Proceedings of the

European Conference on Promotion of Mental Health and Social Inclusion

MINISTRY OF SOCIAL AFFAIRS AND HEALTH

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Juha Lavikainen, Eero Lahtinen and Ville Lehtinen (Eds.)

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European Conference on Promotion of Mental Health and Social Inclusion

10-13 October 1999, Tampere, Finland

MINISTRY OF SOCIAL AFFAIRS AND HEALTH

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Summary

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This report is a collection of the speeches and presentations of the *European Conference on Promotion of Mental Health and Social Inclusion* that was held in Tampere, Finland on 10–13 October 1999. The report assembles the contents of the plenary sessions, panel discussions, and the recommendations of the conference workshops and also includes the resolution passed at the Health Council on 18 November 1999. The conference, part of the official programme of the Finnish Presidency of the European Union, was jointly organised by the National Research and Development Centre for Welfare and Health (STAKES), the Ministry of Social Affairs and Health, the Secretariat for the Finnish Presidency of the EU, and the European Commission.

The report contains the speeches given by the European Commissioner for Health and Consumer Protection, the Director-General of the WHO, and by the official high-level representatives (Health Ministers and/or Secretaries of State) from Finland, France, the Netherlands, Sweden, United Kingdom, and Portugal. It covers the presentations and invited comments given in the priority areas selected for urgent European action on mental health: enhancement of the value and visibility of mental health, development of mental health indicators, promotion of mental health of children and young people, promotion of mental health in old age, working life, employment policy and promotion of mental health, and telematics in mental health promotion and substance abuse prevention. It also includes the presentations given by representatives of non-governmental organisations in the round-table discussion under the theme of *Wider partnership for promotion of mental health*.

The implications for the future, based on the workshop conclusions, are included in the report as well. The themes of the workshops were closely linked with the development of European mental health policies, public policies and societal activities. The workshops proved to be a very important part of the conference as they aimed to produce concrete recommendations for European mental health policies concerning each of the six priority areas.

The conference was an integral part of the project on *Putting Mental Health on the European Agenda* which has been financed by the European Commission (DG Health and Consumer Protection) from the Community action programme on health promotion, information, education and training within the framework for action in the field of public health (1996-2000) between December 1998–December 2000. The conference in Tampere marked an important step in the *European Mental Health Agenda*, which is a long-term process striving to gain more value and visibility for mental health issues within the European context.

The report is expected to serve as a recollection of the event for those who attended and it probably also provides motivating reading for anyone else interested in the theme of promotion of mental health and social inclusion.

Keywords: mental health, promotion of mental health, social inclusion

Tiivistelmä

Juha Lavikainen, Eero Lahtinen ja Ville Lehtinen (toim.). Proceedings of the European Conference on Promotion of Mental Health and Social Inclusion (Euroopan mielenterveyskonferenssin julkaisu), Tampere 10.-13.10.1999. Helsinki, 2001. 166 s. (Sosiaali- ja terveysministeriön selvityksiä, ISSN 1236-2115; 2001:3.) ISBN 952-00-0926-4

Tämä raportti koostuu Tampereella 10.-13.10.1999 järjestetyssä EU:n mielenterveyskonferenssissa (European Conference on Promotion of Mental Health and Social Inclusion) pidetyistä puheista ja esityksistä sekä terveysneuvoston 18.11.1999 hyväksymästä mielenterveyden edistämistä koskevasta päätöslauselmasta. Raportissa kuvataan konferenssin täysistuntojen ja paneelikeskustelujen sisältöä sekä työryhmien suosituksia. Suomen EU-puheenjohtajuuskauden viralliseen ohjelmaan kuuluneen konferenssin järjestivät yhteistyössä Stakes, sosiaali- ja terveysministeriö, Suomen EU-puheenjohtajuussihteeristö sekä Euroopan komissio.

Raportti sisältää EU:n terveys- ja kuluttajansuoja-asiain komissaarin, WHO:n pääjohtajan sekä Suomen, Ranskan, Alankomaiden, Ruotsin, Englannin ja Portugalin virallisten korkean tason edustajien (terveysministeri tai valtiosihteeri) puheet. Siihen sisältyvät myös esitelmät ja pyydetyt puheenvuorot niiltä keskeisiltä mielenterveyden alueilta, joilla Euroopassa tarvitaan kiireellisiä toimenpiteitä: mielenterveyden arvostuksen ja näkyvyyden lisääminen, mielenterveysosoittimien kehittäminen, lasten ja nuorten mielenterveyden edistäminen, mielenterveyden edistäminen vanhuusiässä, työelämä, työllisyyspolitiikka ja mielenterveyden edistäminen sekä telematiikan käyttö mielenterveyden edistämisessä ja päihteiden väärinkäytön ehkäisemisessä. Se sisältää myös kansalaisjärjestöjen edustajien esitykset pyöreän pöydän keskustelussa aiheesta laajempi yhteistyö mielenterveyden edistämiseksi (Wider partnership for promotion of mental health).

Raportti esittelee myös työryhmien työskentelyyn perustuvat johtopäätökset mielenterveyden edistämisessä tarvittavista toimenpiteistä. Työryhmien aiheet liittyivät kiinteästi eurooppalaisen mielenterveyspolitiikan, yhteiskuntapolitiikan ja yhteiskunnallisen toiminnan kehittämiseen. Työryhmät osoittautuivat hyvin tärkeäksi osaksi konferenssia, sillä niiden tarkoituksena oli tuottaa Euroopan mielenterveyspolitiikkaa koskevia konkreettisia suosituksia kultakin kuudelta keskeiseltä alueelta.

Konferenssi kuului kiinteänä osana EU-projektiin ”Mielenterveys EU:n asialistalle” (Putting Mental Health on the European Agenda), jota Euroopan komissio (terveys- ja kuluttajansuoja-asioiden pääosasto) tuki terveyden edistämistä, terveydestä tiedottamista, terveyskasvatusta ja -koulutusta koskevasta yhteisön toimintaohjelmasta joulukuusta 1998 joulukuuhun 2000. Tampereen kokous merkitsi tärkeää askelta EU:n “mielenterveysagendassa”, pitkäjänteisessä prosessissa jonka tavoitteena on saada mielenterveyskysymyksille enemmän painoa ja näkyvyyttä eurooppalaisissa yhteyksissä.

Raportin tarkoituksena on dokumentoida terveyspoliittisesti ainutlaatuinen tapahtuma ja osoittaa suuntaa tulevalle mielenterveystyölle Euroopassa.

Avainsanat: mielenterveys, mielenterveyden edistäminen

Sammanfattning

Juha Lavikainen, Eero Lahtinen och Ville Lehtinen (Redaktörer). Proceedings of the European Conference on Promotion of Mental Health and Social Inclusion, 10-13 October 1999, Tampere, Finland (Handlingar från den europeiska konferensen om främjandet av mental hälsa och social integration, 10-13 oktober 1999, Tammerfors, Finland). Helsinki, 2001. 166 p. Reports of the Ministry of Social Affairs and Health, ISSN 1236-2115; 2001:3.) ISBN 952-00-0926-4 (Social- och hälsovårdsministeriets rapporter).

Denna rapport består av en samling tal och presentationer från den *europeiska konferensen om främjandet av mental hälsa och social integration* som ägde rum i Tammerfors, Finland, den 10-13 oktober 1999. Rapporten sammanställer innehållet ur plena, paneldiskussioner och rekommendationerna som gavs av konferensens arbetsgrupper. Den innehåller också en resolution intagen av Hälsorådet, den 18 november 1999. Konferensen, som utgjorde en del av Finlands officiella EU ordförandeskapsprogram, organiserades som samarbete mellan Forsknings- och utvecklingscentralen för social- och hälsovården (STAKES), social- och hälsovårdsministeriet, sekretariatet för Finlands EU-ordförandeskap och Europeiska kommissionen.

Rapporten innefattar tal som hölls av den europeiska kommissionsledamoten med ansvar för hälsa och konsumentskydd, WHO:s generaldirektör och officiella representanter på hög nivå (hälsoministrar och/eller statssekreterare) från Finland, Frankrike, Nederländerna, Portugal, Storbritannien och Sverige. Rapporten täcker presentationer och inbjudna kommentarer givna inom de prioritetsområden som valts för brådskande europeisk verksamhet i området mental hälsa: förbättring av den mentala hälsans värde och synlighet, utveckling av indikatorer för mental hälsa, främjande av mental hälsa bland barn och ungdomar, främjande av mental hälsa i ålderdomen, arbetslivet, sysselsättningspolitik och telematik i främjande av mental hälsa och motverkning av rusmedelsmissbruk. Rapporten innehåller också presentationer av representanter för medborgarorganisationer vid diskussionen omkring temat *Wider partnership for promotion of mental health* (Mera omfattande partnerskap för att främja mental hälsa).

Reflektioner över framtiden, på basis av arbetsgruppernas slutsatser, ingår också i rapporten. Arbetsgruppernas teman hörde nära samman med utvecklingen av europeisk politik gällande mental hälsa, offentlig politik och samhällelig aktivitet. Arbetsgrupperna visade sig också vara en mycket viktig del av konferensen, eftersom de strävade efter att producera konkreta rekommendationer för europeisk mentalhälsopolitik i alla sex prioriterade områden.

Konferensen utgjorde en väsentlig del av projektet för den mentala hälsans placering på den europeiska agendan, som har finansierats av Europeiska kommissionen (Generaldirektoratet för hälsa och konsumentskydd) ur åtgärdsprogrammet för gemenskapen för främjande av och upplysning, undervisning och utbildning om hälsa inom ramen för verksamheten på folkhälsoområdet (1996-2000) december 1998 – december 2000. Konferensen i Tammerfors utgjorde ett viktigt steg på den europeiska agendan för mental hälsa, som en långsiktig process som strävar efter att ge mera värde och synlighet åt frågor gällande mental hälsa inom Europa.

Denna rapport förväntas fungera som ett minne för dem som deltog i konferensen och torde även utgöra motiverande läsning för andra intresserade i temat gällande främjandet av mental hälsa och social integration.

Nyckelord: mental hälsa, främjande av mental hälsa, social integration

Preamble

This report offers a window to the contents of the plenary sessions and the workshops of the *European Conference on Promotion of Mental Health and Social Inclusion* that was held in Tampere, Finland on 10–13 October 1999. It assembles the speeches and presentations held in the plenary sessions of the conference and presents the recommendations stemming from the workshops. Furthermore, the Council resolution on the promotion of mental health is included in this report. The report serves as a recollection of the event for those who attended and probably also provides motivating reading for anyone interested in the theme.

The conference was part of the official programme of the Finnish Presidency of the European Union. It was jointly organised by the National Research and Development Centre for Welfare and Health (STAKES), the Ministry of Social Affairs and Health, the Secretariat for the Finnish Presidency of the EU, and the European Commission.

The conference was an integral part of the project on *Putting Mental Health on the European Agenda*. This project was financed by the European Commission from the programme of Health Promotion. At the same time, the conference marked an important step in the *European Mental Health Agenda*, which is a long-term process striving to gain more value and visibility for mental health issues within the European context.

The conference brought together representatives from the European Union Member States and the Candidate Countries, the EEA Countries, the European Commission, the European Parliament and the World Health Organization jointly with European policy makers and experts as well as representatives of NGOs, to discuss and elaborate the themes of promotion of mental health and social inclusion.

Convened by Ms. Eva Biaudet, Minister of Social Services and Health of Finland, the conference gathered around renowned speakers such as Mr. David Byrne, European Commissioner for Health and Consumer Protection and Dr. Gro Harlem Brundtland, Director General of the World Health Organization. Accordingly, health ministers from France (Ms. Dominique Gillot), the Netherlands (Ms. Els Borst-Eilers), and Sweden (Mr. Lars Engqvist), and Secretaries of State from United Kingdom (Ms. Gisela Stuart), and Portugal (Mr. Francisco Ventura Ramos) participated in the ministerial panel discussion and expressed their views on future challenges of European mental health policy.

The two main goals of the conference were

- to enhance the value and visibility of mental health at European level; and
- to seek synergies and agree on strategies concerning future European action and co-operation.

These goals were approached by

- presenting and discussing the results of the preparatory work at European level;
- analysing and enhancing the European added value of the proposals and initiatives;
- stimulating new activities, refining priorities and strengthening co-operation; and
- emphasising the role of mental health in Community action for public health.

The themes of the conference workshops had strong links with the development of European mental health policies, public policies and societal activities. In view of the efforts needed to develop the recommendations within each priority area, the workshops proved to be an important part of the conference. They discussed proposals for European mental health policies concerning a specific topic and produced concrete recommendations in each of the areas, respectively.

