



IMPROVING THE MENTAL HEALTH OF THE POPULATION

Policy briefs



IMPROVING MENTAL HEALTH IN THE POPULATION

POLICY BRIEFS

Mental Health in Youth and Education

Mental Health in Older People

Mental Health in Workplace Settings

Prevention of Depression and Suicide



Technical Consortium:



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More information and the electronic version of the paper are available at:

<http://www.ec-mental-health-process.net>

A great deal of additional information on the European Union is available on the Internet. It can be accessed through the Europa server (<http://europa.eu.int>).

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PREVENTION OF DEPRESSION AND SUICIDE

Policy brief

Depression is a common mental disorder in Europe, causing unnecessary human suffering and enormous costs for society. Depression is the leading cause of suicide. At least 59 000 deaths in EU27 in 2006 were due to suicide. Promotion of good mental health, preventive measures, early recognition and adequate treatment of people with mental disorders are the key measures in avoiding depression and suicide. Multisectoral comprehensive suicide prevention programmes achieve best results.

Policy context

Depression was the subject of Council conclusions in 2001. The Commission's Green Paper "Improving the mental health of the population" (2005) highlighted prevention of depression and suicide as priorities for action. The Commission's White Paper "Together for Health. A Strategic Approach for the EU 2008-2013" announced the development and delivery of actions on mental health involving the Commission and Member States.

One of the aims of the Commission's White Paper is to reduce inequities in health. Inequities are significant in the field of suicide. Some Member States have low rates of suicide, while others have rates that are among the highest in the world. Even within countries, rates of suicides vary between socioeconomic groups and regions.

The White Paper aims to develop actions on environmental and socioeconomic factors affecting physical and mental health. The broad approach needed for prevention and action on depression and suicide is entirely consistent with this aim.

The renewed EU Sustainable Development Strategy (2006) identified improving mental health and tackling suicide risks as one of the operational objectives of the strategy in the field of public health. Addressing mental health and suicide has therefore become a focus of EU policy making.

Although Member States themselves are in charge of the organisation and delivery of health services and medical care, there are specific competencies and powers of the EU institutions that can influence the major determinants of depression and suicide.

Depression is a common, treatable disorder with high costs for individuals and society

Depression is a common mental disorder characterised by lowered mood, loss of interest and enjoyment and reduced energy. 17 % of women and 9 % of men in EU suffer from major depression at some point in life. Impact on quality of life of major depression is estimated to be equivalent to that of a severe physical illness, e.g. severe stroke. Because of early onset, depression makes a major contribution to the burden of disease in developed countries.

Depression causes an increasing number of sickness spells and early retirements in EU. People with major depression in Europe report more than seven times more work days lost than people without any mental disorder. People with major depression lose more work days than e.g. people with heart disease or diabetes.

In 2004, economical costs of depression were estimated to be € 253 per inhabitant, or total € 118 billion in EU25 and EFTA. Healthcare costs account for only about 35 % of the total costs of depression. Data from Sweden indicate that the costs for depression may have doubled from 1997 to 2005, mainly due to increase in indirect costs due to loss of productivity.

Yet depression can be prevented and successfully treated: Psychological interventions may reduce the risk of a depression by a third. Few Member States have implemented prevention programmes.

Also under-treatment is common. Only a third of Europeans with mood disorders have had a contact with health services in the previous year. Only about half of them have received adequate treatment. Reasons for under-treatment include stigmatisation of mental disorders, difficulties in accessing health services and under-recognition of depression by professionals.

Suicide is a major cause of premature death in Europe

Suicide is a major cause of premature deaths in Europe, causing death of 12 of 1000 EU citizens. In 2006, about 59.000 persons, 45.000 men and 14.000 women, in the 27 EU Member States (EU27) completed a suicide. In comparison traffic accidents caused 50.000 deaths. Globally, many Member States are among the leading suicide countries. Seven Member States are among the global top 15 male suicide mortality countries, and five Member States are among the top 15 female suicide mortality countries. In EU, proportion of deaths due to suicide to all deaths has not decreased.

90% of suicides are associated with mental disorders. Suicides are most often linked to major depression (60 % of suicides) or with substance use disorders. Other groups at risk for suicide are persons with severe somatic illness, the socially disadvantaged, those with a recent loss, those who perform non-fatal self-harm, some migrant groups and some professional groups.

Choice of a suicide mean varies according to the country, inside one country, according to age and gender and over time. Hanging, self-poisoning, firearms, drowning, jumping from a high location or in front of traffic seem to be the most used means in the EU.

