FUTURE MENTAL HEALTH CHALLENGES IN EUROPE
Strengthening co-operation between EU and WHO

Seminar in the European Commission
Luxembourg
11–12 December 2002

Introduction

The first ever joint EU-WHO meeting in the field of mental health was held in Brussels in April 1999. This meeting focused on "Balancing mental health promotion and mental health care". The meeting established a consensus on what balance between mental health care and mental health promotion activities in Europe would be appropriate and what policy should be developed in the years to come in order to meet the needs of both the population, and of the profession answering these needs.

Later in November 1999, following the Finnish EU presidency conference in Tampere on "Promotion of mental health and social inclusion," a Council resolution on the promotion of mental health was adopted. In the resolution the Council invites the Commission to:

- consider, after consultation of the Member States to draw up a proposal for a Council recommendation on the promotion of mental health.

In 2001, during the Belgian EU presidency, a second joint EU-WHO meeting focussed on "Coping with stress and depression-related problems in Europe." As a result of this meeting, the Council adopted conclusions on combating stress and depression-related problems in Europe in which it invites the Commission to:

- consider undertaking activities on the theme of stress and depression-related problems, such as facilitating exchange of information, experience, and good practice concerning recognition, prevention and monitoring of stress and depression-related problems;
- consider developing strategies for the prevention of stress and depression-related problems.

Following on the above conference and the World Health Report 2001, the Executive Board of WHO and the World Health Assembly accepted the Resolution on Strengthening Mental Health. This resolution highlights the urge to

- support for analysis of the mental health situation based on research and assessment of needs, in order to contribute to greater understanding of mental health issues among policy-makers and other partners and facilitate effective development of policies and programmes to strengthen and protect mental health.

Co-operation with international organisations is an explicit requirement under the health competence of the European Union. This is emphasised in the programme of Community action in the field of Public Health (2003–2008). The European Parliament and Council decision clearly states that this co-operation needs to

- ensure cost effectiveness;
- avoid overlapping of activities and programmes; and
- enforce synergy and interaction.

The urgent need to emphasise actions to strengthen activities in the field of mental health has become evident from various sources. This seminar therefore focused on how best to continue the collaboration between the European Commission DG SANCO Directorate on Public Health and the WHO/Europe Mental Health Programme.

Objectives

Building on the previous conclusions, the seminar aimed at discussing and developing the required mental health activities within the WHO/Europe mental health programme and the mental health activities of the programme of Community action in the field of public health (2003–2008), bearing in mind the balance between mental health care and mental health promotion.

Stress, depression, depression-related problems, suicide, and the associated economic burden are well-known phenomena in all European countries. As such, these problems invoke a strong demand to join forces and tackle these difficult questions collectively. Hence, strengthened co-operation between different stakeholders at all levels is needed in order to achieve sustainable results.

The seminar put emphasis on:

- 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, national, local and regional levels and in partnerships
- the economic burden of stress and depression-related problems in Europe.

Participants

The seminar brought together policy-makers with representatives of the academic world.

Organisers

The seminar was jointly organised on the initiative of DG SANCO/G3 of the European Commission and of the WHO/Europe Department of Mental Health. A steering group, responsible for the programme and practical arrangements, consisted of the following people:

Mr. Horst KLOPPENBURG	European Commission SANCO/G3
Dr. Wolfgang RUTZ	WHO/Europe
Dr. Rodney ELGIE	European Patients' Forum
Dr. John HENDERSON	Mental Health Europe-Santé Mentale Europe
Dr. Juha LAVIKAINEN	STAKES, Finland
Ms. Leen MEULENBERGS	Federal Ministry of Health in Belgium

Outcomes

Four working groups were established to outline preliminary conclusions which could be drawn from the themes of the seminar. The results of this work are presented in the following.