Now, when writing these lines, it seems that the ambitious goals of the conference have been achieved. An extremely important result has been the Council Resolution for the promotion of mental health (adopted on 18 November 1999) included in these Proceedings (see Appendix 2). Moreover, the mental health theme has been maintained on the official agendas of the subsequent EU Presidencies of Portugal, France and Sweden.

Thus, the work so far has provided valuable in raising the value and visibility of mental health within the European context and even more globally, and in strengthening contacts and collaboration. In view of the future, however, we feel that there is still a lot to be done within the wide frame of promotion of mental health and it is a challenge for all of us to carry on this work. Endorsing the idea put forth by Minister Biaudet in her closing statement, it could also be worthwhile to organise a follow-up conference in a couple of years time, as there is a need to look carefully at the process that has been successfully started.

Dr. Jarkko Eskola
Director General
Department for Promotion of Welfare and Health
Ministry of Social Affairs and Health

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Executive summary

The European Mental Health Agenda

The European Mental Health Agenda is a long-term process which aims at gaining more value and visibility for mental health issues in a European Union context and thereby contributing to the living conditions, lifestyles, well-being and participation of the European citizens.

In June 1997, Finland proposed at the EU Health Council that the need for public health action in the field of mental health should be discussed in the European Union. The proposal underlined that a broad European agenda would enhance the visibility of and draw attention to the promotion of mental health.

The Commission, the European Parliament and EU Member States supported the proposal. The discussion was facilitated by two newly established Community networks, the "European Network on Mental Health Policy" and the "European Network on Mental Health Promotion". Co-operation with non-governmental and international organisations, including the World Health Organization, was essential to take the ideas forward.

The first concrete step was the consultative meeting, *Mental Health Promotion on the European Agenda*, held in Helsinki on 15–16 January 1998. The meeting listed priority themes for the promotion of mental health and reached a consensus on the most urgent areas requiring future action.

Encouraged by the positive feedback the Finnish Presidency took mental health on its agenda and hosted the *European Conference on Promotion of Mental Health and Social Inclusion* which was held in Tampere on 10–13 October 1999. The conference had two goals:

- to enhance the value and visibility of mental health at European level.
- to seek synergies and agree on strategies concerning future European action and co-operation.

These two goals were approached by

- presenting and discussing the results of the preparatory work at European level;
- analysing and enhancing the European added value of the proposals and initiatives;
- stimulating new activities, refining priorities and strengthening co-operation; and
- emphasising the role of mental health in Community action for public health.

In addition, the themes of conference workshops have strong links with the development of a European mental health policy, public policies and societal activities.

This Executive Summary picks out the salient points of the themes discussed at the conference. Ideas and recommendations in this summary are opinions presented by speakers or elaborated in workshops.

Need for action at European level

Ms Eva Biaudet, Finland's Minister of Health and Social Services, Mr David Byrne, Commissioner for Health and Consumer Protection of the European Commission, and Mr John Bowis,

Member of the European Parliament, spokesman for the Committee on the Environment, Public Health and Consumer Policy set the scene by highlighting several crucial issues.

Ms Biaudet highlighted the relevance of mental health to every European citizen as a resource laying the foundation for creativity, productivity and social life. She went on to stress some issues that are considered important by the Finnish Presidency of the EU. Firstly, developing an information system for mental health as a joint effort of the Member States with the support of the European Commission would provide us with comprehensive data on these issues. These data would offer a real interface between policy, practice and the everyday life of European citizens. A report on mental health in Europe would be a good starting point. Secondly, the dissemination of good practices, including quality in mental health was considered important. European collaboration, particularly in the prevention of mental health problems of children and young people, was emphasised. Finally, Commission Recommendations were called for as desirable specifically because they would help in clarifying the concepts and in creating a conceptual framework for future discussions. They would also signal the importance of mental health to the entire international community.

Mr Byrne congratulated Finland for its initiatives during the Presidency to hold a number of important conferences on issues that matter to people. He repeated his earlier words to the European Parliament: "*I am actively looking at the possibilities for improved promotion of mental and physical health. As a guiding principle, I believe that we must target our measures at the biggest threats to public health. In this respect, mental health merits consideration as a focus of future actions*".

Mr Byrne outlined European Union's public health mandate and stressed the fact that health has to be taken into consideration in all Community policies. Therefore, all policies should be closely monitored for their potential contribution to mental health. With regard to this, the Commission is planning to develop recommendations to the Council on the promotion of mental health with a specific view to take account of mental health aspects in all policies. He noted that although mental health is not explicitly given priority in the current public health framework there are several major projects implemented in the Health Promotion and Health Monitoring programmes. Mr Byrne briefly reviewed the projects that are relevant to mental health and underlined that the preparations for the public health framework beyond the year 2001 are underway.

Closing his address Mr Byrne mentioned that although mental health is already on the agenda, a better and clearer understanding of mental health problems is needed. Comparable and reliable information would allow us to refine and elaborate mental health policies. He also expressed his confidence on the issue of mental health having a significant place in the development of the new Community public health framework for action.

Mr Bowis first outlined some statistics on the burden of mental illness and stressed the fact that in the United Kingdom and Finland, for example, more people die by their own hand than are killed in road accidents. He went on by underlining Europe's crucial role in collecting and sharing best practices in promotion and prevention. He noted that more research has to be conducted into effectiveness measurements and cost-effectiveness in order to convince finance ministers and budget committees that we should invest now in mental health for the future. He also stated that the Council of the European Union and the European Parliament must support the Commission by giving them a budget line on mental health.

On several occasions, close collaboration with NGOs, carers, service users and their family members in refining and elaborating mental health policies was emphasised.

Enhancing the value and visibility of mental health

One of the main obstacles to a correct understanding of the value and adequate visibility of mental health in society is the fear of coming into contact with mental suffering and mental disorders. Another barrier is the continuing strong influence of the strict biomedical model on the training and practice of health professionals, despite the wide acceptance now given to the biopsychosocial model. The messages about the value of mental health should always be clear and easy to understand.

Intervention priorities can be found at levels of concepts and research, politics, legislation, health services, health professionals training, education, social services and other sectors, the media and international co-operation. Mental health must be built up and protected by all of us in all places.

There is a need to:

- formulate an explicit mental health strategy in the EU in the field of public health policy;
- recognise mental health and social inclusion as essential elements of everyday life;
- acknowledge the social and economic burden caused by mental disorders; and
- disseminate and utilise existing knowledge of promotion and prevention measures.

The EU should encourage:

- general cross-sectoral action on the promotion of mental health and prevention of mental ill-health across policies;
- specific mental health activities; and
- options for co-ordinating action with WHO, other international agencies and NGOs.

Development of mental health indicators

While there are at the moment many indicators pertinent to mental health to be found in a wide variety of statistics and projects, there is no coherent database on mental health or co-operation between these projects. The need for better European data is urgent.

A step-wise approach to specific mental health indicators was suggested. Step 1 would include simple and robust indicators already to be found in existing databases (e.g. suicide rates, alcohol and drug-related deaths, general health, and impairment for mental health reasons). Step 2 would contain a short list of questions on mental health to be included in the European Community Household Panel (ECHP). Step 3 would be the addition of a more complex set of questions as part of the European Labour Force Survey. Step 4 would be a specific mental health survey in Europe directed by Eurostat.

There is a need to:

- obtain information on needs, interventions, unmet needs and outcomes concerning mental disorders;
- develop indicators for positive aspects of mental health;
- collect the information from both routine data and national surveys;
- ensure the quality of indicators, instruments and reporting of the data;
- establish a common system for mental health monitoring within the general EU health monitoring system;

- elaborate the system with attention to the comparability and validity of the data, and to its acceptability for all cultures, Member States, users and carers; and
- provide citizens and users with easy access to the system, e.g. by telematic means and websites.

Evidence of effectiveness in mental health promotion

There is ample evidence that mental health promotion and interventions to reduce the risk of mental disorders could be effective and cost-effective. On the other hand there is still a great need for political measures to implement effective mental health promotion.

There is a need to:

- focus on a small number of priority areas, taking into account both the existing prevalence and burden as well as current perspectives on effective interventions: good candidates are school mental health promotion, aggression, and depression;
- make better use of the large range of existing, evidence-based interventions by facilitating their large-scale dissemination and implementation;
- develop a comprehensive world-wide overview of available evidence-based programmes;
- conduct replication studies and to evaluate their effectiveness in the community;
- focus evaluation research on the identification of key effect predictors and their translation into principles and guidelines for effect management that could then be used in practice and in policy-making;
- develop a more efficient collaborative structure between the many organisations and international networks currently active in the field**,** including the World Federation for Mental Health; and
- remove the barriers posed by the lack of national policy for mental health promotion, the inadequacy of support for national and local infrastructures and the shortage of mental health promotion experts with a view to creating effective prevention and a targeted balance between mental health promotion and mental health care.

Promotion of mental health of children and young people

In today's society children and adolescents face severe risks that were unrecognized or unknown as little as a generation ago. Family, school and community violence, early sexual activity, the single parent family, frequent family disruptions and the financial problems and family breakdown that so often follow – are but a few examples of the stresses faced by today's children and adolescents.

The cost of untreated**,** partially or ineffectively treated, emotional or behavioural problems among school children and adolescents is high. Children and adolescents with such problems show poor school performance, high delinquency rates, low rates of employment, and little or no success in finding employment after leaving school. They have an increased likelihood to be involved with the police, criminal justice, and as adults, end up as users of mental health and public welfare services. The resources of mental health services are not sufficient to meet the needs of the growing number of families in need.

All Member States should develop mental health prevention and promotion programmes for children and adolescents. Important channels could be the school systems or public health services, the primary health care services in particular. First, though, it is necessary to develop

and implement programmes able to serve the communities in need, and to see how existing methodologies could be refined in order to achieve more effective utilisation of the allocated resources.

There is a need to:

- raise awareness of the mental health and well-being of children and young people using a developmental, child-centred approach in all sectors and policies and in the whole population;
- support preparation for parenthood and active parenting;
- focus more on vulnerable children and adolescents;
- make better use of existing research on good mental health promotion practices in education, health and social fields;
- ensure adequate funding for new research on child mental health; and
- support and further develop learning environments (in and out of school) for children, young people, teachers and carers.

Promotion of mental health in old age

The key factor in health promotion in late life is personal, active participation by the elderly themselves at all levels. Other factors are the necessity to combat ageism, promote autonomy and empowerment, facilitate social support, social integration and social participation, and reduce social isolation. There is also a need for evidence-based information and for increasing research initiatives in the field of ageing and mental health.

There is a need to:

- increase the knowledge, competence and skills of social and health care professionals, members of NGOs and carers in the field of normal ageing and ageing with deviations;
- reduce risk factors for impaired mental health and well-being such as isolation, poverty, disability, malnutrition, abuse, pain and drug side effects through
  – special programmes for risk groups,
  – community based mental health promotion programmes for all elderly people, and
  – dissemination of good practices;
- focus research on the risk factors, prevention, recognition, treatment and care of mental ill-health; and
- establish a network promoting mental health in elderly people to serve the efforts of research, information, dissemination of good practices, monitoring and training.

Working life, employment policy and promotion of mental health

The EU employment guidelines present an opportunity to promote mental health among the employed and unemployed. There is a need for an agreement between the Member States on a common action programme. Mutually agreed indicators would enable development and evaluation of national employment policies. Advances made by the EU in employment policies must be complemented by appropriate strategies for promoting mental health.

There is a need to:
- bring together the mental health promotion and equality agendas;
- increase cross-referencing between policy areas;
- ensure collaboration between EU, WHO, and ILO;
- incorporate the promotion of mental health with the concepts of corporate responsibility;
- include the voice and expertise of disabled people; and
- include more references to occupational transitions, life-long learning, and personal development to the European employment guidelines.

National employment action plans should
- include consultation with NGOs; and
- be linked to other national policy areas.

Telematics in mental health promotion and substance abuse prevention

The measures and actions available to develop and promote the European Information Society can be grouped into three categories: regulatory procedures, research and development, awareness raising and promotion. The Information Society strategy brings together not only technologies but also a whole range of societal, legal, economic and cultural aspects. In that way, efforts in this area reflect real life in all its dimensions.

The guidelines drawn up for the information society emphasise
- improved access to information;
- enhanced democracy and social justice;
- promoting employability and lifelong learning;
- achieving and enhancing equal opportunities between men and women;
- promoting inclusion, encouragement of people with special needs and those lacking opportunities to improve their position; and
- improving the quality and efficiency of public administration.

A European network, Prevnet Euro, was used to highlight the possibilities of and problems in telematics and substance abuse prevention. The issues included social and psychological distance and anonymity, differences between the real and the virtual world, and the advantages and disadvantages of information and communication technologies.

