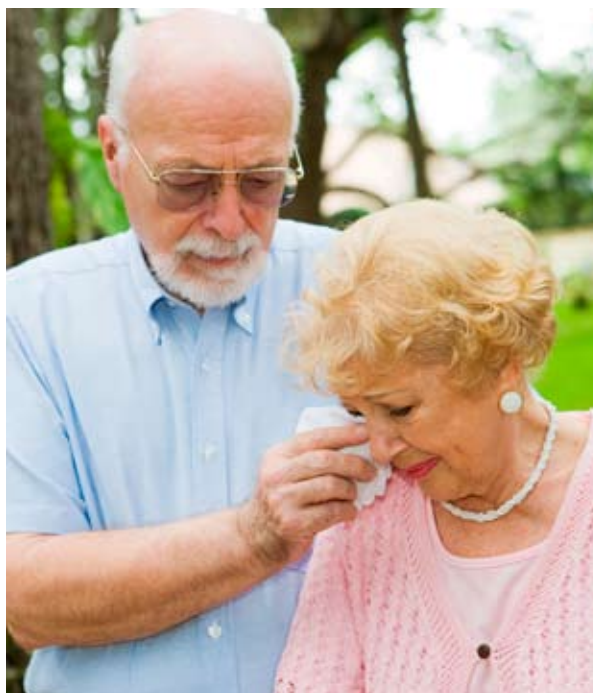
SHARE indicates that the prevalence of depression rises consistently with age. In every country, depression seems to be more common among women than men. According to SHARE, almost one third of the people aged 50 and over have symptoms of depression.

Figure 3: Percentage of Older People Reporting Current Symptoms of Depression, by age group (Source: SHARE)
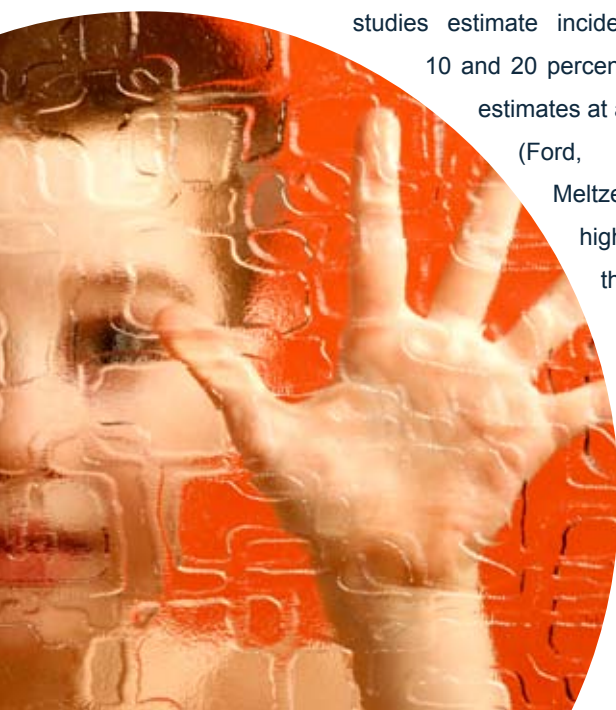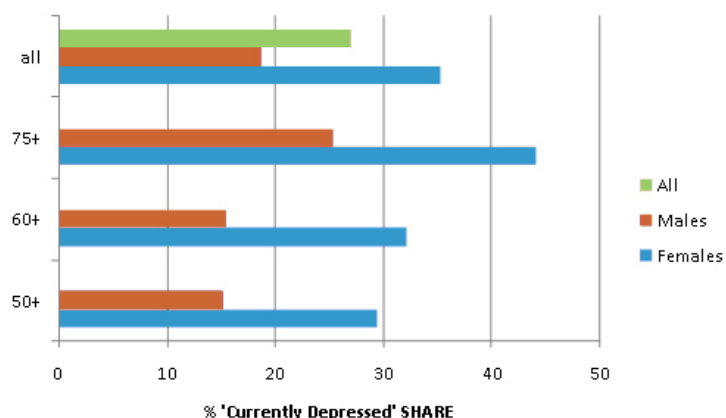
In total 27% of SHARE respondents reported current symptoms of depression. Most serious is the situation among women over 75 years old, with nearly half of them reporting current depression (Figure 3). There is substantial variation between member states in the SHARE survey, with particularly high rates of depression in older Spanish women. The lowest rates were seen in Denmark, though even here rates approached 25-30% in some age groups.

Depressed older people are 2-3 times more likely to have multiple chronic illnesses. They are significantly more likely to have one or more limitations in activities of daily living[8]. Many older people may attribute depressive symptoms to physical causes, effectively contributing to under diagnosis and under-treatment[9]. Older people with depression are more likely to require early placement in nursing homes and require more frequent and costly professional help.[10],[11]

Suicide

Around 60,000 EU citizens take their own life each year (Eurostat). An EU citizen is ten times as likely to die by suicide (2006:58527) than to die of HIV/AIDS (2006:5833) (Eurostat).

In the EU, at least one child under 14 dies by suicide every 48 hours (Eurostat, 1996). In 2006 approximately 20 young adults aged 15-29 committed suicide every day; among those aged 30-59, approximately 87 people died every day by suicide; and 56 people aged over 60 took their own lives every day(Eurostat).

Depression is a major cause of suicide in European older people. Rates of suicide and self-harm are approximately 26% higher in Europeans over 65 than amongst the 25-64 age groups (WHO HFA Database) and in 90% of EU countries the suicide rate is highest in those over 75[12].

People who experience mental health problem are at increased risk of suicide or intentional self-harm.

There are good quality data on suicide in Eurostat and in WHO databases, which allows comparisons between different member states, age groups and genders and tracking of change over time.

The suicide and intentional self-harm rate in the EU has continuously decreased from the 1995 to 2005 but is still relatively high. According to WHO (HFA-DB and HFA-MDB) databases the suicide and self inflicted injury rate in year 1995 was 13.31 per 100 000 in EU (27) member states. By 2005, the rates had decreased to 11.09.

Comparisons between member states indicate that suicide rates are highest in Eastern European countries, whilst Mediterranean countries and United Kingdom have the lowest suicide rates. Both Eurostat and WHO Europe statistics show that the highest rates in all age groups are in Lithuania, where suicide rates are three times the average for EU(27) member states.

Monitoring Eurostat statistics from recent years allows comparisons between age groups and different member states. In 2005, the total suicide rate per 100 000 was 11.3 considering all age groups. Highest rates were in Lithuania (28.9), Hungary (23.2), and Slovenia (22.0). Lowest rates were in Cyprus (2.4), Greece (3.1), and Malta (4.2). Among those aged 15 to 19 years the suicide rate in EU (27) was 4.8 per 100.000. The highest

8. SHARE 2005
9. Beekman, A T F, Copeland J R M, and Prince M J. 1999. Review of community prevalence of depression in later life. British Journal of Psychiatry 174:307-11.
10. Federal Institute for Occupational Safety and Health. Mental Health Promotion and Prevention Strategies for Coping with Anxiety, Depression and Stress-related disorders in Europe. Final Report 2001-2003. 2004.
11. Katon WJ. et al. 2003. Increased medical costs of a population-based sample of depressed elderly patients. Archives of General Psychiatry, 60(9):897-903.
12. European Commission 2004. Actions against depression Improving mental and well-being by combating the adverse health, social and economic consequences of depression. Health and Comsumer protection Directorate General. Brussels.
http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/depression_en.pdf

rates were in Lithuania (15.0), Estonia (12.2), and Latvia (10.4). The lowest rates were in Greece (1.5), Portugal (2.4), and Spain (2.9). In those aged 50 to 54 years, the EU (27) suicide rate was 18.5 per 100 000. Highest rates were in Lithuania (70.6), Hungary (45.8), and Latvia (43.2). Lowest rates were in Greece (3.9), Cyprus (6.3), and Portugal (8.5).