Determinants of depression and suicide are amendable

Negative life events in childhood and adolescence can lead to severe long-lasting mental and social problems in adulthood: Poor parenting increases the risk for depression in adulthood two- to threefold. Childhood sexual and physical abuse is linked to adult depression. It seems that high risk for depression in some cases is an expression of genetic vulnerability in combination with early adverse life events.

Suicides are strongly linked to health inequity. Suicide rates in deprived areas are up to six times higher compared with affluent areas. Unemployed people, people with low education and people with low socio-economic status commit more suicides. Yet depression and suicide may hit persons regardless of the socio-economic status.

Substance abuse is mutually linked with depression and suicide. The link between alcohol use and suicide is more pronounced in countries where strong spirits and heavy episodic drinking dominate the consumption, where almost half of the suicides are associated with alcohol dependence or abuse.

Policy actions reduce depression and suicide

Several countries have developed national strategies in a comprehensive policy approach to prevent depression and suicide. Most policies acknowledge that the multiple causes of depression and suicide are mostly not amendable by the healthcare sector alone. A comprehensive approach develops actions across sectors at all levels (individual, family, community, region, nation and the EU). Common approaches include promotion of good mental health, eliminating stigma of mental disorders, prevention and early detection of depression and suicidal behaviour, and support for recovery.

National suicide prevention programmes share many common characteristics: improved recognition and treatment of depression, restriction of suicide means, restrictive media coverage of suicides, drug and alcohol measures, improved access to mental healthcare, and healthcare staff capacity building. Some countries have adopted a comprehensive population approach across sectors, while others have adopted more restricted programmes targeting mainly high risk groups. National suicide prevention programmes are associated with documented reductions of suicide rates.

Promotion of a healthy lifestyle and avoidance of harmful drinking are cornerstones in promotion of good mental health and prevention of suicides. Limiting availability of alcohol, for example by rising alcohol taxes, adhering to purchase age limits, limiting opening hours for sale and banning usage in public places, is effective measure in reducing alcohol related harm. Brief alcohol-related advice ("mini-intervention") in healthcare settings is also effective in promotion of good mental health and prevention of suicides.

Fighting inequity is fighting suicide. Targeting socio-economical disadvantage and inequality by measures in education, employment and social policies, can support prevention of depression and suicide. This is particularly important, as socioeconomic deprivation often has long-reaching consequences over generations.

Restricting access to means of suicide is successful in reducing suicides and has been used by several Member States. Restriction of suicide means by e.g. environmental planning or control of firearms, chemicals and drugs, does not seem to lead to a switch to other means.

Stigma and discrimination are hurdles for adequate measures to prevent and treat mental disorders. Public information campaigns aim at de-stigmatising depression and promoting early help-seeking by increasing knowledge and awareness of common signs and symptoms of depression and suicidality.

Responsible media coverage of suicides reduces mortality. Glamourising or sensationalising suicide has provoked copycat suicides. Successful media guidelines on reporting of suicides have been developed by international organisations and individual countries.

Health services are key actors

Health services are an efficient delivery channel for mental health promotion and disorder prevention. Community-based, multi-faceted mental health services are more beneficial than hospital-based traditional services. One in three depressions may be avoidable by preventive psychological interventions. Still, preventive public health programmes to reduce incidence of depression are only in the beginning. Information technology solutions

Training of health care staff and other gatekeepers, such as clergy, teachers, military personnel, or caregivers, i.e. persons who have the possibility to meet persons at risk of suicide, improves treatment of depression and recognition of suicidal ideation, and has been shown to successfully reduce number of suicides.

Suicide attempt survivors as well as people bereaved by suicide are at high risk of suicide. Effective aftercare and easily-accessible health services prevent further suicide attempts. Bereavement after a suicide is often prolonged and associated with guilt, shame, anger and search for motives for the suicide. Support given to those bereaved by suicide is likely to be beneficial.

Multi-level approach, i.e. targeting the public, gatekeepers and health care, is most successful in suicide prevention and has been shown to prevent even one of three suicides.

The Web constitutes a cost-effective, 24/7 accessible means for combating depression as a first step by offering self-help interventions and referral to treatment. Virtual social networks offer a new channel for suicide prevention. Some Member States use web-based information technology for prevention, recognition and treatment of depression.

**Prevention of depression and suicide throughout the
lifespan**

Early childhood development programmes have proved to be the most cost-effective measures. A nurturing early relationship between caregivers and the child promotes life-long good mental health and well-being. Corporal punishment, harsh parenting and child abuse, both physical and mental, is associated with adverse psychological outcome. The mental health and wellbeing of children in disadvantaged families and families with mental disorders can be promoted by selective interventions. The whole school approach creates a supportive environment and reduces risk for mental disorders.