There is a need to:
- support professionals in appropriate information and communication technology (ICT) skills and applications by training, intersectoral co-operation and exchange, and identification of best practices;
- support users and communities in use of ICT by easy access, networking, socially inclusive ICT-based arts, and ICT-based mental health promotion and prevention;
- reintegrate people into employment by developing their ICT skills;
- study the social and cultural impact of ICT on well-being, the cost effectiveness of ICT in mental health promotion, and ethical dimensions; and
- promote awareness and dissemination of ICT-based solutions for mental health by the media, at work and school, and in local communities.

Wider partnership for promotion of mental health

A round-table discussion brought together participants from a non-governmental organisation, two European networks and WHO.

Dr Vivian Barnekow Rasmussen from the WHO Regional Office for Europe presented the new guidelines for WHO actions in areas where social and economic development is considered to affect health. The *Health 21* programme has several targets closely related to the themes of the conference: improved social wellbeing, multisector responsibility for health, and mobilisation of partners for health.

The representative of the Health Promoting Schools network, Dr Katherine Weare said that mental health work is conducted under several mandates and by several bodies in WHO, the EU and the Council of Europe. She emphasised that programmes are more effective if they are aimed not only at risk groups but at everybody, as in the case of the promotion of children's and young people's mental health at school. Four key dimensions in the programmes are relationships, participation, clarity, and autonomy.

Mr Peter Lehmann from the European Network of (ex-)Users and Survivors of Psychiatry (ENUSP) wanted to see the user's point of view emphasised in the treatment of mental diseases. He maintained that pharmacotherapy should be voluntary and that problem-solving endeavours should take social causes into account.

Ms Solja Peltovuori from the European Federation of Associations of Families of Mentally Ill People (EUFAMI) brought up the important role of family members as care-takers of mentally ill persons.

Main issues in a comprehensive mental health policy

Professor Rachel Jenkins (Institute of Psychiatry, United Kingdom) summarised the outcome of the conference workshops. She emphasised that the details of mental health policy will vary, depending on the needs, culture, circumstances and opportunities of each individual country, but that the main issues should nevertheless include the following elements:

National components

- National strategy to promote mental health, reduce morbidity and reduce mortality
- Policy links with other government departments, e.g. housing, employment, education, media
- Legislation
- Mechanism for implementation and accountability
- Funding streams

Support infrastructure

- Mental health information strategy
- Research and development strategy
- Human resource strategy

Service components

- Mental health promotion in schools, workplaces, the media, the community
- Primary and secondary care to do primary, secondary and tertiary prevention
- Good practice guidelines
- Health service links with other sectors, such as social services, schools and criminal justice system
- Health service links with NGOs

The following common themes arose from all the workshops:

- Mental health is not just for the professionals.
- Mental health needs to be across policies, across sectors and across all levels.
- A EU mental health and social inclusion policy should incorporate user perspectives and participation along with those of mental health professionals and have clear links to local community activities.
- **There is no health without mental health.**

Global perspectives on mental health

Dr Gro Harlem Brundtland, Director-General of the World Health Organization picked out three dominant factors affecting the living conditions and well-being of the world's population: rapid societal and economic changes, poverty, and ageing. She also underlined the problems related to poor mental health, specifically those linked to major depression and to stigmatisation in general, and stressed the great challenges that lie ahead.

Dr Brundtland introduced the new WHO strategy, which is centred on three issues: advocacy, policy and cost-effective interventions, and pointed out that European collaboration could be of great value here. In addition, epidemiological information is needed to assist in defining focused policies and in planning appropriate interventions. Dr Brundtland supported the proposal of Ms Biaudet concerning the establishment of a joint European mental health information system for collecting information and good practices related to mental health from various countries. Dr Brundtland thanked Finland for its intensive efforts to get mental health issues put onto the agenda of the EU.

Dr Brundtland concluded by stressing the importance of not only addressing mental health issues and problems in Europe but also Europe's opportunities and responsibility in assisting the rest of the world to develop cost-effective, equitable and humane ways to promote mental health and care for the mentally ill.

Future challenges of European mental health policy

A ministerial panel brought together participants from France, The Netherlands, Sweden, The United Kingdom and Portugal to reflect on the conference themes. The panel was chaired by Ms Eva Biaudet, the Minister of Health and Social Services of Finland.

The French Secretary of state for Health and Disabled People, Ms Dominique Gillot described the French action programme on mental health. It focuses on patient's rights, issues of mental health promotion policy (such as improved communication), mental health research and information systems, and maintaining a favourable environment for improving the well-being of people. Ms Gillot also emphasised improving mental health care. Therefore, information exchange and co-operation between the Member States are important. She highlighted the possibilities opened by the Treaty of Amsterdam for health issues in all policies and emphasised particularly the role and importance of mental health in this respect. She emphasised that all policies, for example culture, environment, employment, and social policies can have an impact on mental health. Furthermore, the actions at the European level may, in fact, be of great help to the national or regional mental health policies.

The Dutch Minister of Health, Welfare and Sport Ms Els Borst-Eilers emphasised the importance of common European actions in the field of mental health and stressed the fact that by common actions, clear European added value will be gained. Ms Borst-Eilers introduced three priority areas for such common actions. First, research into mental health is considered of a very high priority, and therefore, a significant amount of the community funding in life sciences should be devoted to research in mental health. The justification for this is the costs caused by mental illness at personal, social and economical levels. Secondly, exchange of good practices should be emphasised. In order to improve information exchange and the dissemination of good practices, a monitoring centre could be set up and collaboration with WHO should be strengthened. Common action would be needed to establish a mental health information system. Thirdly, Ms Borst-Eilers reminded of the importance of not forgetting the patients. Common actions should provide better quality of life and better opportunities for those suffering from mental illness. Eventually, mental health undoubtedly contributes to the well-being and functioning of European citizens.

The Swedish Minister of Social Affairs, Mr Lars Engqvist emphasised the high priority in life given to being healthy. This also means being mentally healthy and free from substance abuse. According to him, health promotion strategies can be successful only if they are implemented as a part of an overall welfare policy for which all sectors of society share responsibility. Mr Engqvist stated that all the evidence suggests that mental health will be an increasingly significant factor in the context of health and welfare development within the EU Member States. He also outlined equality in health as an overall objective for a future European mental health policy. More specifically, Mr Engqvist underlined the close connection between mental problems and alcohol abuse and drug use and outlined the importance of focusing attention to these problems at the EU level. He closed his speech by stating that comprehensive strategies on alcohol and the promotion of mental health are – and must be – challenges for the EU if we are to improve the quality of life of every European citizen.

Ms Gisela Stuart, Parliamentary Under-Secretary at the Department of Health of the United Kingdom, highlighted two issues in her speech. First, the recognition of the importance of the European mental health agenda and secondly mental health issues associated with children and young people. She stated that the conference had brought together a distinguished group of experts and interested parties to discuss a broad range of complex multidisciplinary issues; to explain and share knowledge about good practices and to raise the profile of the mental health agenda. Illustrating the importance of this agenda, Ms Stuart gave examples of the prevalence and costs of mental illness in the United Kingdom, and described the recently launched National Service Framework for mental health. She emphasised the importance of sharing knowledge on these issues. The specific needs of children and young people, ethnic minorities and refugees were also highlighted. In particular she referred to the importance of

being sensitive to the needs of the individual in the early years of the child development. Mental health programmes should be part of the new public health framework.

The Portuguese Secretary of State for Health, Mr Francisco Ramos described the recent development that has taken place in Portugal since the inclusion of mental health into the national health policy in 1995. Mr Ramos outlined the goals of the national strategy and described some important advances which have been achieved through this development, among them a new mental health law, several new community services, improvements in the national information system and the integration of mental health targets among the general health targets. He also stressed that the development of a mental health strategy within the EU will be needed to the full implementation of national mental health policies of the Member States. This strategy should be centred not only in the Community public health but also have links with social, education, employment and justice sectors. The future challenges, according to Mr Ramos, include the exchange of experiences in promotion of mental health, issues of human rights, development of mental health indicators and the integration of mental health in the health monitoring system of the EU. Mr Ramos closed his speech by assuring that during the Portuguese presidency, the work done in the field will continue.

Ms Eva Biaudet summarised the discussion by first drawing attention to the large amount of work still to be done in mental health promotion. In view of the huge social and economic costs and burden caused by mental problems, it would seem that the efforts made to promote mental health and mental health care have not been effective enough. In the European perspective, however, it is clear that we can learn from each other by comparing information about care systems and models, and thus we have a good basis for making the work more useful and effective.

Making further progress on the Mental Health Agenda

In her closing statement, Ms Biaudet noted that *"…European activities in the development of mental health policies and the promotion of mental health will in the end benefit everyone – not merely our citizens of the European Union – through the increased visibility and through the concrete results we will and shall achieve in the European context"*. She emphasised the importance of mental health as an integral part of health and as a precondition for social inclusion. She highlighted the support given by the following presidencies of the EU – Portugal, France and Sweden – and their intention to keep promotion of mental health on the agenda during the development of the new EU strategy for public health. Finally, Ms Biaudet suggested that a follow-up conference should be held within three years.

Opening address

Eva Biaudet, Finland

Minister of Health and Social Services

Mr Commissioner, respected guests, ladies and gentlemen,

When we speak about mental health, we are referring to a broad concept with relevance to every citizen. Mental health concerns each and every one of us. Mental health is realised in our everyday lives - in schools, at workplaces and in our leisure activities. Mental health is an indivisible part of our general health and an essential element of our well-being.

Mental health can also be seen as the human resource that lays the foundation for our creativity, productivity and social life, including particularly our closest relationships. It can be compared to a renewable natural resource that is accumulating all the time. We can develop our societies so that they foster the growth of mental health resources. Badly functioning societies waste these resources at a rate that outstrips their natural ability for renewal. The responsibility of us all, but especially of us politicians, is to make sure that this does not happen.

The theme of this conference - 'promotion of mental health and social inclusion' - refers to the strong link that exists between mental health and social inclusion, to a sense of belonging. Every human being needs to have a strong sense of belonging to a social network, whether family, group of friends or community.

Social exclusion, marginalisation or alienation are major determinants of mental ill-health. There are many things going on in society today that may expose people to the risk of mental ill-health. Take, for example, long-term unemployment, substance abuse, loneliness -particularly among the elderly - and the problems faced by migrants and refugees. Prevention of social exclusion is an urgent task in the promotion of mental health.

Mental disorders, together with cardiovascular and musculoskeletal disorders, are a leading cause of disability, so much so that the proportion of people on disability pension due to mental disorders is actually increasing in many European countries today. Consequently, the total costs of mental-ill health are high.

And what about the people who take their own lives? It is a fact that the number of suicides exceeds that of deaths due to road accidents. The number of attempted suicides is still higher. We need to ask what this tells us about our societies and about inclusion, solidarity and connectedness, and why this matter is not given high priority everywhere?

One aspect of mental ill-health which must be mentioned relates to the stigma it carries. When thinking about this stigma, one's first association tends to be the situation of people with severe disorders. Modern society may marginalise the mentally ill due to the cultural interpretations linked to ideas about mental illness and to the social norms regulating tolerance of deviance. The crucial point here is that, in many cases, the social consequences of the stigma become the disability, even in the absence of an actual disability.

Distinguished delegates, by seeking to promote mental health - the theme of this conference -we are taking another look at the issues related to both mental health and mental ill-health.

We should recognise the value and importance of mental health, analyse mental health needs, and act accordingly. We have to realise that we need to emphasise many levels, from the individual to the societal. Our activities should focus on many sectors and settings with a bearing on mental health. The development and revitalising of mental health services is an essential component of the promotion of mental health, although beyond the competence of the European Community.

Two years ago, the Consultative Meeting on Promotion of Mental Health suggested a number of strategic approaches for mental health promotion. They included new models for supporting families and children; approaches targeted both at the long-term unemployed and at the workplace; and - generally - efforts to foster understanding and dialogue between citizens, patients and professionals. These are but a few of the issues we shall ponder at this conference.

In the course of the next few days we will doubtless return many times to the question: what is to be gained in practical terms by tackling the issue of mental health promotion at European level? I would like to raise some issues that the EU Presidency considers important.

With regard the burden of mental ill health, we need to know much more. Psychiatric epidemiology is able to tell us that at any given time in any population one in five persons will be suffering from a mental disorder that can be assigned a medical diagnosis. The lifetime prevalence has been put as high as 50%. Too little, however, is known about the processes leading to mental ill-health.

Our knowledge of the epidemiology of heart disease and cancers is excellent. Detailed information is gathered on these major health scourges with the aid of national registers and special studies. Valid international comparisons can be made, and the costs and benefits of promoting, preventive and protective actions can be analysed.