Figure 4: Suicides and Self-Inflicted Injury, all ages per 100 000 in EU (27). (Ref. WHO/ HFA-MBD)

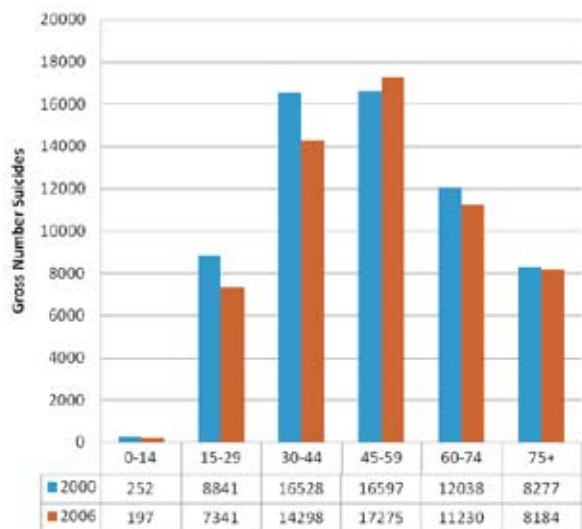|	0-64	65+	0-14	15-29	30-44	45-59	60-74	75+	25-64	Total
■1995	11.83	23.76	0.31	9.58	17.13	19.57	19.31	29.61	17.42	13.01
■2000	10.85	20.70	0.26	8.84	15.19	18.27	17.36	25.69	15.92	11.91
■2005	10.19	18.75	0.21	7.90	13.02	18.10	16.38	22.97	15.11	11.09

Crude death rate from suicide and intentional self-harm per 100 000 people, not including deaths from events of undetermined intent
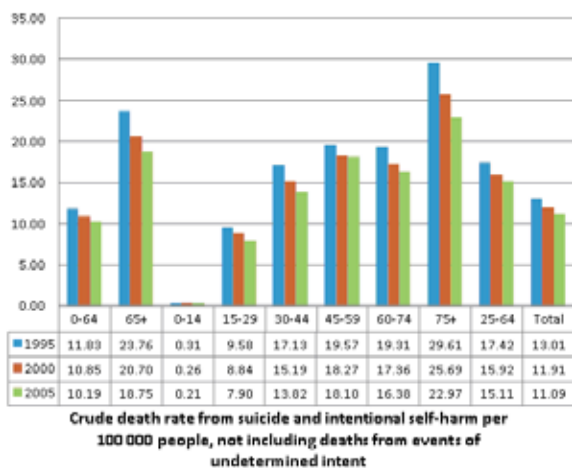
Suicide and intentional self-harm rates have been decreasing in all age groups in EU (27) during the last decade (Figure 4). Gender differences in suicide rates remain striking, with males are more likely to die by suicide than females (Figure 5).

Figure 5: Number of Suicides in EU (27) (Ref. Eurostat)

	0-14	15-29	30-44	45-59	60-74	75+
■2000	252	8841	16528	16597	12038	8277
■2006	197	7341	14298	17275	11230	8184

3.2 THE SITUATION OF PEOPLE WITH MENTAL HEALTH PROBLEMS

Mental health problems have costs and consequences that impact at different levels on: individuals; families; health and social systems; and society and the economy (House of Lords, 2007).

3.2.1 Individuals

The symptoms of mental health problems are in themselves distressing and impact on functioning in a variety of roles and on social and personal relationships. These effects can persist for long periods.

Enduring mental health problems tend to be associated with impoverished quality of life as measured by levels of income and quality of housing and by levels of social support.

People with long-term mental health problems are significantly less likely to be in employment than people with other forms of disability or long-term health condition (EFILWC, 2003).

Those with mental health problems tend to have higher rates of physical ill health and premature mortality and experience barriers in accessing appropriate care and treatment for physical illnesses (Disability Rights Commission, 2007; Sayce and Curran in Knapp et al, 2007).

People with mental health problems can experience prejudice, stigma and discrimination in many spheres of life including education, civic society, employment and housing. This can lead to isolation and social exclusion (Thornicroft, 2007; MHE Social Inclusion Project www.mentalhealth-socialinclusion.org).

3.2.2 Families

The stresses and strains associated with looking after a family member or friend can affect both carers' health and social and familial relationships and can lead to lost income. Carers are more likely to work fewer hours and to receive lower wages in work and lower pensions on retirement (Magliano et al in Knapp et al (eds), 2007, Stengård 2005). Many of the issues are discussed in a 2008 review by Magliano for WHO Europe[13].

Poor parental mental health during infancy and early childhood is strongly associated with poor mental health outcomes for the child into adulthood (Beardslee, Solantaus, and van Doesum, 2005). Children of depressed parents have a significantly higher risk of developing a depressive disorder before the age of 20 (Beardslee et al 1998).

For young people, communication with parents is a good measure of the quality of parent-child relations. The HBSC survey indicates that older adolescents tend to experience more difficulties with parental communication than those who are younger. Twenty–three per cent of 15-year old girls and 22.7% of boys find it difficult to talk with their mothers and 53.3% of 15-years-olds girls and 34.7% of 15-year old boys find it difficult to talk with their fathers (WHO 2004c).

3.2.3 Groups at risk of mental health problems

Mental health problems affect all population groups irrespective of age or socio economic status. However, there are considerable

disparities in the distribution of mental health problems across the EU population. Exposure to the factors that promote mental health or present risks for mental health are not randomly or equally distributed but are closely linked to social and economic inequality (Melzer et al, 2005; Myers et al, 2005). Mental health problems are more common in areas of deprivation and poor mental health is consistently associated with unemployment, less education, low income, or material standard of living, in addition to poor physical health and adverse life events.

Social and economic inequality and exclusion are both a cause and a consequence of mental health problems (Rogers and Pilgrim 2003; Social Exclusion Unit 2004). Social position influences how people feel, think, and function. In planning activities to promote mental health and prevent mental ill health, consideration needs to be given to the extent to which mental health promotion interventions may reinforce or widen mental health inequalities.

The two surveys mentioned earlier of children and young people indicate that low socioeconomic status is indirectly associated with poor mental and emotional health in this age group, for example, depression, hostility, anxiety, poor self-esteem and psychological stress. The European KIDSCREEN study shows close links between the socioeconomic determinants of health and measures of mental health and wellbeing in childhood and adolescence (Rueden et al, 2006). Low or medium familial wealth is a risk factor for various dimensions of quality of life including psychological wellbeing, moods and emotions, social support, home life and parent relations and bullying. These effects are most marked in adolescence. The HBSC family affluence scale (FAS) that measures socioeconomic status of young people indicates that family affluence is higher in Northern and Western European countries and lower in Eastern European countries and middle in the Mediterranean countries.