Work place interventions can promote mental health and reduce the risk of depression. A favourable psychosocial working environment, “healthy working climate” should be the target of every working place. Easy access to occupational health services promotes early treatment of mental problems. Special emphasis should be put on improving employment and work conditions of people who return to work after a depression or suicide attempt. Mental and financial support and creation of possibilities to re-education/retraining and learning new skills for those unemployed assist to prevent social isolation and hopelessness.

In many Member States suicide rates of older people are higher than in any other age group. Health promotion and preventive interventions targeted to reduce loneliness assist in maintaining good mental health at older age. It is essential to carefully search for and treat depression among older people.

MENTAL HEALTH IN YOUTH AND EDUCATION

Policy Brief

The foundation for good mental health is laid in the early years; investing in children and families benefits society as a whole.

Good mental health in childhood is a prerequisite for optimal psychological development, productive social relationships, effective learning, and economic participation in adulthood.

Promoting positive mental health through shaping early childhood experience, positive parenting, effective educational services, school programmes and youth involvement is effective.

Schools and the community are central in determining youth's mental health; promoting mental health in these settings strengthens the core objectives of the education and the youth sectors.

The EU policy context for lifelong wellbeing starting in childhood

Enabling young people to have a successful start into life is a key objective of Member States and EU-policies, and it is a condition for Europe's sustainable success as a social entity, knowledge society and economy. EU policies and initiatives such as the European Youth Pact, the Open Method of Coordination on Social Protection and Social Inclusion, the protection of children's rights, the Framework on Key Competences for Lifelong Learning, and the Commission Communication "Promoting young people's full participation in education, employment and society", improve the consistency of youth-related policies across sectors and the opportunities for young people in society.

Mental Health and well-being are essential to positive growth and development

Mental health is a basic human right, and is fundamental to all human and social progress. It is a prerequisite to a happy and fulfilled life for individual citizens, starting at birth, for functioning families and for societal cohesion.

Mental health and mental health problems are high in the EU

Around 80% of young people in Europe report a high level of mental well being. However:

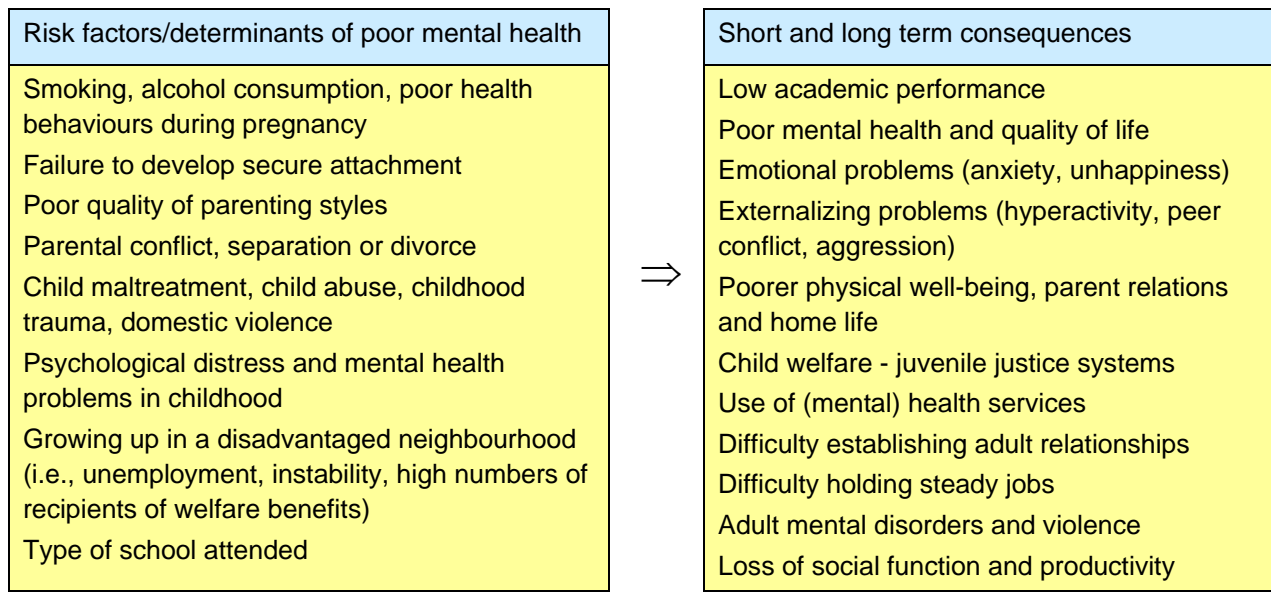
- One fifth of children and adolescents suffer from developmental, emotional or behavioural problems
- One in eight have a mental disorder
- Half of all lifetime mental disorders begin before the age of 14 years
- Suicide is one of the three most common causes of death in youth
- Non-fatal self-harm is 10–40 times more common than actual suicide
- Data is incomplete and not comparable across the EU

Deprivation and inequalities are key determinants of poor mental health

In the EU, one in four children grows up under poverty and deprivation. The circle of deprivation affects mental health and vice versa: low socioeconomic status leads to poorer mental health outcomes, and poor mental health reduces the individual's ability to improve or attain a high level of socioeconomic status.