Clearly, what we need first and foremost, then, is a similar, equally effective information system for mental health. As this is a multidimensional and highly complex subject, establishing such a system would pose a real challenge. We have to agree on definitions and indicators, and look at the feasibility of different surveillance methods. It would be to everyone's advantage - and also save scarce resources - to develop the system as a joint effort of the Member States with the support of the European Commission, rather than on a national basis. Some preliminary steps have already been taken in this direction by the Commission in unison with networks made up of experts and representatives of the Member States.

I would like to emphasise that we do not need information on the prevalence of psychiatric disorders alone. The multidimensionality of mental health is such that we must also collect information on positive mental health and on mental health in special settings: in health policies, promotive and preventive practices, health and social care systems, schools, families, workplaces and even in prisons, just to mention some examples. Only then can we hope to penetrate more deeply into the complicated social and societal processes that determine mental health and mental ill-health, and measure the success of our undertakings. The participation of non-governmental organisations, users, carers and family members in this work is essential.

Comprehensive data on mental health systems, activities and well-being would eventually give us a unique set of data with a real interface between policy, practice and the everyday life of European citizens. We would have the means to create resources for the development of health policy, research and practices. I am convinced that such a unique exercise would, in the end, be useful for other areas of health policy, too. Cross-country comparisons would be par-

ticularly valuable here. I, therefore, very much look forward to the first report on mental health in Europe, as this will give us a good starting point.

Another aspect I would like to bring up is even more practical. It concerns the dissemination of good practices, including quality in mental health. Mental health programmes are not developed overnight: according to one estimate, it takes 15 years from the first idea to the final implementation of a programme in a health system. Such programmes have to fulfil numerous requirements, and in mental health the processes are very slow and very demanding. Especially challenging is the fact that the results can often be evaluated only after several years. And - let us not forget - long processes cost money.

We particularly welcome European collaboration in the prevention of mental health problems among children and young people. I should like here to refer to a pioneering study on parenting support made in Finland by Professor Terttu Arajärvi and her co-workers back in the 1960s. The 15-year follow-up study showed that parenting support not only improved the mental health of children and young people but also prevented juvenile delinquency and other social problems. This outcome was reached after only a relatively small amount of parenting counselling carried out in homes by specially trained mental health nurses. We understand the importance of the study today when we look at it against the increase in social, mental health and drug problems among adolescents.

In other words, good research on the promotion of mental health has been done for many years. Unfortunately, the number of actually implemented international mental health programmes giving us a model on which to build up our activities is still rather low. European cooperation will provide added value in this respect and benefit all partners. In Finland, we have implemented two major programmes in the field of mental health during the last 20 years: one on schizophrenia and one on suicide prevention. Both of them were national, multisectoral, properly funded, of sufficient duration (over ten years) and carefully evaluated. The results have been extremely useful.

Finally, I should like to pose one more question. Having noted the importance of mental health for public health in the light of statistics on mental disorders, would it not be desirable for the Commission to give Recommendations on mental health?

I am convinced that we would all stand to gain. Most important, these Recommendations would help us to clarify our concepts and create a contextual framework for future discussions. They would also help us to look at the field in a more comprehensive way. I am, of course, aware that subsidiarity in health matters makes this a rather delicate task. Finally, by presenting Recommendations on mental health, the European Commission would signal the importance of mental health, not to Member States alone but to the entire international community.

Honourable participants, Finland is therefore pleased and honoured to host this conference. Your very presence here has shown that the importance of emphasising mental health is widely understood and acknowledged in Europe. We are grateful to all of you for the encouragement and support you have given us. The Commission, the Parliament and the Member States have all been involved in making mental health a more visible issue on the European Union's public health agenda.

I wish you all a very pleasant stay in Tampere and a productive conference.

Thank you.

Mental Health as a part of future community action in the field of public health

David Byrne, European Commission
Commissioner for Health and Consumer Protection

Minister,
Director-General,
Ladies and Gentlemen:

The Finnish Presidency is to be congratulated for taking the initiative to hold a conference on the promotion of mental health and social inclusion. And I am very pleased to present the views of the European Commission in the matter.

I am only a few short weeks in office. But, I consider it the most important part of my responsibilities to bring Europe closer to its citizens. The EU has done a great deal in promoting European integration and citizens have benefited in the process. I can point to the Single Market and Economic and Monetary Union as just two examples.

However, the EU has been far less successful in making its presence felt in citizens everyday lives. They often have difficulty in seeing the benefits of the EU in their day-to-day concerns. We are seen as remote, uncaring, bureaucratic and concerned only with trade, business and competition.

This has to change. And, it will not change through a public relations exercise. Instead, we have to prove to our citizens that we can bring benefits to the things that really matter to them - the safety of their food, their environment and of course their health.

Finland has shown the initiative during its Presidency to hold a number of important conferences on issues which matter to people. This conference on mental health is a fine example. I know that I am in the presence of many experts in the field of mental health. I will not therefore spend much time in speaking of the seriousness of the problem of mental illness in society. Or of the huge suffering it causes to so many citizens. Or the many measures which take be taken to address the problem.

Instead, I will speak of the role the EU can play in making a real contribution to promoting improved mental health.

I have already stated in front of the European Parliament that "I am actively looking at the possibilities for improved promotion of mental and physical health. As a guiding principle, I believe that we must target our measures at the biggest threats to public health. In this respect, mental health merits consideration as a focus of future actions".

Mental health and physical health are closely linked. I agree with the conference statement that "There is no health without mental health." This statement was also emphasized at the joint European Commission and WHO conference on balancing mental health promotion and mental health care which took place in Brussels earlier this year.

The European Union's public health mandate

The European Commission acts on a very focused legal basis in public health. It was not until

1993, when the Maastricht Treaty establishing the European Union came into force, that the Community gained a specific competence in public health which allowed the creation of a coherent Public Health Strategy.

Article 129 of the Maastricht Treaty stated that emphasis should be given to Health Promotion and the Prevention of Diseases. On this legal basis, in March 1996, the European Parliament and the Council adopted a program of Community action on Health Promotion, Information, Education and Training, with a total budget of 35 MECU for a period of 5 years.

The Treaty also emphasized that health has to be taken into consideration in all Community actions, for example in the fields of education, social affairs, environment, employment and communications. This aspect was clarified and strengthened in the Amsterdam Treaty.

This is where the real potential to promote mental health at the EU level lies. We have to escape from the past tendency to deal with mental health within the narrow confines of our healthcare systems. Of course, our health systems have a critical role to play, especially in addressing mental illness. But, as you know, the real gains are often to be made in our education systems, in housing provision, in employment policies and perhaps most of all in how society perceives mental health.

EU policies all touch on these areas to a greater or lesser extent. Some clear examples are our policies on employment where the Community's Social Fund is used to provide assistance towards the re-integration of persons who are disadvantaged, whether physically or mentally.

Another clear example is the Community's policy on research and development. Under the fifth framework programme there is a strong emphasis on the human dimension. There are opportunities under this programme to be exploited which can lead to improved solutions to mental health issues.

I could cite many more examples. The point I am making is that *all* Community policies should be closely monitored for their potential contribution to mental health. There is now a clear Treaty obligation to take health into account in all these policies and we must all be vigilant - especially me - that this takes place.

Turning to my own specific responsibilities, at the moment preparations are under way to outline the future public health framework beyond the year 2001. The discussions and feedback on the Commission communication on this matter from April 1998 provides a good basis for this work.

At present mental health is not explicitly given priority in the current public health framework. For example, while there are programmes on Cancer, AIDS, drug prevention etc, there is no specific programme on mental health.

However, under the Health Promotion program major projects are implemented in this field. Also, under the Health Monitoring program, much emphasis have been given to mental health issues, and I am pleased that Finnish expert organizations have taken a very active role here.

Why mental health?

As I said earlier, you need little reminding of the damage caused by mental illness. It results in an immense deterioration of the individual's well-being and severe suffering at all levels of society - personal, family and society. It also affects our working capacity, our social relations, our family life. It is a leading cause of invalidity.

The financial costs, both direct and indirect, are also huge. As our social protection systems come under ever increasing pressures, there are clear incentives to try and address the problem of mental illness in a more cost-efficient manner.

One of the major reasons for setting up this horizontal action program was to develop possible ways for containing the cost explosion in health care. Today the total health care expenditures in Europe amount to 5 to 10 % of the GDP and there is a continued tendency for these costs to rise.

The reasons for such an increase in the health care costs include an aging population, new and more expensive medical technologies and drugs and a rise in expectations of health care at all ages.

When drafting the proposal for the health promotion program, it was thought that one answer to the explosion of health care costs could be found in Europe-wide policies. Well educated and informed European citizens want to take more responsibility for their own health. They are aware that decisions on life style (e.g. concerning smoking, following a balanced diet, keeping themselves mentally and physically fit) contribute to better health and keep them out of hospital.

This clearly has huge potential in terms of improved health and longer life expectancy. Our challenge is to make these healthy choices available in an appealing and affordable way to as many people as possible. All this also applies in the mental health field.

In implementing the Health Promotion and Health Monitoring Programs the Commission has focused significantly on mental health.

The first concrete priority has been given to mental health promotion for children up to 6 years of age. The objective of this project is to identify models of good practice in the Member States and to develop European policies based on these experiences.

We have fifteen Member States. All have their own approach to these issues. While there is a very strong cultural dimension to our approaches and experiences in mental health, there are still lessons to be learned from one another. This is where the real value added of Community action lies - learning from one another successes and failures.

The focus on pre-school age developments of this project is of prime importance for the later healthy development of children and their families. Parental influence plays a key role in the mental health of a child. It has been proven that early attention and care is essential. This in turn has decisive and long-lasting effects on how people develop and learn, how they control their own emotions and how they cope with stress. Supporting the development of self-esteem and providing a good basic of security during the years of growing up are essential for any child.

Another project supported within the framework of the health promotion program was the clarification and determination of key concepts in mental health and mental health promotion.

For taking this project forward a European Network on Mental Health Policy was established to collect information about existing relevant databases, information systems and indicators and to give recommendations concerning data collection.

The objectives of the network were threefold. First, to create a European mental health monitoring system with specified indicators. Second, to establish unambiguous definitions of those indicators and finally to assess their feasibility and usefulness.

Another project, the key concepts project, has dealt with all aspects of mental health. These include the environments, the relevant population groups and the sufferers of mental ill-

health and mental disorders such as depression and schizophrenia. This project has identified a significant challenge in mental health - the need to develop quality indicators and criteria for health and social services to evaluate and measure the effectiveness and efficiency of mental health promotion activities.

The conceptual clarity in the mental health field and the indicators to measure the effects of mental health promotion and care must be further developed. As a step forward, European definitions on mental health and mental ill-health will be developed. It is vital that these will are understood not only by mental health experts, but by the health policy makers, too.

Based on these reports the Commission is planning to develop recommendations to the Council on the promotion of mental health with a specific view to take account of mental health aspects in all policies. This refers back to what I said earlier about ensuring that mental health is not confined to a narrow role. It should and must be a consideration in all relevant policies.

Furthermore the Commission in close co-operation with the relevant European networks develops policies on how to tackle mental health problems related to unemployment in Europe. These policies aim at:

- improving the mental health and well-being among individuals, families and communities affected by unemployment;
- raising awareness among the different stakeholders about the multiple links and complex interactions between mental health and unemployment;
- effective dissemination of the results and recommendations set up within this project.

In pursuing these goals all relevant actors and parties have to be committed to secure and strengthen:

- effective ways of support, consulting and counselling, including self-help measures, for unemployed people and those facing the threat of losing their jobs;
- effective approaches to develop work environments in a way that takes into consideration the special needs of the ageing employees, the disabled and of persons with mental health problems;
- the identification of models of good practice;
- the enhancement of co-operation between different actors and stakeholders;
- the support for a wide dissemination of innovations in the field.

This Century has seen impressive increases in life expectancy in the Member States of the European Union and yet in all countries we are experiencing considerable and increasing differences in health between different social groups. These inequalities in health are rooted in the social, economic and environmental living conditions of the people. The Commission is taking this challenge very seriously. In tackling the issue we should consider for example:

- advocating social policies that improve health;
- creating healthy settings for living and working conditions;
- encouraging community development for health;
- enhancing personal health skills;
- building responsive health services that prevent as well as cure.

Mental health is already on the agenda. However, better and clearer understanding of mental health problems is needed. Here we need comparable and reliable information which will allow us to further develop mental health policies.

I am sure that mental health will remain high on the health agenda of the European Union and the Member States. I am also confident that this issue will have a significant place in the development of the new Community public health framework for action which the Commission is at the moment preparing.

Mental health in all Community policies

John Bowis, United Kingdom
Member of the European Parliament

There are some statistics which are engraved on my heart.