Other key factors that are correlated with mental health in childhood or adolescence and

for which European data are available include:

• Body image: the relationship between body image and self-esteem is high, especially with girls. On average one in three girls report being dissatisfied with their body weight and in one, five are engaged in dieting and weight control. Comparable rates for boys are one in five and one in ten (WHO, 2004c)

• Bullying: childhood bullying has long-term effects into adulthood and is associated strongly with antisocial behaviour. Bullied children have lower self-esteem, are more depressed than others are and are more often users of mental health services. The HBSC study shows that bullying is more common among younger respondents (11-13 years) and among boys than girls. Among 13 year olds, 31% of girls and about 45% of boys reported having bullied others at least once in the previous couple of months. About 34% of girls and 38% of boys reported having been bullied at least once in the previous couple of months. Highest rates were in Lithuania, Austria, Portugal, Latvia, and Estonia. Lowest rates were in Sweden, Czech Republic, Greece, Malta and Hungary (WHO 2004c)

• School pressures: older adolescents experience more pressure from schoolwork than those who are younger. Highest rates are reported by 15 year old girls, almost half of whom find schoolwork a source of pressure. Rates vary between countries with highest rates in Lithuania and Malta and lowest in the Netherlands, Austria, Belgium (French) and Germany (WHO 2004c).

Key groups whose social and economic circumstances may put them at increased risk of mental health problems include the following:

• Those living in relative poverty and in financial insecurity
• Ethnic minority groups
• Recent migrants and refugees
• Those who are homeless
• People with a long term physical illness or disability
• Those who care for someone with a disability or long term illness (including young carers)

• People who have drug or alcohol problems
• Victims of violence or abuse
• Those undergoing significant life transitions, trauma, loss or change
• Prisoners and ex-prisoners.

3.3   WIDER IMPLICATIONS OF THE STATE OF MENTAL HEALTH IN THE EU

In view of the scale of the social and economic consequences and the costs of mental health problems, the benefits are enormous of effective action to reduce prevalence and impact of mental health problems and to promote the mental health of the population as a whole. These benefits can be described for health and social systems; the economy and productivity; and civil society.

3.3.1 Health and Social Systems

Implications of Poor Mental Health

The prevalence and duration of mental health problems place a considerable burden on health and social care systems. The proportion of the health budget devoted to mental health in 17 western countries varies considerably from 4% in Portugal to 13% in England and Luxembourg, although definitions and comparability of data require caution (Knapp et al 2007).

Furthermore, the close association between mental health and physical health makes heavy demands on health care services. Firstly, poor mental health is associated with higher rates of a range of physical illnesses and conditions including heart disease, stroke, diabetes, infectious diseases, and respiratory disorders, with implications for health service costs. Depression, for example, significantly increases the risk of cancer and heart disease. In addition, mental ill health is linked with a range of risk behaviours including smoking and sexual risk behaviour (WHO 2003).

Secondly, physical health problems or disability are associated with a greater likelihood of experiencing poor mental health. Major depression for example is twice as common among medical patients in a general hospital as in the general population. Depression is associated with poorer outcomes in these medical patients (Royal College of Physicians and Royal College of Psychiatrists, 2003).

Gains from Improved Mental Health

Improvements in mental health can lead to improved physical health outcomes including better overall health, reduced risk of stroke and heart disease and to   reductions in tobacco and alcohol consumption and reduced obesity (Friedli and Parsonage, 2007). Prevention of mental health problems will also benefit the physical health of people with mental health problems who tend to have poor physical health (Disability Rights Commission, 2007; Sayce and Curran in Knapp, 2007).

3.3.2 The Economy and Productivity

Implications of Poor Mental Health

The social and economic consequences of mental ill health include lost productivity due to ill health of individuals as a result of absenteeism and / or under performance; the impact of caring responsibilities assumed by family members; and premature mortality, including death by suicide:

• The economic impacts of suicide and non-fatal suicidal behaviour that fall on everyone in society are substantial (McDaid & Kennelly 2007)

• Across the EU mental health problems account for 25% of all new disability benefit cases (EFILWC, 2003)

• Welfare costs associated with mental health problems are substantial: in France 25% of illness related social security expenditure is due to stress; in Finland between 1990 and 2003, disability for mental health related problems increased by 93%; in Spain the General Workers Union estimates that 50 – 60% of sick leave is due to stress at work (MHEEN Project 2007)

• It has been estimated that in relation to the costs of depression, the impact on employment and therefore lost productivity, is many times greater than the costs to the health service (Sobocki et al, 2006)

• Lifetime effects of poor mental health are evident from the results of a number of studies that indicate children with

emotional or behavioural problems are much less likely than their peers to be in employment in adulthood (House of Lord, 2007).

Gains from Improved Mental Health

Improved mental health in the workplace leads to reduced employee sickness absence, better staff retention and increased productivity and performance (Friedli and Parsonage, 2007). Those who are not able to secure or retain work because of mental health problems represent a considerable resource of skills and labour that are underutilized (Gabriel and Liimatainen (2000).

For the European Union, therefore, improved mental health will contribute to the attainment of key strategic policy objectives, such as the EU's Lisbon Strategy, which aims to make the Union the most dynamic, competitive, sustainable knowledge-based economy, enjoying full employment and strengthened social and economic cohesion.

3.3.3 Civil Society

Implications of Poor Mental Health

Many of the social and economic trends that affect the EU are altering traditional patterns of social connections and civic roles and responsibilities. Changes in the demographic profile, in family life, in mobility and in migration, in the availability and type of work, in patterns of consumption all affect how citizens relate to one another.

Low levels of mental health and wellbeing are linked with weak social cohesion and lack of engagement and participation in civil society. This can be seen in tensions between communities, crime levels, social isolation, and disaffection.

It is now also evident that many of the social problems that are common across the EU such as crime and violence, drug misuse, educational under-achievement and consequently poor employment outcomes are associated with emotional and behavioural problems in childhood (Friedli and Parsonage, 2007). Over a lifetime, the costs to society of such childhood problems are enormous, in terms of costs incurred by welfare and justice services and the costs of lost productivity (Scott et al, 2001).

Gains from Improved Mental Health

Higher levels of mental health and wellbeing are known to be associated with increased participation and civic engagement and measures of social capital such as volunteering.

In addition, investment in early years and childhood to address emotional and behavioural problems can produce significant long-term individual, social, and economic benefits.

3.4 RESEARCH AND INFORMATION

Good information and relevant research are prerequisites for sound decisions and evidence based policy-making. There is a need to develop mental health research in order that it can respond more effectively to the information requirements of policy and implementation and provide a useful resource for decision makers.

Many plausible policy interventions may be expected to affect mental health directly or indirectly. Further research into the links between population mental health and public social and economic policies is needed, as are policy analyses and mental health impact assessments of public policies (WHO 2004a).

Evidence from research and from policy and practice experience is accumulating to guide the planning and implementation of interventions to promote mental health and prevent mental disorders (Jane Llopis and Anderson, 2005), although further evaluative research is required, in particular large scale trials and evaluations of multisectoral complex interventions. There are promising examples of programmes being transferred to different cultural contexts, with appropriate adjustments to fit particular host communities or service system whilst adhering to the core principles of effectiveness. Examples include the JOBS programme described later and a range of parenting and family interventions.