Early exposure to risk factors leads to mental health problems later in life

In addition to poverty and deprivation, exposure to other risk factors and lack of protective factors leads to mental disorders and health social and economic consequences later in life.



Mental health facilitates learning and education achievement

Many children still leave education without complete secondary education qualifications. The attainment of general skills, educational qualifications, and future productive employment, are facilitated by good mental health.

Mental health problems lead to early school leaving

Mental health problems, stress and bullying impact on school attendance and early school leaving rates, which are above 10% in the majority of EU countries.

Youth unemployment leads to mental health problems

Unemployment in youth is linked to later mental health problems, depression, anxiety and ill health, along with its associated costs. In 2006, 17% of 15-24 year-olds in the labour market were unemployed in EU-25.

Costs to other sectors

The costs of poor mental health are larger for other sectors than for the health care sector, including costs of lost employment, reduced productivity, and increased levels of crime. Costs of conduct disorder at age 10 are estimated to be, 18 years on, 6 times larger for the education sector, and 20 times larger for the social justice system, than for the health care system.

Need for an intersectoral approach

Given the multidirectional connections between health and well-being, youth empowerment, participation, learning and educational outcomes, actions and outcomes should take into account the interplay of forces in multiple sectors.

Approaches are available to achieve better mental health and educational outcomes in children and adolescents while contributing to a productive Europe on the long term.

Health dimension: Promotion from the early years of life

Parenting support is conducive to mental health and can prevent child abuse

Home based interventions that include education on health behaviour, parenting skills and mother baby interaction for pregnant women or early mothers at high risk, increase

psychosocial health of mothers, such as depression anxiety and stress, and have short and long term positive health outcomes for their children, from prevention of child abuse to increased educational attainment and employment later in life.

Bullying and aggression can be prevented

Effective programmes in the management of school bullying that incorporate a holistic approach involving pupils, teachers and families, can reduce risk factors for poor mental health, bullying, violence and exclusion as well as improve social climate of the classrooms.

Depression and anxiety can be reduced

Preventive strategies for depression and anxiety such as cognitive-behavioural models, life skills, problem solving, and stress management techniques can decrease depressive and anxiety symptoms, reduce mental health problems, and can prevent new cases of depression.

Addressing violence and childhood trauma

Administrators, teachers, and staff can help reduce the impact of trauma on children by recognising trauma responses, accommodating and responding to children, and referring them to outside professionals when necessary. National specialised centres can provide adequate support for traumatised youth, and protect their rights in relation to their mental health.

Support to children and adolescents with a mental disorder

Schools and infrastructures in the wider society provide valuable support to young people who are experiencing mental illness, their carers and families. Initiatives to aid recovery and prevent negative knock-on effects from the occurrence of mental disorders in youth include those based on cognitive behavioural models, provision of support, information to patients, relatives and professionals and interdisciplinary work.

Combat stigma and discrimination

Tackling issues of stigma and the resulting discrimination against those with existing mental illness, through measures that address the youth sector, include the dissemination of information on the ubiquity of mental health problems, scrutiny and re-assessment of national legislation and practices, and dialogue and control of the media with regards to representations and labelling of mental illness.

Education: School as a setting for mental health promotion

Children spend a large amount of time in schools. Schools not only establish the competencies for learning and professional skills, they are a setting for establishing interpersonal relationships and transferable skills and are a unique resource to promote the healthy development of children.

Effective mental health promotion in the school setting includes approaches that combine traditional health education with comprehensive, whole-school approaches that create a supportive physical, social and learning environment, and bring together the combined resources of teachers, parents, local communities and organisations over a long period of time.

Pre-school education improves mental health

Pre-school education, and/or high quality child care improves children's cognitive, language and socio-emotional development and leads to long-term psychological, social and economic benefits, such as increases in employment, mental health, literacy and social responsibility.

Mental health promotion in schools leads to educational outcomes

Integrating mental health promotion in the school policy helps the school to improve the quality of teaching and education, improve mental health and reduce the risk for mental disorders. Socio-emotional learning programmes and preventive strategies for those at risk increase pupils' academic achievement, acquisition of transferable cognitive and social skills, increasing academic performance and mental health concurrently. There are effective examples across Member States of mental health integrated into the school policy and curriculum without becoming an additional burden for teachers.