- In the UK as in Finland more people die by their own hand than are killed by road accidents.
- Of the ten leading causes of disability five are psychiatric with unipolar depression alone counting for 10 % of lives lived with disability.
- The percentage of the global burden of disease attributable to neuropsychiatric disorder is 10,5 % rising to 15 % by 2020.
- In 2020 it will have overtaken cardiovascular disease.
- In the UK we lose 92 million working days a year through mental illness.
- The cost to our nation alone is over £20 billion in health care, social care and social benefits; and probably more if you include the cost to individuals, carers and the nation of lost earnings.

In human terms one in seven of us have some form of mental illness, one in three of us will do so during our lifetime and one in two of us will be directly affected by illness in ourselves, our family or our close friends. One in three of us visiting our family doctor has a psycho-social disorder; only one in six of us has it diagnosed by that doctor.

In personal terms, it could be me or my elderly mother, or my wife, or one of my children. That is why, as Health Minister, as MP and now as MEP, I wanted and want to ensure that my family and all families in Europe have access to good quality care and treatment, in human conditions and as near to home as possible. And I want it with dignity and without stigma. I want effective system with the three prongs of prevention, treatment and rehabilitation.

That is why I am pleased to be in Tampere and it is why I have been singing Finland's praises for the past two years. This conference's success will be measured by its outcome as we move to the Portuguese Presidency, then the French Presidency and beyond.

The world has not been very good at mental health but now the United Nations, WHO and the World Bank have seen, learned, understood and made it a priority. Europe has not been very good at mental health and it is important that Western Europe helps Eastern Europe with the costs and expertise of meeting high standards in mental health. I doubt whether this is compatible with wholly insurance based health care systems.

I am optimistic on three counts: 1. The Finnish initiative, 2. The Treaty of Amsterdam, 3. The IUHPE report for the Commission on the effectiveness of health promotion.

You know in Finland, from the North-Karelia initiative on coronary heart disease that, as the Ottawa Charter says, that knowledge leads to self-help and self-help leads a healthier community.

We can protect our own mental health by learning to live healthier lives and to pace ourselves. Employers can help with good mental health work policies. Doctors can help by recognising

symptoms in their surgeries. The media can help by promoting understanding and not horror when something goes wrong.

Governments can help with their programs on employment and poverty and by seeing for example the importance of housing, rural transport and social benefits to a mental health care package.

Europe has a crucial role, not in running health services or seeking uniformity, but in collecting and sharing best practice on promotion, prevention and provision. Post-treatment rehabilitation and re-integration, with training, jobs, housing and money are also part of illness prevention. With mental health we must go further than physical health. With a latter you catch something, have it cured and that's it. With mental health, you build up to a problem, reach a crisis, receive treatment, are discharged. Then you live with it in periods of calm interspersed with bouts of turbulence. Mental health promotion is inextricably intertwined with health care. So we must look at the range of the facilities needed and we must listen to service users.

We must also do more research on effectiveness, measurements and cost effectiveness if we are to convince Finance Ministers and budget committees that they should invest now for mental health later. To follow Tampere, Council and Parliament must support the Commission by providing them a budget line on mental health. If they are looking for a source of finance, then I suggest they take some of the 960 million Euros currently spent on subsidising tobacco growing. It is outrageous set against the 35 million Euros currently spent on health.

We need Europe at long last to take up the mental health baton and run with it. Thank you Finland for firing the starting gun.

Mental health is public health: need to enhance the value and visibility of mental health

José M. Caldas de Almeida, Portugal
New University of Lisbon

Health is one of the most — if not the most — valuable treasures of human beings and mental health is an essential dimension of this treasure.

Mental health and physical health are inseparable from each other and both of them are mandatory dimensions of health in general. Mental health, however, is not only a mandatory dimension of health. It is also the dimension of health which is more closely connected with the most specific capacities of human beings — the capacity to think, to establish affective relations of interdependence with others, to create, to produce culture, to find a meaning to existence.

For this reason, mental health has a special importance in the development and the differentiation of individuals and communities. Mental health is not only one of the main challenges in public health; it is also a decisive issue in the future developments of our societies. One part of the importance of mental health has to do with the consequences of mental disorders — which, as we know today, are extremely negative. Mental disorders are responsible for enormous suffering at the individual level, for a good part of the disabilities caused by illnesses, for inflicting huge burden and dysfunctions on families and for a significant part of the direct and indirect costs to society of illnesses in general.

However, the burden of mental disorders reflects only a part of the importance and the impact of mental health issues. In fact, mental health is not a simple absence of mental disorder, but something that has to do with capacities and qualities which have a value for their own (regardless of the existence or not of mental disorder) — for instance, the ability to adapt to change, to manage the situations of crisis, to establish meaningful relations with others, to enjoy life — and that must be seen, mainly, as a state of equilibrium and harmony at the levels of the internal psychic life of individuals and of their interactions with the environment.

From all the fields of science we receive the same idea: order and disorder, in open systems, are not entities placed in opposed poles of the same continuum, one excluding the other; order and disorder are dimensions of the same process, with complex relations between them.

Therefore, it is the paradigm of current science itself that leads us to a more complex, comprehensive and less dichotomic view of health and illness. And that helps us to understand the real dimension of the importance of mental health.

Of course, the quantification of the impact of some aspects of mental health is much more difficult than the quantification of the burden of mental disorders.

It is impossible to have an exact estimation of the impact, to individuals and societies, of family support in the first years of life, of social support in situations of crisis, of unemployment and social exclusion, of violence on women, and of so many other aspects closely related to mental health.

But it is easy to understand that all these aspects can have a tremendous impact on the happiness, the creativity and the harmony of people and societies.

As the philosopher Ortega e Gasset said, to understand a man it is to understand the man and his circumstances. That's why mental health, the most specifically human dimension of health, must be understood as a result of the interaction between personal factors — genetic factors, childhood experiences, personality — and factors related to the circumstances in which that person lives. Therefore, mental health must be built and protected, day by day, by all of us — politicians, professionals, citizens — and in all places — homes, schools, workplaces, etc. The problem we have to face is the following: are the different people involved in this process, in general, aware of the real importance and impact of mental health in current societies? Has mental health the place it deserves in our scale of priorities?

The answer, unfortunately, is a negative one. At all levels, mental health occupies a very modest place in the rank of our priorities. In spite of all the advances registered in the last decades in economic and social areas, in spite of the spectacular advances registered in health — which have given valuable benefits to human beings —, it has been and it still is very difficult to overcome many of the problems that occur in the mental health area (even after so many progresses have been made in the treatment of mental disorders).

This means that we must urgently find ways of enhancing the value of mental health (understood as an essential dimension of the state of equilibrium and well being we call health) and find ways of enhancing the visibility of mental health (understood as the actions which can facilitate the development of the above mentioned state of equilibrium and well being).

What can we do to attain these objectives, that experience has demonstrated to be so difficult to attain?

The first thing to do is trying to understand which are the obstacles to a correct understanding of the value and an adequate visibility of mental health in our societies. If we identify and understand the nature of these obstacles it will much easier to find the most appropriate strategies.

The main obstacles

There is one universal fear among human beings — the fear of contacting with psychic suffering and psychic disorder, the fear of thinking about the problems related to mental health and mental disorder.

It is an understandable fear if we take in consideration the threats that many of the phenomena of our complex psychic life represent to the vulnerable and fragile beings we are. But this fear has also a significant responsibility on the stigma of mental illness and on the general belief according to which there is little or nothing we can do to protect and promote mental health. For these reasons, this universal fear is one of the main obstacles to a correct understanding of the value of mental health.

Another important obstacle has to do with the influence that the strict biomedical model continues to have on the training and the practice of health professionals.

The so-called biopsychosocial model has apparently become universally accepted: it is difficult to find someone, nowadays, openly contesting this model. However, in the universities, in

health services, at the operative level, the psychosocial component still continues to be undervalued and dissociated from the biologic component of health and illness.

This means that, in medicine, a true change of paradigm has yet to occur. And it explain why so little is done, in most places, to involve the individuals and the communities in the protection of the great treasure that mental health constitutes. This is made even easier by the fact that in our societies — and here we have another important obstacle — people tend, more and more, to believe that technology will solve all problems — including health problems — and that their active participation is dispensable.

The main goals

To enhance the value of something means to influence the way people understand what is in question regarding that same thing. In other words, it means to contribute to the correction of distorted visions and to the promotion of knowledge in ignored aspects of the reality.

Therefore, if we want to enhance the value of mental health, the first priority is to convey to people a message that they have not yet received in a effective way.

So, in the first place, we must do whatever is possible to assure that our messages about the value of mental health will be clear and easy to understand. On the other hand, we must learn to use in the most effective way all the available means of communication — from the most simple and traditional to the most sophisticated and modern ones.

To enhance the visibility of mental health, we have to assure a higher position for mental health in the rank of priorities.

But this is not enough: we have also to ensure that some actions aiming at the promotion of mental health will be implemented.

Therefore, the mobilisation and involvement of people in the implementation of these actions is the second important goal in our task. We must try to mobilize, in first place, the key persons in society — those who, by their power, their enthusiasm or their influence, may be particularly helpful in our efforts to influence decisions and to find resources. But, as everybody is important to the promotion of mental health, we must also find ways of mobilising the public in general.

With these two main goals in mind — to convey the right messages to people, on the one hand, to mobilise and involve people, on the other hand — we will be able, then, to find the strategies which are the more appropriate to attain these goals. These strategies can have some variations according to the characteristics of the country or the region where we work. However, regardless of the place where we want to enhance the value and visibility of mental health, there are some priorities that we must always take in consideration in each of the different levels of intervention.

Priorities in the different levels of intervention

At the conceptual and research levels - Change of ideas is the most effective instrument in the enhancement of the value and visibility of mental health. We can say that everything else will follow.

This means that all efforts must be done to create and disseminate new knowledge.

The studies developed in the last 20 years in the areas of epidemiology and evaluation of mental health interventions allowed us to accumulate a significant amount of data, which has

been most valuable to demonstrate the importance of mental health problems and to prove the effectiveness of many mental health interventions (at the treatment, preventive and even mental health promotion levels).

However, these studies are not so largely known as they should be, even by mental health professionals. So, it is urgent to assure a larger dissemination of the knowledge that already exists and to create the conditions that are needed to develop more studies. For this last purpose, it is specially important to assure a more balanced distribution of the resources allocated to research in mental health and to get more support to areas as epidemiology and evaluation of preventive and promotion interventions.

At the political level - The existence of a national mental health policy is a fundamental contribution to the enhancement of the value and visibility of mental health in every country.

A mental health policy must be well integrated in the general health policy and must have the necessary articulation with the policies of other sectors (education, social area, etc.). The important thing is that this policy includes a clear formulation of it's goals, strategies, principles of action and programs, at the level of mental health care and at the level of preventive and promotion activities. It is equally important that an appropriate balance between these different levels of intervention is assured. The existence of a national mental health policy — if based on a discussion with the participation of professionals, users, relatives and representatives of different sectors — contributes not only to the rational use of resources; it contributes also to the creation of new consensus and synergies, which are extremely important to the promotion of mental health.

The existence of a specific office for mental health in the Ministry of Health can be very helpful to the implementation of the mental health policy. This office must be technically prepared to plan and evaluate mental health programs and must have the capacity to defend the interests of the mental health sector in the processes of decision regarding the division of resources, the co-ordination between sectors, etc.

In some countries, national and regional councils for mental health have been created. These councils, integrating representatives of all sectors involved in mental health issues, can certainly give a good contribution to the discussion, the definition and the monitoring of mental health policies.

At the legislative level - Most European countries have specific mental health legislation. Some have, in the last years, reformulated their legislation and approved new mental health laws. These laws, in general, include the main goals of the mental health policy, the definition of the rights of people with mental health problems, the regulation of compulsory treatment and, in some cases, the organisation of mental health services.

There is some discussion about the advantages and disadvantages of laws which are specific to mental health, because they could contribute to the dissociation of mental health from health in general. This is a relevant question. But, at the present moment, I think that the advantages outweigh the disadvantages. I even think that mental health laws can give a crucial contribution to the enhancement of the value and visibility of mental health, specially if they include a clear formulation of the goals to be attained in the different areas of mental health — care, prevention and promotion.

Firstly, because they contribute to make the protection of mental health and the defence of the rights of people with mental health problems a precondition for full access to citizenship.

Secondly, because they can play a decisive role in the development of mental health care of good quality. Finally, because they can have a positive influence on the involvement of the different sectors of society in the promotion of mental health.

Relevant contributions can also be given by legislation related to other areas which have significant implications on mental health of the populations. This is the case, for instance, of the laws that promote support to families, education, employment, quality of life, etc.

The existence, among members of Parliament, of people specially interested on mental health can be of great help in the promotion of laws taking in consideration the importance of mental health. Another important contribution to this objective can be given by mechanisms assuring that the opinion of those responsible for mental health is taken in account during the process of elaboration of these laws.