Primary economic data on the relative costs and benefits of mental health promotion interventions, as in many other areas of promotion, are sparse but growing. The Mental Health Economics European Network (MHEEN) projects[14] and research group have contributed many useful studies in this field.

The evidence-base on prevention activities is rapidly developing. There is sufficient evidence to support prevention actions at different levels and for different target groups. A need remains for further European cost effectiveness studies on prevention measures (WHO 2004b; Zechmeister et al, 2008).

Information systems

Mental health has been poorly covered by existing health monitoring systems. Many international and national health information systems collect primarily disease- or condition-specific data. A full picture of the mental health of the population would require data on the social, cultural, demographic, and economic determinants of mental health, as well as data on promotion and preventive infrastructures and activities. These data are hardly ever available at national or international level. Furthermore, data on resources available for mental health inside and outside of the health sector are usually not available.

The development of robust information systems is urgently needed to enable comparisons within and between countries, through monitoring and evaluation and to guide the development of services and of promotion and prevention activities. Utilising common indicators remains a major challenge to measure mental health status (not only mental disorders) and to gather information on the determinants of mental health and on outcomes.

Insufficient and poorly co-ordinated mental health information limits the effective evidence-based development, delivery and monitoring of mental health strategies and interventions. The lack of data compromises needs-assessed distribution of resources and generates gaps in services.

3.5   MENTAL HEALTH AS A PRIORITY FOR ACTION

Although the mental health status of the EU population can be demonstrated to have substantial consequences socially and economically, mental health has been accorded relatively low priority. Mental health is influenced by a wide range of factors including genetic, biology, individual experiences, family situation, social circumstances, and economic and environmental conditions. Different risk and protective factors for mental health come into play at different stages in the life cycle (See Table 1 in Appendix).

Historically, however, within the field of public health, mental health has tended to be regarded as a specialist topic area rather than as a necessary underpinning for wider public health policies and interventions. In health care, responsibility for mental health has generally been assigned to specialists and the generic health care workforce tends to lack understanding of the role they could play in promotion and in prevention. Other sectors such as education and the workplace are becoming more aware of the relevance of mental health, with promising developments emerging. However, there is still a considerable need to broaden understanding of mental health and build commitment that leads to effective action.

14. www.mheen.org

4. Taking Action to Improve Mental Health

4.1 WHAT WORKS: KEY PRINCIPLES

Actions to promote the mental wellbeing of the EU population need to extend across policy arenas, service sectors and settings (e.g. workplace, home, health care, and community environments), strengthening the factors that enhance mental health and reducing the impact of factors that are detrimental to mental health. There are three dimensions to this:

Strengthening individuals and families by increasing emotional resilience through interventions designed to promote self-esteem, life skills and coping skills e.g. communicating, negotiating, relationship and parenting skills.

Developing and maintaining strong, safe communities by increasing social support, social inclusion and participation, improving community safety, neighbourhood environments, promoting childcare and self help networks, developing health and social services which support mental health, improving mental health within schools and workplaces e.g. through anti bullying strategies and mental health or stress strategies.

Reducing structural barriers to mental health through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable (Mentality, 2003; WHO 2004a).

4.2 AREAS FOR ACTION

The European Pact will focus on four priority themes:
• prevention of depression and suicide
• mental health in youth and education
• mental health in the workplace
• and the mental health of older people.
It will consider social exclusion and stigma in each of these arenas.

Each theme anticipates actions on the following levels:
• promotion of mental wellbeing; prevention of mental disorders
• support for those with mental health problems
• and improvement in the knowledge base and data availability.

This section presents some examples of steps that can be taken by key sectors at each of these levels for the four priority themes, drawing from current practice and research evidence.

4.3 PROMOTING MENTAL WELLBEING ACROSS POLICIES AND SECTORS

In view of the role played by a wide range of sectors, not only health, in promoting mental wellbeing, a key challenge is to convey the importance of mental wellbeing to policy makers, stakeholders and the general public. This can require:

• Education and awareness raising with the public to counter the lack of understanding and the stigma and discrimination that continue to surround mental health

• Raising the priority attached to mental health as an important component of public health. The effectiveness of many health promotion interventions hinges on addressing the psychosocial aspects of health-related behaviour

• Developing concepts and terminology to talk about mental health that are culturally appropriate and sensitive and meaningful to different sectors

• Advocating with policy makers and decision makers to explain the relevance and importance of mental health to health, social and economic policies

• Mainstreaming mental health in policy areas such as health, education, housing, the economy, justice and the environment

• Promoting understanding among public institutions and service provider organisations of their role in contributing both to the mental wellbeing of the population and to the social inclusion and human rights of people with mental health problems.

EXAMPLES: Raising Awareness and Tackling Stigma

The NHS Health Scotland WHO Collaborating Centre on Mental Health-related Stigma and Discrimination has produced an International Briefing Paper and Practical Toolkit providing information, tools and examples of work in a range of countries to address stigma and discrimination (Myers et al 2008) Both resources are available at http://www.euro.who.int/mentalhealth/20080428_1

The see me campaign in Scotland (www.seemescotland.org), EUFAMI's "zero-stigma" campaign (http://eufami.org/index.pl/en/list/316) and the activities in many countries under the auspices of the "Open the Doors" campaign of the World Psychiatric Association are examples of activities to combat stigma and discrimination against people with mental health problems.

The evaluation of the 'Open the Doors' programme in Germany (Gaebel et al, 2004) found that education of the public about mental illnesses and opportunity for direct personal contact with people with mental illnesses were important in promoting acceptance by the general public (Gaebel et al, 2002).

The Greek national anti-stigma programme (www.epipsi.gr) researches population attitudes, runs educational events for mental health professionals, service users and their families, and informs and cooperates with the media. The programme coordinates a network of volunteer "stigma busters" and advocates and promotes the rights of people with mental disorders. Attitudes in the Greek population have been regularly monitored (Economou et al, 2005).

EXAMPLES: Mental Health in Mainstream Policies

The National Programme for Improving Mental Health and Wellbeing in Scotland
This is an integrated approach that encompasses policy, strategy, programmes, research and evaluation, capacity building and indicator development. The Programme, which has undergone independent review, works across policy fields and sectors to:
• Promote and improve the mental health and well being of the whole population
• Prevent mental health problems, mental illness and suicide
• Support improvement in the quality of life, social inclusion, and health of those with mental illness and to tackle stigma and discrimination.
www.wellscotland.info

Mental Health Impact Assessment:
The Northwest Development Centre in the UK has developed a tool kit to assess the mental health impact of a policy, service or programme. The toolkit is designed to be used with stakeholders to assist with indicator development and ensure mental health is integrated into health impact assessment processes (Coggins et al, 2007). www.northwest.csip.org.uk/mwia

Adolescents en Souffrance Report - France
In France the office of the Ombudswoman for Children (Defenseur des Enfants) has conducted a national inquiry into young people's mental heath to examine the nature of and reasons for mental health issues experienced by young people. A review of existing policies on education, health and suicide prevention, consultation with experts and stakeholders including young people and an investigation of good practice led to a series of recommendations for action. A key priority is now to improve access to information advice and support on mental health related issues.
www.defenseurdesenfants.fr/defens/index7.htm