THEME 1: PREMATURE MORTALITY AND SUICIDE PREVENTION

Conclusions on premature mortality

- There is a need to raise awareness of the importance of social stress on mental health of individuals and the population and its consequential morbidity and mortality.
- Methods for assessing the impact of political decisions and policies on mental health need to be developed.
- Monitoring systems for assessing morbidity and premature mortality related to stress and mental ill health (in view of e.g. depression, suicide, alcohol, addiction, delinquency, violence and risk taking life-styles) as well as stress-related vascular morbidity and mortality must be put into use.
- Proactive monitoring and support needs to be directed to the accession countries (countries in transition) and focus should be increasingly put on community-based services.

Conclusions on prevention of suicidal behaviour and suicide

- Suicide can be viewed as part and outcome of a cluster of self-destructive and risk-taking behaviour affected as well by biological, social and psychological conditions.
- National suicide prevention programmes should be multidisciplinary and multi-sectorial (including e.g. church, trade unions, service users, families) and inclusive of implementation, evaluation and monitoring activities.
- There is a need to focus on raising awareness and on giving recommendations to the mass media about prevention of suicide (e.g. how to move from sensational to educational reporting).
- Accessibility of methods needs to be diminished, gender-specificity should be appreciated, and focus has to be put on risk populations on different settings in society (schools, workplaces).
- Health personnel, teachers, other professionals and the public at large should be given evidence-based information about the early recognition of warning signals of an impending suicide, so that timely action can be taken.
- Areas that need to be taken into account in suicide prevention include personality development, diagnosis and treatment of mental disorders, crisis services, limiting suicide opportunities, screening and monitoring of risk populations and crisis management.

THEME 2: LIFECYCLE TRANSITIONS AND DEPRESSION

Conclusion 1. Lifecycle periods of transition have a high potential risk for depression and depression-related problems.

- Vulnerability is increased for example during transition from childhood to working life and from working life to retirement.
- Other lifecycle transitions in childhood during educational progress may also be stressful and induce depression and depression-related problems.
- In working life progress and promotion may similarly engender stress, anxiety and depression.
- Specific interventions need to be developed, focussed on different settings and on vulnerable groups in the community.
- Mental health promotion and prevention activities are most effective when integrated within general health policies and plans.
- Older people are especially prone to depression and depression-related problems and managing the age related needs of a large and growing ageing population is one of the key challenges in public health.

Conclusion 2. Societal transitions, as experienced in the European Accession countries and others, present opportunity for mental health promotion and prevention strategies and actions to counteract the potential risk for depression and depression-related problems.

- Mental health promotion and prevention strategies and actions need to be developed and integrated within many community environmental, educational, employment and social settings.
- Attention should be given to gender vulnerabilities and discrete interventions introduced as both promotional as well as preventive actions.
- A Europe wide knowledge base of models of best practice in the field of mental health promotion and prevention should be established.
- In promotional and preventive actions to combat depression and depression-related problems the involvement of all stakeholders is essential in the development of appropriate strategies and actions to be introduced in a community, or in a specific setting such as the workplace.

Conclusion 3. The burden of depression and depression-related problems is a staggering one. While medical treatment costs are substantial the non-medical costs are however much larger. Disability adjusted life years (DALYs) is a measure of the number of years lost to morbidity and mortality and thus is a measure of the largely non-medical costs. Major depression alone represents more than 10% of DALYs and the lifetime prevalence of depression and depression-related problems is generally agreed to be around 10%-15%.

- Primary health care offers open access for patient consultation, diagnosis and treatment. However the skills and aptitudes of general practitioners in the recognition of depressive symptoms and their treatment needs to be improved.
- Depression and depression-related problems are becoming the most prevalent disorders of our time. They seriously affect the quality of life, they are the

significant precursors of suicide and attempted suicide and they are prone to recurrence during the lifetime.

- Improvement of undergraduate and post graduate medical education in the field is required.
- Early detection and diagnosis may justify psychological therapies and counselling and the supportive interventions of biological treatments. However preventive and promotional interventions, culturally and ethnically determined, will provide positive protection against the social factors of depression and depression-related problems.
- Capacity building on a broad scale is necessary for the wider implementation of mental health promotion and prevention as a necessary component of the public health programme in Europe.