At the level of health services - The specialized mental health services can have a relevant role in a strategy aiming at the enhancement of the value and visibility of mental health.

Firstly, because mental health care of good quality may help to rehabilitate the image the public usually has about mental health services, may help to fight the existent stigma and may help to show that it is possible to develop effective interventions in the mental health area. Secondly, because mental health care of good quality means community-based care, means the involvement of the populations, and this involvement can be used to develop actions of mental health promotion. In other words, if the mental health services are real mental health services, with the capacity to integrate care, prevention and promotion — they will contribute to the enhancement of the value and visibility of mental health.

Of course, the specialized mental health services can just do a part of what is necessary to do and the co-operation of other sectors of health services is absolutely essential in mental health. Primary health care, particularly, has a very important role in mental health care, and in mental health promotion, because of the proximity and continuity of contact that exists, in this level of care, with individuals, families and communities.

For all these reasons, although mental health depends on much more factors than health services, the truth is that in order to enhance the value and visibility of mental health it is important to have services that are able to provide good mental health care. That's why, it still is necessary, in many countries, to fight for the reform of mental health services and for the development of mental health in primary care.

At the level of health professionals training - The improvement of mental health professionals training is one of the measures that must be considered in a strategy aiming at the enhancement of the value and visibility of mental health. In spite of all the advances that occurred in this area, many professionals continue to be trained in a way that does not assure a correct preparation to manage mental health problems and that does not motivate them to work on health promotion. Therefore, it is necessary to promote the integration of mental health in the new curricula and to develop new and more effective models of training.

At the level of education, social services and other sectors - Mental health depends on many other sectors than health. Among these sectors, a special reference must be made to education, social services and employment.

Education, because a good part of the responsibility for the transmission of knowledge, values and culture and of the opportunities of social interaction for children and young people belong to schools. Therefore, schools have a large participation in the building and protection of mental health.

Social services, because it is their responsibility to provide a large part of the support given to people living situations of vulnerability and exclusion – situations representing special dangers to mental health.

Finally, employment, because of the well known influence that work has on mental health.

If we want to enhance the value and visibility of mental health, we have to find effective ways of facilitating the co-operation of these sectors. This can be done, for instance, improving the training of their professionals or developing the articulation between them and the mental health professionals. All this has to do not only with public services but also with NGO's, which have a growing participation in mental health interventions in European countries.

At the level of the media - The media are fundamental in the transmission of information. So, it is necessary that newspapers, televisions and radios receive regularly information that can help people to better understand the main mental health issues.

The organisation of information material specially prepared to the media and the development of actions to raise the awareness of journalists towards mental health are some examples of what can be done in this domain.

In our societies it became more and more common the involvement of public personalities in initiatives organised to promote noble causes. This kind of initiatives has also been used in the promotion of mental health and it will certainly be even more frequent in the future. In the area of mental health, the involvement of patients' relatives in promotion initiatives is specially important, because they know better than anybody the value of mental health. The cooperation of artists is also important because, through art, people can understand some aspects of mental disorder and mental health that would be very difficult to be communicated in other ways.

Finally, we should not forget how important can be small initiatives at the local level – cultural activities, distribution of information etc. – to convey information on mental health to the people.

At the level of international cooperation – I would like to stress, in a very particular way, the importance of international cooperation in a strategy of enhancement of the value and visibility of mental health. In fact, when I look to the evolution of mental health in my country, in the last 25 years, I can find very good examples of the impact of international cooperation. WHO has had a decisive influence, mainly in the areas of mental health services organisation and evaluation, development of mental health in primary care and epidemiology; the European Regional Council of the World Federation for Mental Health gave a significant support to the development of the national mental health association and to initiatives like the celebrations of the world mental health day; the European Commission gave very important contributions, namely in the area of employment, where the Horizon program had a very significant impact.

The initiatives developed by the European Union, in the last years, in order to include mental health among the main goals in public health have already given some good results. However, a lot more can be done; and I am sure that this Conference will help us to find out which are the best ways of the European Union to contribute to the enhancement of the value and visibility of mental health.

Invited comment

Marc Servaes, Belgium
Ministry of the Flemish Community, Public Health Department

First of all I want to thank professor José Caldas de Almeida, for his presentation especially because he brought together in a very clear way what priorities in the different levels of intervention we should focus on in order to make mental health a greater priority than it is today.

Your points, professor, are so well elaborated that it is difficult for me to comment on it.

Perhaps I can stick to the next three points
1. the context of your presentation: what is the meaning of our strategy-approach
2. a comment on the statement: mental health is public health
3. to share our experiences on how to build bridges between different sectors.

1. What is the meaning of our strategy-approach

The first point starts with a question: How is it possible that mental health takes such a low priority in our policies. And how can we decrease the gap between the real value of mental health and the value (or shall I say the money) it gets when priorities are translated in budgets.

I think we made the right choice in our approach using modern concepts of policy-making as they are evolving in Europe.

I refer to the common thought that modern budget spending and policy making should respond to the demands of economy, efficiency and effectiveness.

Within this framework we come to questions about values, added value, value for money, we better understand the urgent need to build monitoring systems to guide us in our efforts to assess the needs of our citizens and to monitor the effects of our work, we search for answers to the questions asked in order to provide evidence of effectiveness of our same efforts, thus making things more visible.

These are exactly the topics we will speak about in our plenary session today. And I feel the use of these methods is very helpful for making good policies, for making our problems understood and for achieving results. Policy-makers, government, parliament and citizens understand this way of thinking very well, and our own experience is very much in favour of this approach.

This is my first comment: I felt it useful and necessary to give the questions of value and visibility the place it deserves in our strategy-approach.

2. Mental health is public health

My next statement or comment is about the theme: mental health is public health as it is mentioned in the title of our activities today.

This statement was also the major conclusion of the joint world health organisation and European Commission meeting held in Brussels 22–24 April earlier this year.

It is of extreme importance to stress this point, but perhaps it is also necessary to explain why this is so.

For me this statement is so important because it gives mental health an identity, different and better than the one it had before. It opens the gate, or better said, it keeps the gate open for our patients to social security, to the health budget.

These are two very important points.

My question here is: What is the exact place of mental health, mental health care, mental health prevention and promotion, what is the impact of models on these policies?

Professor, you raised this question when talking us about the main obstacles. Reminding us of the time not so long ago that mental health was not seen as a health matter at all.

I think the impact of the models you told us is indeed a very huge one. There is a direct relationship with the value-issue.

The religious model lead to both charity and rejection, the security approach to isolation. The medical model lead us into health care, health insurance, but today we recognize that this model is as you told us far from perfect. The social model had an impact on the development of community psychiatry, but is also responsible for the progress made in the preventive and promotion area.

So if there is one lesson that we have learned throughout history, it is that we should be well aware of the extreme importance there is to estimate well in advance what the impact of our chosen model will be:

We cannot go back to the time that mentally ill patients were dependent from charity, having not the same rights as somatically ill patients, our model should protect from dependency and the risks of marginalisation.

You told us that the biopsychosocial model is the model that has become universally accepted, that has the greatest intrinsic value.

But does this model fulfil the demands we just pointed out?

I think we do not have here clear-cut answers: the biopsychosocial model places us at the crossroad of health and social policies, the risk is indeed that mental health policy drops in between them.

So I think with you professor we should make our mental health care prevention and promotion policies strong enough to avoid these problems and I don't see other ways than the one you showed us when pointing out your priorities in the different levels of intervention.

So my comment here is that the model we chose is very important, not just as an obstacle but as a starting point for policy, legislation, provision of health services etc. The value is within the model we choose.

3. Our own experiences on how to build bridges between different sectors

At the policy level, you told us that a mental health policy must be well integrated in the general health policy and must have the necessary articulation with the policies of other sectors (education, social area, etc.). This is indeed the only way not only in mental health care but even more so in mental health prevention and promotion.

I want to share with you the way we in Flanders try to build the bridges between these different sectors in order to do so. I will give two examples.

First we have policy-networks bringing together policy-makers from these sectors. We have, for example, an official agreement between our department and the ministry of justice, bringing together in a interdepartmental working group responsible for the fields of education, sports, welfare, health, and others together with the responsible persons from the ministry of justice in order to formulate common goals, strategies and principles of action and programs, just the way you recommend us. This is for us an extremely effective and efficient way of working.

A second example is about the approach in our prevention and promotion policy. We try to think globally and to act locally. Globally: we have a central agency, that brings together know-how and that gives advise, and helps us developing more comprehensive prevention and promotion strategies. Locally, we try to establish local agencies which bring together those locally responsible for the realisation of our health targets, both in the somatic and the mental health field. We call it the logo's (locoregional agencies).

Need for a comprehensive mental health monitoring system in Europe

Viviane Kovess, France
MGEN, DRESP

1. Introduction

European Parliament and Council launched an action programme on health monitoring within the framework for action in the field of public health [COM(95) 449 final]. The main objectives of this Programme, which was adopted by the Parliament in June 1997, were:

- to establish a set of Community (core and background) health indicators for monitoring health in the Community that would facilitate the planning, monitoring and evaluation of Community programmes and actions, and that would provide added value to Member States' own health information systems, thus supporting the development of national health policies;
- to specify the content of a network to be set up for the collection and dissemination of health data and indicators, mainly with the aid of telematics; and
- to establish a capacity to undertake analyses, and to support the preparation and dissemination of reports on health status, trends and determinants and the impact of policies.

Mental health is mentioned under the heading 'Functioning and Quality of Life' as one area for which health indicators might be established under a future Community health monitoring system.

This presentation is embedded in a two-year action project to establish indicators for mental health monitoring in Europe in order to fulfil the objectives and principles of the Community action programme in the specific field of mental health monitoring of the population. The aim is to collect information on existing mental health and well-being indicators and information systems, and agree on harmonised definitions for European mental health indicators, which can be integrated to comprehensive health monitoring systems. A literature review made by J. Korkeila was used in preparing this presentation.

This project follows another EC-funded project on key concepts for mental health promotion in Europe.

2. Indicators

2.1. A comprehensive health monitoring system

A comprehensive health monitoring system must cover the multi-faceted aspects of mental health. The following are the basic starting points of the project:

- Need for unanimously defined indicators describing the different aspects of mental health (e.g. affect, personality traits, psychological resources, emotional resilience) as well as its interactional and societal prerequisites or consequences (e.g. human relationships, social and physical environment, level of well-being, quality of life, public safety, need and use of services)

- The system must be sensitive to change and cultural differences
- Different mental health activities (policy, promotion, primary, secondary and tertiary prevention and prevention of excess mortality) must be covered by the system
- The mental health monitoring system must be an integrated part of a comprehensive community health monitoring system
- The system must include indicators to describe relevant aspects of the structure, process, quality and outcome of the mental health service system
- The system must have relevance for planning and political decision making.
- Citizen's participation and user's views are increasingly important elements in mental health today, which have to be taken into account if the needs of the population at large are to be served in the best possible way
- A comprehensive mental health indicator set will serve both the European Commission and EU Member States: It will enable the satisfactory follow-up of the mental health situation of populations.

A common indicator set for mental health monitoring enables establishment of joint efforts in the field of mental health, comparison of policies and activities in different Member States as well as evaluation and dissemination of good practices.

The system will also serve the planning of national and Community mental health strategies and policies, and contribute to evaluations of the impact of different mental health programmes. The deliverables of the monitoring system can also be used in the joint effort to enhance the visibility of mental health issues in the European context. This system can be used in collecting data for national health databases, and in defining the minimum amount of data needed for monitoring Community health.

2.1.1. Requirements for the indicators

Mental health indicator is defined as measure on the state and course of mental health; it is a variable that has been proved to be related to mental health and indicates a priority or a problem. These may be items in health surveys, statistical data gathered etc. and are often repeated measures.

The objective is to create a indicator set with **a few good** indicators that are valid and reliable (most crucial minimal set of indicators).

2.1.2 Areas covered by the indicators

Areas in need of indicators are those central to the definition of mental health: 1) predisposing factors, 2) precipitating factors, 3) social interaction, 4) individual resources and 5) individual experiences. The indicator set will have to cover these areas.

Tentative grouping of the possible indicator areas is presented below.

This grouping may be viewed as a frame to guide the choice of areas in need of indicators.

- Demographic indicators
- Social stress indicators
- Indicators of social support
- Indicators of positive mental health
- Indicators reflecting the subjective experience of the individual

- Indicators based on the need, use and demand for services
- Indicators describing disability and morbidity
- Indicators of mortality

A practical, and realistic goal is to have from each group selected the smallest number of indicators necessary to have reliable measures.

2.1.3 Quality criteria

The mental health indicators should have clear and unambiguous definitions, and be maximally feasible and acceptable for the use of different Member States.