EXAMPLES: Mental Health Promotion in Education

The Schools for Health in Europe Network has 43 participating countries. SHE focuses on the role of schools in contributing to health development and on the importance of health for education outcomes. SHE is founded on research evidence that supports: a whole school approach; linking classroom education with wider initiatives in the life of a school; and the relationship between good health, educational achievement and school completion. SHE acts as the European platform for school health promotion by providing information, encouraging research, sharing good practices, expertise and skills and advocatinge for school health. www.schoolsforhealth.eu

The Good and Healthy Schools initiative in Germany aims to support schools in the fulfillment of their educational aims and objectives. The emphasis is on education promotion through or with health rather than on health promotion alone. The approach developed integrates the promotion of mental health with core indicators of quality within schools including : learning and teaching, leadership and management, climate and culture. www.anschub.de

EXAMPLES: Promoting Mental Wellbeing in the Workplace

CSR Europe Laboratory on Wellbeing in the Workplace
Early 2007, CSR Europe, a European network of multinational businesses, created a 'laboratory' group to promote a business-to-business exchange on wellbeing. Led by Johnson and Johnson with, the laboratory is holding a series of four meetings to share best practices in participating companies, and collaborate to produce a toolkit that managers in these companies can use with employees.
http://www.csreurope.org/whatwedo/alliance/CompaniesandEUAlliance/Laboratories/wellbeingintheworkplace

European Network for Workplace Health Promotion
The network has worked extensively on addressing psychosocial risk factors at work, and promoting mental health in the workplace. The network has coordinated or been involved in several EU projects with direct relevance to this field, including the MOVE Europe Network, led by the University of Perugia.
http://www.enwhp.org/index.php?id=4
www.defenseurdesenfants.fr/defens/index7.htm

4.4 PREVENTION OF MENTAL DISORDERS

Prevention of mental disorders requires the active engagement of key sectors including health care, education, workplace, and community to take targeted action appropriate to different age groups. Examples of work that can be built on are given below.

4.4.1 Preventing Depression and Suicide

EXAMPLES: Whole Population Programmes Preventing Suicide and Depression

Ireland's Suicide Prevention Programme had the support of the Irish President setting out actions at four levels: a general population approach, targeted approach towards those at risk, responses to suicide, and information and research activities.
www.president.ie/download.php?do=9
http://www.dohc.ie/publications/pdf/reach_out.pdf?direct=1

The Finnish Suicide Prevention Programme grew out of an intensive programme of research to investigate the circumstances surrounding all suicides during a one year period. This information was used to inform the development of preventive interventions targeted at those at risk, combined with awareness-raising with the public and with professionals.

Netherlands programme to prevent depression
The prevention of depression is one of five priority areas in the Dutch national public health policy for 2007- 2010, along with tackling overweight, smoking, alcohol abuse and diabetes. To implement the national public health policy objective of preventing depression, a programme has been initiated by the Trimbos Institute and the Dutch Mental Healthcare Association GGZ
http://www.trimbos.nl/default37.html

4.4.2 Prevention in Youth and Education

Children and Families

Examples of interventions that promote the mental wellbeing of children and families and prevent the development of mental health problems include:

• Psycho social interventions to support families
• Parenting support:

o Group programmes for families at risk (e.g. perinatal maternal mental ill health, poverty and deprivation, child behaviour problems)

o Programmes to prevent the development of conduct disorder and reduce antisocial behaviour in childhood

o Peer support using lay workers / community volunteers

o Early detection of and support for parents at risk of mental ill health

o Screening and brief educational interventions to reduce substance misuse in pregnancy

o Home visiting for first-time parents to facilitate parental care giving and coping with stress and to assist in accessing resources and support systems

o Health screening programmes for school age children that include emotional development and mental health

o Pre-school initiatives that enhance parental competence and resilience

o Initiatives that aim to increase the employability skills of out-of-work parents, provide affordable quality child care for parents who wish to work and ensure appropriate financial incentives to avoid parents being caught in a 'benefits trap'

o Programmes targeted at children and young people at risk of or implicated in offending behaviour

The Triple P parenting programme is a population based programme that aims to enhance the confidence, knowledge and skills of parents. The multidisciplinary approach involving a range of health and community agencies enhances the programme's flexibility and reach. Results show improved parent confidence and reductions in child problem behaviour (Utting et al, 2007).

Mothers inform Mothers is an early childhood care and development programme from the Netherlands. It operates as part of regular child health services and aims to support young parents, through educational and social support. Experienced mothers visit new mothers over an 18 month period, with coaching and supervision from a trained health professional (Vergeer et al, 2003).

The European Early Promotion Project was an EU funded multidisciplinary programme to promote early psychosocial development, delivered in Cyprus, Greece, Portugal, Serbia and Slovenia. The programme combined training for primary health care professionals with interventions to encourage family problem solving strategies. Subsequent programme development has built on the successes of this work, e.g. effective alliances between parents and health care professionals, whilst taking a more targeted approach (Davis et al, 2005).

The Effective Family project aims to develop working methods that help provide support to families and children and prevent disorders in children when a parent has mental health problems or a severe illness. The methods are intended to be used by social and health care professionals, different co-operating partners and organisations. The project aims to strengthen the preventive approach and build up co-operation between services for adults and services for children. Effective Family is a research, development and implementation project that covers the whole of Finland. http://info.stakes.fi/toimivaperhe/EN/index.htm

Sure Start has been introduced in the UK to improve the emotional development of young children under four years living in disadvantaged communities. The programme provides a range of services including outreach, home visiting, support for learning, family health and child development services (National Evaluation of Sure Start. http://www.ness.bbk.ac.uk)

Education Settings

Effective prevention approaches in education settings have the following features:

• Social and emotional programmes with a universal, 'whole school' approach that seeks to develop the culture, ethos, policies, and practices in schools that promote mental health in all who learn and work there. These include programmes that work on a range of related issues, such as skills and attitude development through the core educational curricula and in extracurricular activities, through policy review, improvements in management and communication, preventing bullying, promoting staff wellbeing, and working with parents and the wider community
• Targeted initiatives for children at risk of mental health problems, such as those at risk of depression or suicide; those with emotional problems or conduct disorders; those who misuse substances; teenage pregnancy; children whose parents have a mental health or substance misuse problem; and children looked after in the public care system
• Programmes that target those who are low achievers in education
• Adult education programmes that promote access to learning opportunities for disadvantaged groups including people with mental health problems

4.4.3 Prevention of Mental Disorders in the Workplace

Features of useful interventions in the workplace include:

