Green Paper Consultation: Interface subgroup First Meeting (January 16-17, January, 2006)

Members of the Subgroup
Kristian Wahlbeck (chair), Jordi Alonso (rapporteur), Dagmar Hedrich, Ulrich Hegerl, Cyril Höschl, Eva Jane-Llopis, Heinz Katsching, Lennart Levi, David McDaid, Howard Meltzer, Jan Paehler, John Tsiantis, and Danata Wasserman.

General consideration

The group was concerned about how to go beyond the Green Paper and informing a larger initiative (be it a Strategy and/or White Paper) within the EU Commission. Major emphasis was given to the 3 key components of the process: Research, Policy-Making and Practice.

What is the state of the MH in EU population?

According to a landmark WHO study **Global Burden of Disease Study**, mental disorders are the biggest overall cause of early mortality in Europe (16% of DALYs). In addition, a study estimates that their costs are around 3-4% of the GDP.

There was agreement that we have already important amount of information about the state of mental health of the EU, some of which has been summarised in the recent **Report on Mental Health**. But it was also clear for the group that there are important i**nformation needs**:

- Mental health in **children**
- Mental health in the **elderly**
- **Longitudinal** mental health
- **Promotion** and **prevention**
- Health **determinants**
- Geographical, economic and social **differences**
- **Vulnerable** groups.

It was also agreed that there is need to collect data on **positive** as well as ill mental health, and about their **determinants**. This information should be available for the whole population including **people living in institutions** (1.5% of the population). **Emerging issues** such as immigration should be also considered.

The link between research, policy and practice

A major difficulty in the interface between research and policy is the lack of an **effective interrelationship**. In addition, there is no feed back from practice to both components: research and policy. So, there is need to bridge the following **three gaps**: to inform about the whole evidence of interventions, to do so in a way that is useful for

the information needs of policy makers, and to evaluate the programs that are implemented in practices involving both the policy makers and the researchers[1].

Evidence about interventions includes the provision of valid data on their efficacy (do they work in the ideal situation), effectiveness (do they work in real settings, in usual practice), and efficiency (what are the benefits in relation to the costs).

Information needs for policy making relate to the policy relevance of programs, their costs and benefits and consequences, their acceptability, the populations effects on the short and longer run, and recommendations on what/how to implement. Evidence rising from research grounds only may not completely fit the needs of policy makers.

The review of **current Mental Health Promotion & Prevention (MHPP) programs** revels that many are not evidence-based and most are not evaluated. Evaluations performed are not adequate.

Recommendations include the following aspects:
- Develop the minimum standards for what information fulfils requirements of 'evidence'
- Make explicit the basis of prioritization (to all stakeholders, also researchers)
- Develop guidelines for evaluation of current MHPP programs
- Develop supportive mechanisms.

Difficulties in engaging actors in Promotion and Prevention in Mental Health

It was agreed that there are **objective difficulties** to engage actors in PPMH. First, Promotion and Prevention are difficult political tasks because **other health-related issues** may be considered a priority. Also there is lack of **financing** structures and existing wrong incentive mechanisms for P&P plus a complex **legal** situations and responsibilities, especially in federally organized countries. In addition, politicians tend to prioritize more the curative and rehabilitation services, the threatening health problems and those problems that attract the attention of media.

[1] In this context group member Professor Cyril Höschl made the following additional comments: The output of the research on mental health determinants is only scarcely fully implemented in practice and policy-making. One of reasons is that researchers report their work in a language they use in the research (reflecting an effort for maximal accuracy at the expense of clarity, focusing on details at the expense of a whole) instead of translating research results in more useful language stressing the possibility of exploitation. From this, a general feeling emerges that there is no need to invest in a research of mental health determinants and indicators, because of the lack of practical (clinical) impact. Only usefulness of a survey on prevalence of mental disorders is admitted, because it can help to plan the network of services. Positive health indicators including mental health are largely considered useless, what influences research policy, projects and programmes preparation etc. Public education on practical use and importance of the knowledge of MH determinants could help in this respect, e.g. notion that indicators of care consumption reflect the offer of services, prevalence of mental disorders reflects to some extend presence of risk factors, while positive indicators of MH inform us about favourable factors in social life and society structure. Significant examples should be introduced, e.g., the finding that high proportion of persons who committed suicide met his/her GP briefly before led to efficient preventive measures in some countries. GP's learn for example that the uncertain complaints of patients may reflect their helplessness etc.

Second, there is **mistrust of actors:** policy-makers and researchers. Politicians have large portfolios, so some **short-cuts** should be looked for to facilitate communication. Researchers and politicians live **different realities and needs**.

The group stressed that we have much more a **deficit in implementation knowledge** than in evidence:
- How to use the money more effectively?
- Which programme to prioritize?
- How to implement and disseminate Multisectoral programmes?
- Cooking book to implement interventions.
- Generalisation of successful programmes may proof difficult since many components of the programme may not be explicit.

What researches expect from the EU Commission

Background considerations about Mental Health **determinants**: Some factors affecting health are fixed and others are modifiable. But the factors come in clusters and they cannot be addressed individually (i.e., one by one). Also, there is **comorbidity** between different mental disorders and between mental and physical disorders. They both share a numbers of risk factors. So, there is need to implement **common interventions** (e.g., problem solving skills may enhance capacity to reduce a number of health problems).

Expectations regarding the 7th Framework Programme:
1. A true **focus on indicated goals** (realising the Lisbon agenda)
2. Consider mental health **proportionally to its attributable burden**
3. Consider **intersectoral approaches** to research
4. Support research on **social determinants** of health
5. **Narrowing the 3 gaps**: knowledge/policy; policy/implementation, and implementation/evaluation
6. **Disseminate** (harmonize) relevant knowledge to all relevant actors.

PPMH research and the objectives of he EU Commission

The important of precedent work to the Green Paper was clearly recognised. This includes, at the very least, the following milestones:
- Public Health Amsterdam Treaty (1991)
- Anti-discriminations 2003 (Nice)
- Protection of workforce (2003, Nice)
- Social exclusion (2003, Nice)
- European social funds
- Research Framework.

Priorities for promotion and prevention should include:
1. **Innovation** (investing about mental health and determinants)
2. **Translational research** (cost effectiveness)
3. Implications of **other sectors** (economic reforms)

MH promotion and prevention should **contribute to the Lisbon agenda** by:

- Allowing an investment on the basis **of self-satisfaction and achievement**
- Enabling people to find **social role**
- Contributing to increase **health gains**
- Adding value for the **economy**
- Giving people the opportunity to fulfil their **potential**.