The criteria by which each indicator is selected should be as clearly stated as possible. The indicators should be relevant for mental health policies in the Member States, as well as relevant for practical purposes. The latter refers to that the indicators should 1) provide a measure of variability between the Member States, 2) be sensitive to changes over time and 3) have relevance for the aims of the activities (promotion of mental health, prevention and treatment of mental ill-health) followed.

The indicators should be: specific, measurable, reliable, valid, realistic, practical, cost effective, evidence based and ethical.

2.1.4. Monitoring system

The aim is to create a set of indicators to monitor mental health. Monitoring mental health is defined here as systematic, repeated measures of matters related to the mental health of the population. However, monitoring systems implies the possibility to link interventions to outcome; this means that a parallel survey should describe any actions concerning promotion of mental health in any domains concerned by mental health even though causal inference will be difficult to establish.

2.2 Health data already collected by international organisations

Various international organisations collect health data that may be relevant to European mental health and to development of the monitoring system.

2.2.1. Eurostat

Eurostat has recently (Hupkens 1997, European Commission) published results on an investigation on the Coverage of health topics by surveys in the European Union. This report provides extensive information on all European surveys concerning matters of health.

According to the report, 26 surveys conducted repeatedly in 13 European countries contain questions regarding mental health topics (stress, tiredness, nervousness; anxiety; sleeping disturbance; suicidal thoughts). Self-perceived health is inquired in 37 surveys in 16 countries, social network in 15 surveys in at least 10 countries, participation/integration in 3 surveys, consumption of alcohol in 31 surveys in at least 16 countries, heavy drinking in 11 and frequency of drunkenness in 7 surveys. Use of narcotics/psychotropic substances is inquired in 9 in at least 8 countries, abuse of alcohol/pharmaceutical products in 3, misuse of chemical due to drug dependency and exposure to drugs in 3 surveys.

These results underline the necessity of increasing coherence across countries in order to allow meaningful comparisons.

Actually, information on mental health are produced from four diverse sources:

1) The European Community Household Panel (ECHP) conducted by Eurostat, probes self-reported health in the EC. This panel started in 1994 and will continue until 2002 after re-evaluation. 129 000 persons aged 16 years or over (60 000 households) are followed in 12 European countries.

A few of the questions concern mental health: for example a global question on perception of health, impairment in daily activities because of mental or physical reasons, and hospitalisation within the last 12 months.

2) Eurostat is gathering data from national health surveys on 12 selected topics: chronic conditions, self-perceived health, long-term physical disability, activity limitations/temporary disability, height and weight, present smoking, former smoking, consumption of alcohol, physical activity, inpatient care, outpatient care, use of medicines. These variables are correlated with four background variables: sex, age, educational level, economic activity.

3) Causes Of Death
COD are desegregated by: sex, region (NUTS2), 5-year age groups, 65 causes of the European short list whose alcohol and drug abuse or dependence and suicide and intentional self harm are the most relevant

4) Data on health care
Number of beds in hospitals, number of beds in psychiatric hospitals by NUTS2 regions, overall framework for health care is being prepared.

More specifically a manual of health accounts is prepared together with OECD in order to harmonise collection procedure and classification: rearrangement of data according to "functions" and "providers", pilots carried out year 1999.

2.2.2. WHO-Euro

At the forty-eighth session of the WHO Regional Committee for Europe, in September 1998, Member States adopted the new health policy "Health21- the health for all policy framework for the WHO European Region- 21 targets for the 21st century". The meeting agreed to continue to regularly monitor and evaluate progress towards health for all (HFA), using appropriate set of common HFA indicators. A draft list was presented to the Member States for comments.

WHO Draft list - groups of indicators:
- mortality;
- morbidity;
- disability;
- selected maternal and child health indicators;
- other health status indicators;
- lifestyle indicators;
- environment indicators;
- health care resources indicators;
- health care consumption indicators;
- selected quality of care indicators;
- health financing and expenditure indicators;
- background demographic and socio-economic indicators

The report of the 1998 September meeting included two targets concerning directly mental health (numbers 6 and 12). Target 6: "By the year 2020, people's psychosocial wellbeing should be improved and better comprehensive services should be available to and accessible by people with mental health problems". Target 12: By the year 2015, the adverse health effects from consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all Member States.

It was recommended that the system of the HFA indicators should balance the future oriented needs of the HFA targets and the current data availability. The sources of data should be preferably routine reporting systems of Member States, to ensure feasibility and minimise costs. A major issue is the use of common definitions for indicators used by more than one international agency. Work should be done to harmonise, as far as possible, definitions and age groups with other international agencies and the relevant services of the European Commission using health indicators. The indicators should be valid, comparable and sensitive and, in addition, useful for the Member States themselves. According to the sources used by WHO suicide mortality data are available. However, comparability of other data as such data on attempted suicides between countries is very problematic. The problem concerning indicators of mental health is poor comparability and availability of data.

2.3. Other sources of data or models

For example

- the WHO 2000 mental health survey which is in preparation and concerns six European countries could serve as a reference.

This survey intends to use a revised version of the CIDI to implement severity and impairment due to diverse diagnoses and commune measures of use of services and drugs.

- The Canadian National Population health survey is a huge follow up survey conducted from 94 to 87 into three waves on 20 0000 households across 10 provinces in two languages which provide a sample of 9000 adults; this study is one of the rare survey which investigates positive mental health: sense of coherence, mastery self esteem as well as negative measures: distress, CIDI diagnostic (depression and alcohol), stress: work stress, acute stress, childhood stress, hassles and protective factors as social resources (network, social support, closeness).

This study was using operational measures and product data on incidence and consequently risk factors.

2.4. Recommendations

Ideally, measures in all areas described above should be collected in all European countries. However, we will propose a step by step process.

First of all we should make the best use of what is going on in diverse related fields at the EU level. Many indicators pertinent to mental health could be found in diverse projects and coordination with these projects is an absolute necessity.

A second advantage of this, is to integrate mental health into the fields of health, work, handicap, social fields. We claim here for a systematic participation of a mental health professional in any project dedicated to one of the following indicators:

- Demographics: all variables used for health survey are relevant
- Health status: cause-specific mortality, morbidity, health expectancy by ex: mental health expectancy using GHQ 12 Protective factors: coping abilities

- Lifestyles: smoking, alcohol intake, drug abuse
- Living and working conditions: social network, socio-economic status
- Prevention: health promotion activities
- Health and social services: utilisation and costs of service (hospitals, pharmaceuticals product, doses, duration and non-pharmaceuticals, psychotherapies and other therapies, general practitioners and specialists visits)
- Quality and effectiveness (systematic quality assessment of psychiatric care).

2.5. Specific proposal for mental health indicators

Step 1: simple and robust indicators which could be found in existing data bases

- Suicide rates
- Alcohol: death, sale per capita
- Drugs death because of drug abuse
- Sales of psychotropic drugs
- General health and impairment for mental health reason (ECHP)

Step 2a: Addition of a short list related to mental health to the European panel (ECHP)

- the global question on "feelings" (NCHS)
- GHQ 12 or six questions on distress (NCHS)
- Any care or Hospitalisation for mental health reason
- Social support if not any (3 questions NCHS)
- Life events short list
- alternatively SF 12 will cover physical and mental disabilities, some mental health questions and some social support

Step 2 b: Addition of a more complex set of questions in the labour force European survey (15 to 60 years) 11 possible variables

- The screening questions used by the WHO 2000 survey or entry questions of the UK survey
- Sense of coherence

Step 3: A specific mental health survey in Europe directed by Eurostat

This survey should be a longitudinal survey at least for a subsample; it should include the diverse levels of mental health: positive (feelings and personality resources) and negative (distress and diagnosis). A special emphasis should be given to severity and impairment and to use of the medical and non-medical systems. Determinants of health should be measured including presence of a physical health problem or handicap. The present WHO 2000 survey could serve as a pilot study.

Alternatively, an agreement should be made on sets of instruments for mental surveys conducted in the European countries: a "kit" on agreed instruments by dimensions should be produced: mental health (positive and negative), use of care, various determinants, and a method of reporting should be implemented including accessibility of anonymised files for Eurostat.

This alternative is probably far more difficult to set up and scientifically more hazardous.

3. Conclusions

There are many options which have to be discussed and accepted by the Member States.

One of the major issues is to enter mental health measures at any level of health surveys or collection of data.

To achieve this goal, we need to be able to present different "kits" according the data or space available.

These kits should be able to constitute an agreement among the scientific community and in the same time be simple and easily understandable; we should avoid to battle for inclusions of all which was considered as pertinent for mental health, since we should be operational, and look for variables which will be modified by promoting or preventive actions.

Because many effects are second order, we should never forget that mental health is a complex matter and causality could not be easily established.

Evidence of effectiveness in mental health promotion

Clemens M.H. Hosman, The Netherlands

Nijmegen University and Maastricht University

Introduction

Looking back over the last hundred years it is evident that our society in all kinds of respects is evolving more and more towards a prevention-oriented society. Accident prevention, burglary prevention, pollution prevention, fraud prevention, fire prevention, aids prevention, cancer prevention and prevention of sport injuries, those are words who were almost absent in the daily language of forty years ago. Nowadays we find them almost every day in the newspapers, television news, on posters and billboards and in the daily life of companies and local communities. This steady development towards a more preventive society is an irreversible process and this applies to the mental health sector as well. The dominating answer of the nineteenth century to mental illness was custody and care, the dominating response of this twentieth century was undoubtedly care and treatment. It is very likely that in the end the dominating answer of the next century will be prevention and mental health promotion. At least mental health promotion in balance with care. Striving for such a balance was recently the main recommendation of an EU and WFMH meeting in Brussels with representatives of care and promotion from 34 countries.

The mental hygiene movement, a worldwide movement for prevention of mental disorders and mental health promotion has nowadays a rich history of almost hundred years. It took, however, many decades until the late 70's and the 80's before a serious start was made with research on the effects of its interventions. The start in Europe was even much later.

There is ample reason to conclude that over the last two decades a lot of progress has been made in the development of evidence-based prevention and mental health promotion. Prevention science became a field of science recognized worldwide, with contributions from different disciplines, such as psychiatry, psychology, sociology, biology, neurosciences and health economy. There exists a range of specialized prevention and (mental) health promotion journals and prevention researchers are involved in international networks and multi-site studies across boarders, such as for example the Society for Prevention Research and the European Mental Health Promotion Network.

Without doubt there is still a very long way to go before there will be a full understanding of the long term and complex trajectories that lead to mental disorders and to the adverse social and physical outcomes of poor mental health. Nevertheless, there is already a lot of information available about malleable risk trajectories, mental health promoting conditions and effective, evidence-based interventions. To date, this knowledge offers a useful base to start with designing effective mental health promotion policies at national and European level. From such a policy, when implemented well, significant outcomes could be expected in the next decade not only in the mental health domain but also in several social domains who are narrowly related with mental health, such as school achievements, productivity at work, a safe environment, justice and equity.

Nowadays, many international organizations and European and even broader networks are contributing actively to the further development of this field. Being involved in a range of such organizations and networks, I have to conclude as well that the needed linkages between them are still weak, incidental and sometimes even not existing at all. All together, a rather inefficient structure. To make significant progress in our field it is of utmost importance to develop more efficient and targeted collaboration on a European and worldwide level. This conference in Tampere is an excellent start to improve this situation in the European region and I appreciate very much the initiatives of the European Network on Mental Health Policy to enhance the development of such linkages. Improving the collaboration at a worldwide level is one of the main aims of the first World Conference on Promotion of Mental Health and Prevention of Mental and Behavioral Disorders, to be held in the Carter Center in Atlanta at the start of December 2000. This is an initiative of the World Federation for Mental Health in collaboration with the Clifford Beers Foundation.

Systems for rapid international exchange of prevention knowledge and evidence-based model programmes are emerging. For example, supported by leading health research institutes, the international Society for Prevention Research has started an ambitious project to develop a Worldwide Registry of evidence-based preventive trials in mental health and addiction. In this Registry, available evidence-based programmes, evaluation studies, their outcomes, important effect predictors and the implementation history will be described in a standardized way. Such a system could become an excellent facilitator for international exchange of the latest knowledge and most successful programmes. We are trying to design an information exchange system that is easily accessible and supportive for policy makers, researchers as well as for programme providers in public mental health. It could offer a powerful tool to improve also in Europe the quality of mental health promotion practices and policies.

Slowly but steadily mental health promotion is becoming an accepted issue on the political agendas. I appreciate very much the large effort the Finnish government and our Finnish colleagues have put in getting mental health on the European agenda. In addition to that, I would like to refer to another ongoing, initiative to put health promotion on the European agenda. Just two weeks ago a new report came out for the European Commission and the European parliament summarizing the current evidence of health promotion effectiveness. This action was coordinated by the International Union for Health Promotion and Education. Mental health promotion and its effectiveness got a prominent position in this book.