• Programmes to reduce the strain of unemployment and support work re-entry following periods of sickness absence
• Job retention initiatives to maintain in employment those who develop mental health problems whilst in work
• Mental health embedded in workplace health at work and health and safety policies and initiatives
• Multi-level workplace improvement programmes that address: role clarity and expectations; workplace relationships; stress management; job design; and organisational culture
• Awareness raising and training for occupational health, human resources staff and managers on mental health in the workplace
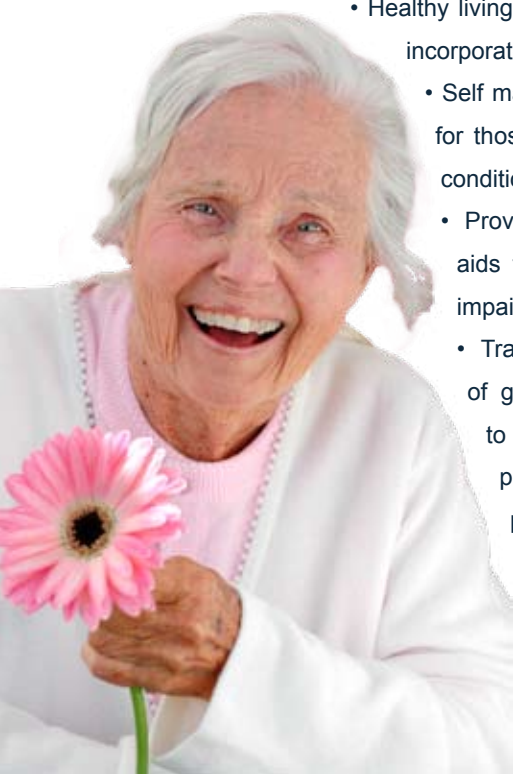
4.4.4 Prevention of Mental Disorders in Older People

Examples of approaches that can be valuable in seeking to prevent mental health problems in later life include:

• Intergenerational programmes that build relationships between age groups to foster trust, respect and social cohesion
• Community safety initiatives including those focused on violence reduction and falls prevention
• Initiatives to encourage activities that promote social capital such as physical activity, volunteering, neighbourhood watch schemes, and participation in the arts
• Social support programmes for those who are vulnerable due to transition / loss / social upheaval for example preparation for retirement and bereavement support
• Social inclusion programmes for minority groups or marginalised groups
• Lifelong learning to promote the development of literacy, numeracy and other skills

In the health sector, the following areas of activity are important:

• Brief interventions for alcohol misuse in primary health care
• Early detection of depression and anxiety
• Early treatment of depression to reduce suicide risk
• Healthy living / lifestyle initiatives that incorporate mental health
• Self management programmes for those with long term health conditions and disabilities
• Provision of communication aids for people with sensory impairment
• Training and development of generic health care staff to detect mental health problems in patients with physical illnesses and to determine how to best to respond

4.5 SUPPORTING THOSE WITH MENTAL HEALTH PROBLEMS

Steps taken to promote the mental health of the whole population and reduce the risk of mental ill health will also be of benefit to those who have experience of long-term mental health problems. There are also direct actions that can be taken by health care and social systems to enhance the situation of people with mental health problems, by improving care, promoting inclusion, tackling stigma and discrimination and protecting their rights as EU citizens. In addition, particular attention is needed to promote access to work and retention of jobs among those who experience long-term mental health problems.

4.5.1 Improving Care

Activities and approaches that are relevant include:

• Screening, detection and treatment of mental health problems in primary care and other health care services
• Ensuring that people with long term mental health problems in hospital and in other settings get access to full assessment, diagnostic and treatment services for physical health conditions and to health promotion resources
• Developing co-ordinated approaches to tackle co-occurring substance misuse and mental health problems
• Integrating the delivery of health and social care interventions to provide person centred care and support with daily living
• For those countries with continuing high levels of institutional care, developing funded strategies to shift the balance of care to community based services, while continuing to provide adequate support to those with mental health needs
• Ensuring safeguards are in place to promote the rights of people with mental health problems, including the right to independent advocacy
• Ensuring that mental health care and treatment services are culturally sensitive and age and gender appropriate
• Promoting peer support and self help / self management programmes for conditions such as bipolar disorder and depression

EXAMPLES: Improving Care

In some countries, special integrated services have been created to care for the complex needs of people with co-occurring mental, physical and social problems. In Finland, **Labour Force Service Centres (LAFOS)** are a successful new one-stop concept for providing employment, social and health services for disadvantaged adults.

Health Promoting Hospitals Network
This European network has a special section for psychiatric hospitals. The network is a good example of European collaborative efforts to promote health.
http://www.hpps.net/enter.html

HELPS Project
An EU public Health Programme Project funded in 2006, HELPS aims to improve the physical health status of residents with mental disorders, mental disability or dependency living in social and health care institutions. HELPS will develop and implement a physical health intervention tool to be used in such institutions as a major step towards protecting human rights and dignity of residents living in social and health care institutions.

4.5.2 Promoting Inclusion

Activities and approaches that can enhance the social inclusion and participation as citizens of people with mental health problems include:

• Targeted social and community programmes to enable people with mental health problems to access opportunities for skills development, training, learning and cultural and recreational opportunities
• Social support e.g. befriending, buddying
• Advocacy services that enable people to have their voices heard and their right protected

EXAMPLES: Promoting Social Inclusion

EMILIA is an FP6 project, which is exploring the use of lifelong learning as a means of achieving improved social inclusion for people with long-term mental illnesses such as schizophrenia. The project aims to improve social inclusion and lifelong learning in learning organisations, such as educational institutions and mental health services
http://www.emiliaproject.net

Cara House in Ireland is a community based members' club which promotes health and well being through social, recreational and educational activities open to the whole community. The club targets those who have experienced mental health problems and those who are socially isolated. http://www.mentalhealth-socialinclusion.org/good-practices/cara-house-members-club.html

The self-help project **Columbus** in the Czech Republic provides advice to patients of mental health institutions. A project in Cyprus aims to identify and report ineffective practices and deficiencies in mental health services to local citizen's rights agencies. These and other practices were identified by the Transnational Exchange Project Good practices for combating social inclusion of people with mental health problems, led by Mental Health Europe. www.mentalhealth-socialinclusion.org

Activities and approaches that promote the inclusion of people with mental health problems in the workplace include:

• Partnerships between mental health services, NGOs and employment services to provide preparation and support for people with mental health problems to find and retain work

• Programmes that place and support people in real work environments
• Educational programmes aimed at employers and workers, to reduce stigma and prejudice by increasing understanding both of the needs of those with mental health problems and their potential to contribute effectively in the workplace

EXAMPLES: Supporting Inclusion in the Workplace

EQUOLISE, an EU-DG Research funded project, showed that personalised support to people with mental disorders can facilitate their return to paid employment, and can be cost-effective. The project confirmed earlier findings from the United States, where employment rates were increased by up to 50%. These results were demonstrated in a randomised controlled trial (Burns et al) published in The Lancet in 2007.
http://www.eqolise.sgul.ac.uk/

The **JOBS programme** was designed as a preventive intervention for unemployed workers. Originating in the United States, it has been adapted and implemented in Finland and more recently in Ireland. Key components of the programme, which is designed for those who are long term unemployed and seeking work, are the enhancement of job search skills and the development of coping capacities. Results show that JOBS aids re-employment, prevents the development of mental health problems associated with prolonged unemployment and inoculates against the negative effects of subsequent job loss (Vuori and Price in Barry and Jenkins, 2007).

The **Vocational Rehabilitation Unit** in Nicosia, Cyprus, places 40 people with mental health problems into employment each year. The unit provides vocational guidance and support in the workplace setting.
http://www.mentalhealth-socialinclusion.org/good-practices/patients-confidence.html

Social firms are proving effective in offering work experience and employment for people with mental health problems in a number of countries across the EU. Social firms offer real work that can be adapted to fit the capabilities and support needs of individuals.
http://www.mentalhealth-socialinclusion.org/good-practices/social-firm-junuv-statek.html
http://www.mentalhealth-socialinclusion.org/good-practices/dobrovita-plus.html

4.5.3 Supporting Informal Carers

Informal carers, many of whom are children, are a vital resource within any mental health system. The support of families and informal carers can play an important part in enhancing the quality of life of people with mental health problems. However, the responsibilities of informal carers can exact a high price on their physical and emotional health and have financial and social costs.

