EBC Response to the Green Paper on Mental Health

1. Background

The issue of mental health has been rising up the EU agenda since the topic was embraced under the Finnish Presidency during the second half of 1999. In November, 1999, the Council of Europe held a meeting specifically on mental health where a number of encouraging signs emerged but, regrettably, these have come to nothing over the past six years. There have only been two further Council meetings covering mental health in the past six years. In December, 2004, Commissioner Kyprianou made mental health one of his four key themes for his term of office. This was followed by the Helsinki Meeting in January, 2005, which has led to the present Green Paper.

2. The Green Paper

This is a comprehensive document which is intended to build upon all of the mental health initiatives at an EU level that have gone before, particularly the work on employment and social inclusion, mental health education and suicide prevention. Its principal weakness is that it attempts to be all embracing and is seeking to be all things to all men in mental health matters. As a consequence, it is lacking in focus. There is also an inherent problem occasioned by the notion of subsidiarity in that the Commission cannot interfere in the healthcare policies of Member States. Hence, all actions pertaining to mental health must fall within the ambit of public health. For this reason the Paper revolves around stress in the workplace, depression, alcohol abuse and suicide. Whilst reference is made to severe mental illness, the Paper does not touch upon schizophrenia or bipolar disorder, the two most severe mental illnesses or, indeed, mention these two conditions by name. Yet bipolar patients account for the greatest number of suicides and attempted suicides in the EU than any other psychiatric condition. Furthermore, the emphasis in the Green Paper on prevention ignores the fact that such strategies will have little effect on the prevalence of the most debilitating mental illnesses and that treatment availability must be part of any practical proposal for mental health.

The Paper outlines the various problems associated with mental illness and also touches on the issue of co-morbidity with many neurological and physical conditions. It stresses the maxim adopted several years ago that there can be no health without mental health. However, some of the suggested solutions may be viewed as naive. For example, there is mention of Article 13 of the EC Treaty prohibiting the discrimination of people on the grounds of disability and the fact that a mental illness is now viewed as a disability. There is no clear indication as to how that applies to the mentally ill who are discriminated against in terms of job opportunities, housing and insurance to name but a few areas.

The economic and social burden of mental illness is well documented. That European countries account for nine out of the top ten in the World with the highest suicide rates only serves to underline the fact that much needs to be done in the area of mental health and needs to be done urgently. The Paper produces three conclusions:

Firstly, that we need to create a dialogue with all Member States on mental health. One deliverable expected is an EU-Action Plan on mental health for health and non-health policies at a country and Community level, including a monitoring mechanism for its implementation. There is no mention as to what this action plan might look like or how it could be implemented.
Another deliverable is a statement on the potential added value of Council Recommendations on the promotion of mental health and on the prevention of depression, suicide and suicide attempts.

It is extremely difficult, if not impossible, to implement a suicide prevention programme. What one can do is to create an environment which significantly reduces the likelihood of the patient attempting or committing suicide. Another problem with an EU-Action Plan is the different priorities given by Member States to mental health and the amount countries invest in this area of health. Romania, as an accession country with a population of 23 million, has a mental health budget equivalent to that of the county of Wiltshire in the UK with a population of around 728,000. This prohibits the possibility of comparing like with like.

The second conclusion is to launch an EU Platform on mental health with the object of developing guidelines for training and care in institutional and residential settings for mentally ill people. Again, the problem is lack of uniformity in terms of the priority of mental health among the Member States leading to significant variations in the quality of psychiatric hospitals and the availability of modern drugs.

The final conclusion is the development of an interface between policy and research on mental health. This is rather self evident and the intention is to create a mental health information and knowledge system with links between databases and action proposals for their development at a Community level.

3. The EBC's response

1. The EBC is concerned about whether the proposals will lead to major improvements in mental health care for the following reasons: -

a) healthcare policy is a member state issue and in general mental health has not been accorded the priority it needs by any member state
b) mental healthcare provision varies enormously between member states
c) possibly as a consequence of the limitations in what can be achieved at European level, the Green Paper ignores the broader and equally important issues of diagnosis and treatment of mental illness
d) budgetary constraints may limit the ability of the Commission to implement its proposals even in their current limited form

2. However, the EBC welcomes any proposal that aims to improve mental health in Europe and that will raise awareness in the member states of the inadequacy of current funding and strategy in this field, compared with its cost to European society. Therefore, the EBC wishes to emphasise how important it is that this initiative be accorded high priority in order to maximise its impact on policy.

3. A comprehensive strategy is needed that covers promotion, prevention and recovery, which therefore must also encompass diagnosis and treatment. Prevention strategies have little impact on some of the most serious mental health conditions.

4. Healthcare providers, systems and organisations must agree on the importance of focussing on relevant individualised patient goals and outcomes, and building treatment and care plans around these that are supported by all players. To achieve this will require greater collaboration and involvement from all stakeholders than has been the case previously e.g. through the creation of networks of care.

5. To implement a European strategy based on patient outcomes will require new ways of gathering and sharing information. There will need to be agreement within and between member states on the kind of metrics to be used to measure patient outcomes, for example, suicide rates or return to work rates. Such measures can be used to identify and compare differences in regional provision. From this base, these data can then be used to establish guidelines for prevention, treatment and care and to measure the effectiveness of the Commission's

programme in the future. Information sharing should be promoted for example, through web-linked physician communities and online workshops.

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