Support for school staff facilitates integrate the well-being concept into curricula

To create an optimal learning environment and healthy school climate, enable development and early identification of emerging problems, schools can be supported by: including mental health education in the curricula of teachers' training, integrating psychologists and counsellors in the school, and, the structure of referring to available psychological systems when needed.

Collaboration between schools and external partners strengthens community cohesion and youth participation

Children and adolescents live and act in different settings: the home, at school, in youth organisations and in the neighbourhood. Building links between schools, parents or families, peers, external service providers (such as health and social services) and the community, will encourage agencies to work together, and enhance the social inclusion of young people.

Youth participation

The more dangerous the neighbourhood and lack of social stability, the more common the symptoms of depression, anxiety, oppositional defiant disorder, conduct disorder and social exclusion. On the other hand, the role of youth organisations and community programmes to promote youth participation are supportive to mental health.

Neighbourhood and community settings for youth participation improve mental health

Lack of a suitable environment and social deprivation limit the possibility of recreation activity (mental, cultural and physical) with detrimental effects to mental health. To approach social and environmental community deprivation effectively, programmes require coordinated services, resident participation, and to focus on a neighbourhood or small area, ensuring access to meaningful participation opportunities. Physical activity and exercise are practiced in community settings and are also beneficial to mental health, reducing depression and anxiety.

Poverty and exclusion can be reduced and in turn improve mental health

Young people living in poverty are at increased risk to all health problems including mental disorders. Prevention or reduction of the negative impact of poverty on mental health has been achieved through benefits systems payable to mothers, which supplement incomes to reduce disparity; and approaches to tackle youth exclusion due to unemployment, by improving employment opportunities for young people through social insertion in the labour market.

Programmes to encourage independent living such as those for youth leaving residential care, which incorporate skills training, personal development and vocational support, are effective in reducing mental health problems, unemployment, dependency on public assistance, and involvement with the criminal justice system.

MENTAL HEALTH IN WORKPLACE SETTINGS

Policy Brief

Employment is generally beneficial to physical and mental health, the main source of income for most people and a defining feature of social status. In some cases however, the working environment can have an adverse impact on mental health. Non-work related poor mental health can also become visible in the workplace.

There is a strong economic case for tackling poor mental health in the workplace: absenteeism, reduced productivity at work and premature retirement because of stress and mental health problems has a significant impact on European productivity and competitiveness.

Interventions to promote well-being, prevent and manage mental health problems in the workplace involve a combination of actions at an organisational level and measures targeted at individuals.

Supported employment programmes, coupled with flexible benefits and enforcement of anti discriminatory legislation can increase the participation of people with mental health problems in the labour market.

POLICY CONTEXT

One priority of the Lisbon Strategy on Growth and Jobs is to 'invest in people and modernise labour markets'. Objectives include improving the skills, employability and adaptability of the workforce, as well as promoting the functioning of labour markets, including the greater participation of population groups that currently face difficulties and may be excluded from the labour market. Promoting and maintaining good mental health and wellbeing in the workplace, as well as helping people with mental health problems return to work, can play an important role in attaining this objective.

RISK FACTORS AND TRENDS

Employment is generally beneficial to physical and mental health, but work can sometimes have an adverse impact on mental health. Non work-related mental health problems may also become visible and exacerbated within the workplace. Emerging psychosocial risk factors behind poor mental health in the workplace include reduced job security and more fixed term employment contracts; work intensification – a higher workload often without additional reward; high emotional demands, including bullying and violence; and a poor work-life balance. Many of these risk factors are widespread across the EU, affecting both men and women.

Impact of work-related stress and poor mental health on absenteeism

Levels of absenteeism, unemployment and long term disability claims due to work-related stress and mental health problems are increasing; in many Member States they have overtaken musculoskeletal problems as the leading cause of sickness absence from work and permanent withdrawal from the labour market. Poor mental health can account for more than 40% of all long term disability claims. Premature retirement on the grounds of poor mental health problems is also increasing.

Participation rates of people with enduring mental health problems in employment

Exclusion from work of people with enduring mental health problems remains a challenge. Where data are available, employment rates are between 20% and 30% of the working age population; in the case severe mental health problems employment rates can be even lower.

Economic impact

Work-related costs due to mental health problems are more than 2.5 times greater than those associated with cardiovascular disease in the EU. The total costs of absenteeism and premature retirement due to mental health disorders in the EU-25 (plus Norway, Iceland and Switzerland) were €136.3 billion in 2007, including €99.3 billion for depression and anxiety related disorders. This estimate is conservative: it does not take into account factors such as the long term loss of skills through reduced career progression and educational opportunities, nor the personal impact of the exclusion from work felt by people with mental health problems.