Policy makers and planners are increasingly acknowledging the valuable role played by NGOs representing carers' interests and involving them as key stakeholders in policy development and service planning.

Health and social systems can do much to provide support to carers through psycho educational programmes for informal carers that include information and advice, facilitating coping skills, and social support. It is also important that the health needs of carers are addressed and that respite care is available.

In the workplace, employers are now subject to regulations on flexible working that present opportunities for someone with caring responsibilities to be able to make adjustments to working conditions to accommodate their caring responsibilities.

Children who act as carers deserve particular support, and should have their own needs recognised and met in sensitive but robust ways, so they can enjoy as normal a childhood as possible.

4.5.4 Policies and legislation to support and protect people with mental health problems

Policy and legislation can enable people with mental health problems to be active and valued as citizens by:

• Maintaining safeguards to protect rights of people with mental health problems, including the right to independent advocacy
• Initiating anti-stigma and discrimination campaigns
• Ensuring that policies in education, employment, housing, health promote the mental health of the population where possible and do not inadvertently contribute to discrimination and disadvantage for those with mental health problems
• Ensuring that the social inclusion of people with mental health problems is considered in National Action Plans for Social Inclusion
• Promoting processes such as personal budgets that place the person who is supported, or uses services, at the centre and gives the opportunity to decide the nature of their own support.
http://www.mhe-sme.org/assets/files/publications/reports/Final%20Results%20of%20the%20MHE%20Survey%20on%20Personal%20Budget.pdf

EXAMPLES: Support for Informal Carers

Legal protections: the legal responsibilities and entitlements of informal carers vary across the EU in relation to compulsory measures for detention and treatment and rights of carers to receive information. Legislation can ensure that families have access to services and supports they require in caring for the person with a mental health problem. Legislation can also ensure appropriate involvement of family and carers in aspects of mental health services, in legal processes and in the development of policies, legislation and service plans.
http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf

Psychoeducational programmes: Psychoedutraining was an FP5 funded project that demonstrated the benefits of family psychoeducational interventions in routine clinical settings in different European Countries. The intervention was associated with a statistically significant improvement in patients' symptoms and social functioning as well as in family burden and coping strategies. One of the main outcomes has been the creation, in each participating country, of a network of mental health service teams trained in the application of family psychoeducational interventions to facilitate further national dissemination of the intervention (Magliano et al, 2005).

4.6 IMPROVING THE KNOWLEDGE BASE AND AVAILABILITY OF DATA

4.6.1 Knowledge Base

A commitment to mental health promotion and to prevention of mental disorders at EU level provides opportunity for the European research community to collaborate in strengthening the foundations for evidence-based mental health policy and implementation.

This will require a number of developments:

• Addressing key research tasks including mental health policy analyses, assessing the mental health impact of other policies, evaluation of promotion activities, strengthening the evidence-base for prevention programmes, and stimulating research on mental health economics

• Bridging the knowledge gap between research and practice, by facilitating collaboration and partnerships between research, policy and practice

• Establishing sustainable partnerships for the planning, implementation and evaluation of new or existing interventions

• Undertaking longitudinal observational studies which can inform mental health policy by providing mental health monitoring data and information on determinants of mental health

• Building a stronger case for mental health as a policy priority, using data on relative cost-benefit and cost-effectiveness. Important areas for future economic research include evaluation of the cost effectiveness of mental health promotion strategies in a variety of settings including the workplace and at school. This research should include the broad economic impact of maintaining good mental health through productivity in the labourforce, long term benefits through better educational performance, in addition to assessing the resource implications for health and other sectors such as social care.

EXAMPLES: Strengthening The Interface Between Policy And Research

'Scientific Support to Policies' (SSP) Initiative under the Sixth Framework Programme (FP6) is designed to support research geared to the needs of policy making by bringing research closer to policy making and thereby improving the quality of policy decisions. Details of all funded projects are at http://ec.europa.eu/research/fp6/ssp/themes_en.htm,

Projects relevant to mental health include:
• **ProMenPol** (Tools for mental health promotion) http://www.mentalhealthpromotion.net
• **DataPrev** (Evidence for mental health promotion) http://ec.europa.eu/research/fp6/ssp/dataprev_en.htm
• **DeMOB.inc** (Better standards of mental health care) http://ec.europa.eu/research/fp6/ssp/demob_en.htm
• **Optiwork** (Ensuring disability is not a barrier to work) http://www.optiwork.org
• **PRIMA-EF** (Tackling stress and violence in the workplace) http://www.nottinghameducationalenterprises.com/iwho/research/prima_home.php

4.6.2 Information Systems

The absence of reliable information on the mental health status of the population is one of the factors that allow mental health to remain a lower priority for policy makers and other players. Information systems need to be tailored to provide information on mental health relevant to EC, national and local objectives, matched with data already collected. New mental health indicators for information not yet available require to be developed. Development of indicators to measure positive mental health and determinants of mental health are priorities. Two types of data are needed for monitoring of population mental health: routine statistics and health survey data. Efforts should be made to include mental health indicators in all health surveys.

European databases on good practices and effectiveness of mental health interventions are a valuable resource to inform planning and implementation and could be developed further and effectively disseminated.

EXAMPLES: Developing Mental Health Indicators

The **National Indicators Project** in Scotland has developed a set of population mental health and well being indicators that match routinely collected data. The project has also developed a mental health and well being rating scale that is now incorporated into population health surveys. A further set of indicators for children and young people's mental health is currently under development.
http://www.healthscotland.com/scotlands-health/population/mental-health-indicators.aspx

The EU funded **MINDFUL** project which undertook a comprehensive review (Korkeila et al, 2003) of relevant mental health indicators has identified a minimum data set of European mental health indicators.
http://www.stakes.fi/pdf/mentalhealth/Mindful_verkkoversio.pdf

The **EURO-URHIS** project is developing a European system of urban health indicators, building on ECHI in order that information on urban health can impact on public health policy. The indicator system specifically includes measures relevant to mental health in its proposed indicator set.
http://www.urhis.eu/

The **SCMHE** Project is a new Public Health Programme (03-08) supported project which will develop and test a tool for monitoring the mental health of primary school aged children. The project is led by MGEN, France.
http://www.urhis.eu/

EXAMPLES: European Databases of Good Practice

The WHO Health Evidence Network aims to provide easy access for policy makers to research evidence and information on health care and health promotion. HEN works in conjunction with the European Observatory on Health Systems and Policies
www.euro.who.int/HEN

The Implementing Mental Health Promotion Action (IMPHA) project, supported by the EC Public Health Programme, brought together information on policy, programmes and practice. This multinational project established a European Policy Action Plan for Prevention and Promotion in Mental Health and compiled an electronic registry of evidence-based mental health promotion and prevention interventions. IMPHA national counterparts contributed to the development of country coalitions to support the dissemination and implementation of IMHPA outputs. www.impha.net