THEME 3: COPING WITH STRESS AND DEPRESSION

Conclusion 1: It is necessary to take action already during childhood and in schools

- Research clearly demonstrates the importance of intervening early by way of mental health promotion and preventative interventions.
- By taking action in ante-natal care, early years, childhood and adolescence the impact of stress and depression (and other aspects of mental ill-health) will be reduced for later adult life.
- Achieving effective actions will require an integrated approach between education and health care (as exemplified by the "European Network of Health Promoting Schools").
- Actions in primary schools entail (1) increasing ability of children to live "stress protective" lifestyles and learning how to gain emotional competence (2) working with parents, teachers and children and health and social care workers.
- Actions in secondary schools includes (1) increasing resilience, emotional health, confidence, tolerance (2) working with parents, teachers, children and facilitating peer support programmes.

Conclusion 2: Depression and depression-related problems can be reduced through multi-level collaborative approaches across Member States

- Results from action research programmes (e.g. the "Gotland study" and the "Nuremberg Alliance against depression") demonstrate the benefits of taking a community-based, multi-level, multi-agency approach to reducing depression.
- A multi-site action programme should be established as a first step in at least 1 region/area of each member state. This programme would focus on reducing depression by working at 4 main levels: primary care, public campaigns, key groups (teachers, police, media), high-risk groups/self-help activities In the second step, based on the experiences and developed materials, the programme should be expanded to other regions in the different countries.

Conclusion 3: National plans and practices need to be shared

- Good policies and materials exist - there is a need to share knowledge and experience across Member States.
- The collection of national plans and examples of implementation (local, regional and national) is recommended as is the translation of documents (the focus on preventing suicide, reducing stress, reducing depression).
- A member states group needs to be established to undertake a critical analysis of the material to produce an annual synthesis of the work to be used to inform and influence action.
- The material should be shared through an annual Member States Knowledge Transfer Forum.

THEME 4: FINANCIAL BURDEN OF MENTAL HEALTH PROBLEMS

Conclusion 1: Data on the wider social costs and consequences of depression (and other mental health problems) should be a key element of any needs assessment and service planning exercise

- The impact of depressive disorders not only on resources required for health care services but also more broadly in terms of impact for instance on need for social and family care, absenteeism and loss of productivity in employment, social exclusion, criminal justice and premature mortality are well documented. They are though often overlooked by service planners, yet such costs can more than outweigh those associated with healthcare services alone.
- By identifying these costs and obtaining information on existing service provision both within and outside the health care system, a case may be made for shifting resources towards interventions dealing with some of these broader consequences and risk factors.
- Data collection instruments for mapping mental health services and estimating socio-economic costs are already available.

Action to improve data collection should ensure that in areas of service description and mapping, costs and social burden should include

- A comparative element should be emphasised.
- All age groups, including children and older people, need to be addressed.
- Information is obtained on individuals across the lifespan, in particular at major transition points, e.g. from school to work, from work to retirement etc, as these are points at which they may be at greater risk of mental health problems.
- Specific population subgroups relevant to local contexts such as immigrant and refugee populations need to be identified.
- Costs need to be assessed from a broad perspective, rather than just from the health perspective. They need for instance to take account of the challenges and time inputs of family carers.

Conclusion 2: More information on the cost effectiveness of interventions to promote positive mental health and alleviate the consequences of depression is required.

- Health and other public sector resources are not infinite, and it is important to use resources in the most efficient way to promote health generally while always taking into account other equally important issues such as fairness and equity of access to services across all of society.
- Increasingly health care systems are introducing requirements for cost effectiveness information.
- Economic evaluation techniques are now widely used to provide information on both the effectiveness and the costs of services, comparing these against alternative uses of resources.
- However while much is written about the cost effectiveness of pharmacological treatments for depression in different countries and settings, much less is known about the cost effectiveness of promotion and prevention approaches. Demonstrating that these interventions are both effective and represent value for

money are important elements in justifying a greater investment in promotion and prevention rather than in other areas of health care or in different sectors.