Costs to business

Many of the consequences of poor mental health fall directly on business. Firstly, there can be substantial costs due to reduced performance at work, sickness absenteeism and early retirement. This may lead to an increased workload and work-related stress in other employees. Employers may incur recruitment costs necessary to obtain replacement workers, and they may also have to invest in additional time consuming training courses for replacement employees.

High levels of absenteeism can also negatively impact on the reputation of a business. It might be perceived, rightly or wrongly, by both the general public and potential future recruits as a signal of the low priority that a company places on having a healthy workforce. Potentially it might lose customers and procurement contracts. The image of a business might also be adversely affected if it is not seen to have a diverse workforce, including people living with enduring mental health problems.

A FRAMEWORK FOR ACTION

A range of measures have been shown to be effective in promoting mental wellbeing, preventing and managing mental health problems and helping reintegrate people back into work. There is growing evidence that the business case for such measures can be strong with costs avoided far outweighing the investment in workplace programmes. Ideally actions should be developed and implemented in partnership between senior and middle management and employees; drawing on employees' on-the-job experience is a vital resource in identifying problems and solutions.

Promotion of mental well-being at work

Environmental measures can help promote well-being. They can include minimising discomfort from excessive noise, poor air quality, uncomfortable working temperature, poor lighting and ergonomic measures. Other measures help people maintain their work-life balance, such as provision of child-care facilities, changing patterns of shift working or ensuring that workers use up their holiday entitlements.

Workplace health promotion programmes focus on both physical and mental wellbeing, e.g. through exercise schemes (e.g. biking to work, exercise classes) or relaxation programmes.

Other programmes aim to provide general health and lifestyle related advice and maybe linked to a general wellness screening programme.

Prevention of work-related stress and mental health problems in the workplace

Organisational interventions

Measures focus on adapting the workplace organisational structure and environment to minimise the risk of undue levels of stress. They include flexible working arrangements; job and or task redesign; dialogue and collaboration between managers and employees and enhanced use of teamwork. Greater participation in decision making by employees can help improve job satisfaction, reduce the likelihood of work-related stress developing and mitigate the impact of non work-related stress. Appropriate levels of reward for efforts within the workplace and the possibility of job/career progression can also be preventive.

Stress awareness and management programmes

Multi component awareness and stress management programmes that combine interventions to help individuals deal with work-related stress and organisational measures to deal with risk factors for undue levels of stress can be effective preventative measures and benefit business productivity. A strong role in these programmes can be played by managerial staff such as line managers and workers' representatives, whose skills and awareness of work-related stress and mental health issues can be improved. This can help develop an environment within the workplace where people feel comfortable talking about mental health issues. Well established, but short, simple and inexpensive education and training programmes for managers and other workers are available. Programmes might also involve the use of specialist trainers or facilitators whose aim is to improve enhance the resilience and coping skills of individuals in dealing with stressful situations, managing their time or deal with harassment in the workplace.

Early detection of undue stress and mental health problems in the workplace

Early detection, coupled with support for people with stress and/or mental health problems, regardless of their cause, is effective. Once identified, support might take several forms. It can include counselling to help individuals focus on problem identification and problem solving. This can also help individuals learn how to cope with non work related causes of stress and depression that nonetheless impact on work, such as problems in personal relationships or a death in the family. Another example of an effective intervention is structured talking therapy (cognitive behavioural therapy). This is delivered either on a face to face, telephone or computer basis. Use has been associated with significantly better mental health outcomes, higher rates of job retention and more hours worked compared to individuals receiving usual care alone.

Reintegration into employment

Interventions to promote a more rapid return to work include regular contact with company occupational physicians from early into any period of absence. Referring individuals to such services within the first two or three months of absences can substantially cut the duration of absence. Reintegration to work may be done gradually, initially on a part time or flexi time

basis and with job redesign or modification. Importantly, return to work plans should consider issues such as disclosure in order to deal with potential stigmatisation and discrimination.

Supported employment

Supported employment programmes seek to match individuals with suitable opportunities on the open employment market and then provide on the job support. They have been shown in Europe to be much more effective than well designed vocational rehabilitation programmes in helping people return to work.

Flexible benefits

Flexible social welfare benefit systems, where individuals can regain their benefits rapidly if employment does not work out help encourage individuals to become more active jobseekers.

Enforcement of anti-discriminatory legislation and support for employers

Better enforcement of existing anti-discrimination legislation, as well as support for employers, including mental health awareness training for both employees and employers, can help increase participation in employment.