Mental Health Europe's project Good Practices for Combating Social Exclusion of People with Mental Health Problems was a transnational exchange project funded under the EC Community Action Programme to Combat Social Exclusion (2002-2006). It involved mental health organisations from ten EU Member States in gathering examples of good practices in a range of sectors including health, social services, employment, training, education and civil and human rights.
http://www.mentalhealth-socialinclusion.org/good-practices/

The Closing the Gap EU Health Inequalities project aims to develop a European knowledge base and infrastructure to implement and strengthen strategies and actions to reduce health inequalities at different levels. This includes mapping and analysing policies and actions to tackle health inequalities and identifying good practices on effective measures and interventions through a Directory of Good Practices. www.health-inequalities.eu

The SUPPORT project has developed a database of EU funded mental health projects from a range of policy areas. The database will be completed in 2008. www.supportproject.eu

PsiTri is a freely available database on published and unpublished controlled clinical trials, reporting on treatments and interventions for a wide range of conditions within the field of mental health. Offering access to the specialised trial registers of the five mental health related Cochrane Review Groups, PsiTri is a comprehensive source of reliable, high quality research. http://psitri.stakes.fi/EN/psitri.htm

European standardisation of data collection is needed to enhance comparability of mental health information. Common approaches need to be developed across stakeholders and international organisations on standards that are sensitive to cultural and economic contexts. Building a European-wide system of comparable data collection and analysis enables international benchmarking. To enable follow-up of the trends and development it is important to collect data on a recurring basis.

EXAMPLES: Establishing Common Data Collection Tools and Data Analysis

Integration of mental health into the **European Health Information System** is progressing. This includes appropriate statistical and surveillance instruments such as modules of the European Health Survey System (EHSS). http://www.echim.org/

The **Mental Health Economics European Network**, funded by the EU Public Health Programme exchanged information and shared evidence on the cost effectiveness of strategies and interventions and added to the body of knowledge on the cost effectiveness of mental health
www.mheen.org

The **Survey on Health, Ageing and Retirement (SHARE)** was first undertaken in 2004 involving 22,000 respondents from 9 European countries. The survey provides useful comparative data on the health, mental health and well being of the population aged over 50. The survey was repeated in 2006 – 07, in the original 9 countries and 3 further countries.
www.share-project.org

The WHO **Health Behaviour of School Children Survey** has been running since 1983/4, most recently in 2005/06. It aims to gather data on 11, 13 and 15 year olds to increase understanding of young people's health and to influence health promotion policy and practice nationally and internationally. There are now 41 participating countries and regions, with 1500 respondents in each. The survey covers many areas that relate to the determinants of mental health www.hbsc.org

Further useful information is available from the EU Labour Force Surveys and the European Quality of Life Survey undertaken by the **European Foundation for the Improvement of Living and Working Conditions**. The Foundation has collated data on a wide range of quality of life related indicators in its EurLIFE database, available at:
http://www.eurofound.europa.eu/areas/qualityoflife/eurlife/index.php

Appendix I: References

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Appendix II: Summary Tables

Table 1: Influences on mental health throughout the life course

	Individual	Psychosocial	Community and services	Socio-economic
Early Years	Perinatal maternal mental health Exposure to addictive substances	Secure attachment with adult carer Experiences of positive parenting Exposure to violence and abuse	Access to pre-school education, in particular for children from lower socio economic groups Parenting support	Socio-economic conditions: poverty, deprivation, insecurity
School Age	Basic literacy skills Educational qualifications/ school performance Development of problem solving skills Physical or mental disability or difference	Availability of confiding adult Support from peers Opportunity to experience success Loss of parent (through death, divorce, or loss of contact) Parental mental health	Marginalization / exclusion Structured opportunities for social and emotional development Access to age appropriate advice, support and counselling	Socio-economic conditions: poverty, deprivation, insecurity Opportunities for participation

	Individual	Psychosocial	Community and services	Socio-economic
Working Age	Physical health / disability	Exposure to violence , abuse or harassment Social isolation / support Workplace organisation and working conditions: demands, control, autonomy, reward / effort balance	Discrimination / respect for diversity Exclusion Social capital (trust, participation, reciprocity) Access to employment and lifelong learning Access to community amenities and resources including open spaces Access to support services and health care Opportunities for arts and creativity	Socio-economic conditions: poverty, deprivation, insecurity Living conditions Insecurity Crime Injustice Migration Opportunities for participation
Older People	Physical health Functional impairment	Social isolation / support Loss and bereavement	Opportunity to play valued social role Access to opportunities for lifelong learning Access to support services, aids and adaptations to facilitate daily living Discrimination	Socio-economic conditions: poverty, deprivation, insecurity

Adapted from: Jane-Llopis and Anderson, 2005; Barry 2006; Myers et al 2005

Table 2: Effective approaches to promotion and prevention in mental health in a range of settings

Setting	Early Years	School Age	Working Age	Older Age
Health care	Early detection of and support for mothers at risk of mental ill health Screening and brief intervention to reduce substance misuse in pregnancy	Health screening programmes that include emotional development and mental health	Brief interventions for alcohol misuse in primary health care Early detection of depression and anxiety Early treatment of depression to reduce suicide risk Psychological, pharmacological and social options at primary care level Healthy living / lifestyle initiatives that incorporate mental health Self management programmes for those with long term health conditions / disabilities	Brief interventions for alcohol misuse in primary health care Early detection of depression and anxiety Psychological, pharmacological and social options at primary care level Provision of communication aids Physical activity programmes Self management programmes
Home	Parenting support: group programmes; peer support; home visiting for first time mothers			

Setting	Early Years	School Age	Working Age	Older Age
Education	Pre-school initiatives Psycho social interventions	Social and emotional learning programmes aimed at all who work and learn in schools Holistic integrated approaches that encompass skills development, relationships, the school culture and the wider community Targeted programmes for children who have or at risk of • depression • emotional problems • conduct disorders • substance misuse • teenage pregnancy • children whose parents have a mental health problem • low educational attainment	Lifelong learning programmes including literacy and numeracy skills	
Community		Community empowerment programmes Intergenerational programmes Violence reduction programmes Youth programmes to promote inclusion of marginalised young people and those from minority groups	Physical activity programmes Community empowerment programmes Social support programmes for those who are vulnerable due to transition / loss / social upheaval Violence reduction programmes Social inclusion programmes for minority / marginalised groups	Social support eg befriending programmes Volunteering programmes Community safety programmes Intergenerational initiatives

Setting	Early Years	School Age	Working Age	Older Age
Workplaces			Programmes to reduce the strain of unemployment and support work re-entry Job retention initiatives Mental health embedded in workplace health promotion / health and safety initiatives Multi level workplace improvement programmes that address: • role clarity and expectations; • workplace relationships; • stress management; • job design; • Organisational culture.	
Societal	Screening of public policies to assess mental health impact Nutrition and healthy eating programmes Housing improvements Access to pre school education and lifelong learning Policies that promote social inclusion and tackle all discrimination Policies to reduce poverty and economic insecurity Measures to reduce access to means of suicide Media controls to tackle stigmatising reporting and portrayal of mental health Promote integration of training in promotion and prevention in mental health into professional education and training curricula			

Sources: adapted from: Jane-Llopis and Anderson, 2005; Barry and Jenkins 2006; WHO, 2004; Friedli and Parsonage 2007