Action to improve both the quality of the evidence base from economic evaluation and it's use should include

- Conduct of more studies in a broader context, particularly at the workplace and in school.
- Non technical, well-presented results have been shown to help build up receptor capacity for economic information. Dissemination is complex and should be tailored for different audience.
- Pooling and sharing of mental health economics information from different countries and settings, as resources for undertaking evaluation across countries are also limited.
- Increasing transparency in the methods used to undertake economic analyses can help improve the usefulness of information in cross country comparisons. The more transparent the data, the more it can be adjusted to take account of local costs and differences in service organisation and practice.

Conclusion 3: Equity considerations for vulnerable populations such as those with depression are of particular importance. Unmet need related to poor mental health generally is high, with as many as two thirds of those who could benefit, not coming into contact with support mechanisms. Socio-economic factors such as the powerful stigma surrounding poor mental health, financing structures in health and social care, poor incentives and co-ordination between different services professionals all contribute to this.

- Improving knowledge and understanding of barriers to access and use of services, increases the opportunity to reduce inequalities in access to services by individuals and facilitate more interaction with service providers.
- It may also be possible to use a range of incentives to change the structure of existing support services, for instance by introducing measure to encourage professionals to work in geographical areas where access to services are limited.

Action to fill the knowledge gap should include

- Assessing the impact of different incentives, e.g. financial, awareness and information campaigns, quality control mechanisms etc and other approaches for service and related professionals, people with mental health problems and their families.
- Improving understanding of how financial incentives and links operate across sectors (such as education, criminal justice system, employment). How might incentive structures be changed to encourage system-wide approaches to mental health, as an integral part of overall health and social capital promotion. Currently investing in interventions within a health portfolio may lead to substantial non-health sector rather than health sector benefits, and vice versa.
- Improving co-operation and exchange of information on initiatives in Europe and elsewhere intended to reduce barriers to service use.

Conclusions

The value and visibility of mental health is rising. This fact has become evident in the activities and programmes of the European Commission as well as in the conclusions and resolutions of intergovernmental organisations such as the Council of the European Union and WHO. Timely examples of the heightened awareness are the programme of Community action in the field of public health (2003–2008) and the mental health programme of WHO/Europe.

This seminar belonged to the series of joint EU-WHO meetings in the field of mental health, initiated in 1999. The themes of the seminar have become central in recent years in the whole European mental health arena.

The seminar covered a wide variety of topics and took into account the whole life-cycle. The scope of the discussions ranged from neuroscience up to international policy-making. Notwithstanding the value of all approaches, there was a strong plea to concentrate on developing practical recommendations, which could be of help in improving the quality of life of European citizens.

The need for compatible data, the importance of disseminating information, and the necessity of maximizing efficient utilization of resources were among the topics which were strongly underlined in this seminar.

The seminar provided a way for the different networks and task forces to commit themselves to an effective exchange of ideas and information. It was noted that today, a great deal of common ground exists between the EC programme of Community action in the field of public health and the mental health programme of WHO/Europe. Eventually, the interplay between the networks and task forces could prove to be highly productive.

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ANNEX 1 Programme

Wednesday, 11 December 2002

10:30–11:00	OPENING OF THE SEMINAR Mr. Horst Kloppenburg Dr. Wolfgang Rutz	
11:00–12:45	SESSION 1: PREMATURE MORTALITY AND SUICIDE	
	Speakers:	Prof. Danuta Wasserman Dr. Anna-Maria Möller-Leimkühler Prof. Tom Bolwig
14.00-15.45	SESSION 2: LIFE CYCLE TRANSITION AND DEPRESSION	
	Speakers:	Dr. John H. Henderson Dr. Karl Kuhn Prof. Ville Lehtinen Mr. Patrick Little
16:15–18:00	SESSION 3: STRESS AND DEPRESSION-RELATED PROBLEMS	
	Speakers:	Prof. Töres Theorell Prof. Ulrich Hegerl Mr. Robert Jezzard Dr. Gregor Henderson

Thursday, 12 December 2002

10:00–12:00	SESSION 4: FINANCIAL BURDEN OF STRESS AND DEPRESSION	
	Speakers:	Prof. Martin Knapp Mr. Vidar Halsteinli Mr. David McDaid
13:00–15:30	WORKING GROUPS AND THEIR REPORTS CLOSING OF THE SEMINAR	