MENTAL HEALTH IN OLDER PEOPLE

Policy brief

Older people contribute fruitfully to society across the EU, and their life knowledge is instrumental to shaping personal, family and community identity.

The majority of older people enjoy good mental health and well-being but some show high prevalence of neuropsychiatric conditions with associated health care and welfare costs.

Interventions addressing a combination of physical, mental and social issues have the greatest impact in improving mental health and well-being of older people

As the number of older people in Europe is growing so will mental health problems; this demographic change will have implications on public health and social protection systems, labour markets and public finances across the EU. Efforts to enable more people to grow old with good mental health and well-being will have cost effective outcomes for all.

Healthy aging is at the heart of the EU policy context

“Fostering good health in an ageing Europe” is the first objective of White Paper “Together for Health: a strategic approach for the EU 2008-2013”. Policies and initiatives on healthy ageing at EU-level, include a strategy for tackling the consequences of “demographic change”, the open method of coordination on social protection and social inclusion, and the debate on how to protect the dignity of older people and prevent elder abuse and neglect.

The challenge of the EU demographic change

The demography of the EU is changing radically: in 2050, 30% of the population will be above 65 years of age and 11% will be over 80. This change will have important mental health implications as poor mental health and mental disorders are common in old age.

Mental disorders are common in older people and are a barrier to active ageing

In general, older people feel less happy with their life than younger people. Moreover:

- 10-15% of those over 65 suffer from depression
- Women, those living alone, and those with physical illness or disability are at higher risk
- Older people with depression are 2-3 times more likely to have chronic illnesses and 2-6 times to have one limitation on their activities compared to younger groups
- Over 5 million people in the EU have dementia (about 1.1-1.3% of the population)
- Alzheimer disease rises from 2% amongst 65-69 year olds to 22% amongst those 85-89
- By 2040, Alzheimer disease will double in Western and treble in Eastern Europe
- Up to 70% of primary care physicians have difficulties to detect early signs of Alzheimer
- Older people are the group with the highest suicide rates in Europe (18.75 per 100000)¹
- Absolute numbers of suicide rates will increase in the coming decades as a result of the demographic ageing of Europe.

Poor physical health and functional limitations are linked with mental disorders

Physical health and functional limitations are central to the concerns of many older people and often intertwined with poor mental health.

- Over two thirds of people has one chronic disease diagnosed, in many cases leading to mental health problems and increasing the risk for mortality.

¹ Rates for EU-27, 65 year olds and above, in 2005

- Up to one third of older people experience mobility limitations and eyesight or hearing impairments, which can lead to poor mental health, lack of social mobility and participation, and depression in 20 to 40% of cases.

Elder abuse: a new mental health challenge to tackle

Elder abuse (physical, psychological, financial, sexual and/or neglect) has a 4% of yearly prevalence for those living in private households, and a 30% prevalence of inadequate care in institutions. Insufficient resources allocated to welfare needs, insensitive policies affecting older people or the disruption of inter-generational solidarity increase the risk of elder abuse.

Women, cultural minorities and those living in rural areas: forgotten subpopulations

Older women, particularly those at risk for poverty or living alone, have increased vulnerability to mental health problems and social isolation. Other vulnerable groups include those living in rural areas, migrants, members of ethnic minorities and disabled persons.

Loneliness is increasing and predicts poor mental health

Loneliness influences the psychosocial well-being of old people and is related to chronic illness and poor self-rated health. Up to 14% of old people have no living children (considered as a major source of support), 23% among the very old. This is expected to increase with the anticipated age growth, leading to increased mental health problems.

The shift away from early retirement will benefit mental health

The number of people aged over 55 will grow by 15% between 2010 and 2030, so a shift is needed away from early retirement to ensure a higher proportion of those aged 55–64 years stay in work. This will benefit mental health as flexible transition from work to retirement is related to higher morale, whereas abrupt retirement is related to depressive symptoms.

Caregivers: up to 50% have depression

Between 50% and 80% of people with dementia are cared for at home, as well as most disabled older people.

Care in the family home brings physical, psychological, social, and financial strains. Almost 25% of caregivers have anxiety and 50% of all caregivers of people with dementia become depressed and have higher levels of stress and burden, along with general health problems and physical injuries such as strained backs associated with lifting.

Cost and Burden of mental health problems in old age

In 2004, the cost of mental health problems in 28 EU countries was €295 billion, 7% of which was due to early retirement.

Dementia contributes 11.2% of years lived with disability in people aged 60 years and older; a burden greater than stroke (9.5%), musculoskeletal disorders (8.9%), cardiovascular disease (5%), and all forms of cancer (2.4%). Clinical dementia is also the single biggest cause of dependency among persons over 75 years.

Many associated costs are still not taken into account; e.g., the cost of Alzheimer's disease care has found to require 10-25% of a family's average net annual income.

Active ageing and social participation

Staying active keeps older people stimulated and engaged, and gives them a sense of meaning, purpose and responsibility that helps to promote mental health and well-being.

Participation in meaningful activities contributes to mental well-being in old age

Involvement in meaningful activities improves well-being and mental health. Lifelong learning programmes foster social, personal and professional realisation, key to successful ageing. Effective education initiatives include affordable fees and adapted curriculums, admission criteria and learning materials. Other participation forms that improve mental well-being are community development initiatives involving older people and volunteering.

Social support is essential

Social isolation and loneliness can be tackled through interventions to enhance social support, for example educational and social activity group interventions, targeting specific old age groups such as recently widowed people or those with mental health problems.

Exercise improves mental health

Exercise leads to increased mental well-being, psychological benefits and reductions in depressive symptoms. Different types of exercise programmes have impacts on both physical and mental health, including strength and resistance exercise, aerobic, walking or mixed exercise programmes, when of moderate intensity.

Housing and Outdoor Environments are key factors for active lifestyles

The design of towns, streets and homes allows older people to stay active, participate in their community, and improve their quality of life.

Special provisions for coping with physical impairments or disability, interventions to improve housing conditions, such as medical priority re-housing, community regeneration or refurbishment, improve physical and mental health. “Age-friendly” environmental measures such well-lit streets for safe walking, accessible green areas, barrier free access to recreational centres, well functioning public transport or free wheelchairs for those in need enable older people with disability to fully participate in the community.

Employment of older adults promotes mental health and economic growth

To improve mental health and sustain social security systems in the long term, longer working lives and later retirement will be required, involving government, the social partners and social dialogue, organisations and companies, and older workers.

Effective measures include: suitable working conditions, e.g., time arrangements and increased flexibility; employment opportunities developing skills and employability of the ageing workforce; maintaining and promoting the health and working capacity of workers; pension reforms; and providing financial incentives for companies to employ older workers.

Prevention of mental disorders and support to those mentally ill

Prevention of mental disorders can be effective in old age and reduce symptoms, incidence and burden of mental health problems. Strategies of support and care improve the quality of life and minimize the adverse consequences of mental illness.

Prevention of depression

Psychological interventions including cognitive training, psycho-education, relaxation and supportive interventions improve well-being in old people and prevent depressive symptoms.

Prevention of suicide in older people

Suicide prevention can be effective, including measures to: reduce the prevalence of depression in old age (e.g., improving detection and treatment of depression, reducing stigma

and barriers to accessing care); limit the access to the means of suicide (e.g., poisons, gas); taxation and restricting access to alcohol; increase mental health literacy; social integration and support to reduce loneliness.

Prevention of dementias

Targeting common cerebrovascular risk factors, such as hypertension, hyper-cholesterolemia, smoking or diabetes mellitus, especially during middle-age; reduction of alcohol consumption; and the prevention of cranio-cerebral traumas by reducing road accidents, reduce the risk of late-life dementia. Good levels of physical and social activity minimise the risk of cognitive decline. Early diagnosis delays onset of severe dementia by facilitating early access to adequate treatment and care; and supports families. Awareness and knowledge in the general population through the media, help reduce associated stigma.

Prevention of elder abuse

Caregiver support interventions such as information to identify caregiver's risk, respite care stress management, or provision of supportive policies, reduce the risk of elder abuse. Awareness rising for the abused supports to identify help and serves as preventive measure.

Good physical health and management of chronic illness reinforces mental health

Generic health promotion interventions, including education sessions to delay onset of physical illness, home visiting, and health literacy, improve mental health and well-being of older people and reduce admission to long-term institutional care/nursing homes.

Integrated services to support old people with mental disorders

An integrated model of care for older people with mental disorders by multidisciplinary teams across the community, hospitals and long-term care settings will support them and their families. Effective services include primary/specialist care collaborations for treatment of late life depression; outreach services to residential care settings and integrated post-discharge mental health services; including partnership among all stake-holders.

Interventions for carers

Psychotherapy and psycho-education interventions (e.g., providing information about the disease and resources available, training caregivers to respond effectively to disease-related problems), are effective for improving caregiver well-being and reducing associated depression and anxiety. Other measures include respite/day care interventions, support programmes, the provision of assistive devices (i.e. hearing aids or electronic alarm systems) or income security (e.g. social security coverage and pensions) and help covering caring costs. The social and economic recognition of the informal carers' role would increase their well-being, as well as the provisions to return to an active working and social life.