The ultimate and most crucial question is of course: Is there any reason to be optimistic about the possibilities for effective prevention and mental health promotion, given the research outcomes over the past 25 years. In my view, the answer is yes, although we need to be cautious too and not overestimate the current possibilities, given the limits of current research and infrastructures for implementation.

What do we mean by effectiveness?

Before I will offer some examples of effective interventions, it is needed to reflect for a moment on the question: What do we mean by effectiveness? What could or should be **criteria of success** of mental health promotion and preventive interventions? The first answer is: there is not just one criterion for success or failure. There are many different criteria and it depends on the position and the perspective from which you look at mental health promotion: Policy makers, financing agencies, researchers, practitioners and programme providers, consumers

and community leaders. Their interests in prevention and mental health promotion will be partly overlapping, but certainly they will use different criteria for success as well. Health insurance companies might be especially interested in cost reductions, departments of health in reductions in psychiatric morbidity, such as depression and suicide, and social services departments in its consequences for welfare benefits. Departments of Justice might be more interested in the social outcomes of improved mental health and reductions in mental illness, such as significant reductions in violence and delinquency or contributions to more equity in our societies. Schools and companies will evaluate the meaningfulness of investing in mental health promotion according to its impact on academic achievements and productivity. Consumers will look to the results for their subjective wellbeing and quality of daily life. Outcomes such as social inclusion and good citizenship might be the special concern of community leaders and local governments. It is very important to take these different perspectives into account in your advocacy for mental health, in defining the targets of your mental health promoting interventions and in designing studies on their effects, defining the targets of your mental health promoting interventions and in designing studies on their effects.

Secondly, the criteria for success are different depending on the moment of measuring during the long term trajectory and the many steps towards the ultimate targets. Practitioners in prevention will consider it as a success when they are able to create in their community a high level of participation in their programme. Of course this is only a first step towards the ultimate outcome. To get programmes against bullying implemented in a large group of schools requires a tremendous effort and attaining such a goal is certainly a success. Change attitudes, skills and social norms of children, parents, teachers and schools in relation to bullying is a next step and a next criterion for success. The actual reduction of bullying is a following criterion, and reduction of depression, anxiety problems, school failures and even suicide, known outcomes of bullying, are even more distal criteria for success. Successful mental health promotion and successful prevention of mental and behavioral disorders is based on a long chain of successive achievements, frequently requiring a range of successive interventions by different agencies and parties. The next figure shows a range of outcome criteria linked to these different levels and perspectives:

- Determinants of mental health / mental disorders
- biological, psychological, social, physical and societal factors
- risk factors and protective factors
- Indicators of mental health
- Improved physical health
- Use of health care
- Social outcomes
- Economic outcomes

Mental health promotion has many different success criteria and together these criteria are representing a chain of interrelated outcomes.

Third, we need to make a differentiation between ‘efficacy’ and ‘effectiveness’. Most of the knowledge which is currently available on the effects of interventions is based on efficacy studies only. Efficacy refers to the evaluation of the effects of first or second implementations in practice under relatively ideal and controlled conditions. We are using the word ‘effectiveness’ only when such programmes still show positive outcomes when they are implemented at a large scale within the routine of daily practice and under much less controlled conditions.

It is a common experience that under such conditions evidence-based programmes it is more difficult to repeat the effects found in efficacy studies. In mental health promotion only a minority of the available evidence-based programmes show effectiveness, defined in this way.

Current stage of development of evidence-based mental health promotion
Where are we to date in the process of developing and implementing mental health promotion. I will give you a short impression of the current stage of development of evidence-based prevention and promotion in the field of mental health.

1. Over the last two decades at least two thousand effect studies have been published in this field and probably many more. To date, there does not exist a comprehensive overview of all the evaluation studies. For several reasons it is difficult to get the whole picture.
2. Based on some reviews covering separate domains within mental health promotion and prevention, I estimate that to date roughly a hundred programmes exist for which there is evidence of at least their efficacy.
3. Unfortunately, in many cases evidence is restricted to only one well-designed study. There is a strong need for replication studies at different sites. In a substantial amount of cases evidence for efficacy is found repeatedly, in some cases even eight times or more (Albee & Gullotta, 1997).
4. There exists in Europe a rich culture of ongoing local or national practices in mental health promotion. This impression is based among others on a recent survey of the European Mental Health Promotion Network on programmes for children between 0 - 6 years old. However, in the far majority cases there is no information available on their efficacy or effectiveness based on controlled studies. Mostly involved programme providers present some anecdotical evidence of effects based on qualitative studies.
5. The programmes with evidence-based effects, show an interesting diversity of positive outcomes:
(1) improvements in a large variety of protective factors for mental health,
(2) reductions of many different risk factors,
(3) reductions in serious mental and behavioral problems and some mental disorders, and
(4) a broad range of positive social outcomes.

The following figures show a range of examples of evidence-based outcomes of mental health promotion. For a more extended overview I refer to our chapter in the book for the European Parliament (IUHPE, 1999) (figure 2 and 3).

The most well-established effects of mental health promotion are the positive outcomes of health promoting and preventive interventions in terms of improvements of self esteem, problem solving skills, social skills, feelings of mastery, and supportive environments. Such outcomes have been found in many studies. These **protective factors** offer resilience even under highly stressful conditions. A range of studies, among others of the well-known British scientist Michael Rutter, has shown that factors such as the amount of protective factors has a strong inverse relationship with presence of mental disorders such as depression, which supports the concept of protective factors. For example Hammen (1991) found that when at least 6 protective factors were present the average lifetime prevalence of depression was zero. Further, there is ample evidence that promoting and preventive interventions could reduce important **risk factors** in mental health, for example preterm deliveries, child abuse, poor parenting skills and social isolation.

Mental health promotion examples of evidence based outcomes

Increases in resilience and mental health	**Reductions in risk factors**
* Self esteem	* Low birth weight
* Problem solving skills	* Preterm deliveries
* Social skills	* Lack of early bonding
* Mastery	* Child abuse and neglect
* Prosocial behavior	* Poor parenting behavior
* Life satisfaction	* Teenage pregnancies
	* Bullying
* Social support	* Unemployment

Mental health promotion examples of evidence based outcomes

Problem behaviors, symptoms and disorders	**Social outcomes**
	decrease in:
decrease in:	* Divorce rate
• aggression	* Family violence
• serious behavior problems	* Youth delinquency
• drinking behavior, drug use and smoking	* Productivity loss
	* Unemployment
• adaptive behavior	* Use of social services
• depressive symptoms	
• depressive episodes	increase in:
• relapses disorders	* Social tolerance
	* Education and income

Especially in the early life situation, preschool age, and the elementary and secondary school a large range of efficacious programmes are currently available. The evidence of significant reductions of mental disorders as a result of preventive interventions is still is still very limited. To date the best perspectives for a successful reduction of **mental disorders** are currently for serious behavioral problems and conduct disorders and for depression. In both cases, to date many malleable risk and protective factors are known and evidence-based preventive interventions exists to influence these factors successfully. In this sense, the strength of currently available programmes is not only the promotion of mental health but as well reducing the risks of mental disorders (Mrazek & Haggerty, 1994). Many studies have shown that preventive interventions could reduce high levels of psychiatric symptoms before they reach a clinical stage. For example in depression, several longitudinal studies have shown that high levels of depressive symptoms are predictive for the onset of later clinical depression. Especially in children and adolescents, reductions in depressive symptoms, as has been shown in a range of evaluation studies, could reduce the risk of later depression. A study of Clarke and others on the Coping with Depression Course for adolescents at risk showed a drop of first depressive episodes from 27% to 14,5%, a reduction of almost 40%.

In addition, several studies show that the implementation of **relapse and reoccurrence prevention** during or following treatment for depression could reduce the reoccurence with 40% or more. When mental health services would decide to implement such relapse prevention strategies systematically in the practice of mental health care, such a measure could have a very significant impact on the development of depressive episodes in the community and lower the existing prevalence rates. This is especially important for depression, given the high risk at relapse and reoccurrence without such (40% within one year and 50% in 2 years).

Another important outcome of mental health promotion and preventive interventions are the **social outcomes** and the evidence for **cost-effectiveness.**

For example, efficacy studies have found evidence for increases in school achievements, safer environments, less family violence, increases in productivity at work and reductions in unemployment as a result of mental health promotion. Several programmes, such as the JOBS program and the Perry Preschool Program show financial benefits several times the costs of such programmes. To advocate for mental health and to recruit financial and political support for mental health promotion such outcomes are of vital. In future evaluation studies in our field these social and economic outcomes should be given a higher priority.

In this short presentation I have not the opportunity to discuss the complete picture. To date, such a complete overview on the efficacy and effectiveness of mental health promotion and prevention of mental disorders does not exist. However, on segments of our field excellent reviews and meta-analyses are available (e.g. Mrazek & Haggerty, 1994, Albee & Gullotta, 1997; Durlak, 1997). For example, the Prevention Research Center of Pennsylvania State just published a couple of weeks ago a review on 34 programmes directed at mental health promotion and mental disorder prevention in school-age children (Greenberg et al., 1999). The study describes the programmes, the evaluation research and their outcomes and discusses the strengths and weaknesses of each programme.

In the next box two more example of effective programmes are presented.

Prenatal/Early infancy project (David Olds, University of Colorado)

Parent education and home visitation over 2 years for at mothers at risk:, especially low income mothers, teenage mothers and unmarried mothers. The intervention stimulates the mothers to healthy behavior during pregnancy to improve the outcomes of pregnancy, the quality of parental care giving and the maternal life course development. In average, the nurses visited the homes of the mothers 31 times over a period of around 30 months. A randomized control study over the two years after delivery showed a drop in child abuse from 19% in the control group to 4% in the prevention group of high risk mothers. 75% fewer preterm deliveries among the mothers who smoked and a significant decrease in low birth weight (400 grms). These are well-known risk factors in psychiatry. In the second year 40% less visits to a physician for injuries and ingestion were found in the intervention group. In addition, low income and unmarried mothers in the intervention group showed increased control over life, a higher rate of ending school and a drop of 42% in subsequent pregnancies during the 4 years after the delivery of the first child. By the time children were 4 years old these low income families cost the government $3.313 less than did their counterparts in the comparison group (Olds, 1997).

The **Perry preschool program** (Weikart and Schweinhart 1988, 1997)

This programme offered children of 3 -4 years old a two-year training in active learning, problem solving and parent education through home visiting. A longitudinal randomized control study over 15 years showed among others the following outcomes (figures between brackets show the results for the control group):

- less developmental delay
- better school achievement
- less school dropout

At age 19:

- rates of unemployment 59% (32%)
- detention and arrest rate 31% (51%)
- less use of welfare benefits

At age 27:

- arrest rates for drugs dealing 7% (25%)
- own home 36% (13%)
- income of $2000 or more 29% (7%)

At age 19 the economic benefit was already 7 times the costs of the programme.

Going on scale and across borders

A further interesting development is that this field is moving internationally into a next stage. Several dozens of efficacious model programmes are now being disseminated and implemented on scale, even across boarders. On many of these programmes, replication studies are currently in progress in the adopting countries. An example of a successful programme that is going on scale is the so-called JOBS programme, developed by the Michigan Prevention Research Center. This programme is a one week training programme of 5 half days for unemployed people. Participants are learning a range of skills, such as job seeking skills, communication skills, and skills to cope with emotional problems and setbacks. The programme shows to be repeatedly effective in reducing unemployment, as well as reducing new depressive episodes. In the group of unemployed people with high risk on depression, this course reduced serious depressive episodes over a period of 2,5 years after the intervention from 39% to 25% in the prevention group, a reduction of almost 40%. This programme is currently going on scale in several states of the US, in some European countries and even in China. The results of a cost-benefit study resulted in a positive net benefit of $ 12.619 over a 5 year period for the participants. In my own country, The Netherlands, over the last five years we have adopted around 15 evidence-based programmes originally developed in the United Kingdom, Norway, Israel and United States. For example, programmes on parent education, reducing child abuse, prevention of depression, aggression, bullying and behavioral disorders and on the development of psychosocial resilience. In most of these cases controlled replication studies on their efficacy are currently ongoing, supported by the Ministry of Health and the Dutch National Prevention Research Programme.

Contributions from health promotion

Another important question is if we could expect that health promotion programmes outside the domain of mental health contribute to positive mental health outcomes as well. For example do exercise programmes influence mental health? There are some indications that aerobic is related with better mental health? There are some indications that aerobic is related with better cognitive skills and less depression. But their causative relationship is unclear. Several intervention studies have showed that aerobic exercise improves memory functioning in the elderly (memory span, short-term memory span) (Fletcher & Breeze, 1999). In some

other studies such effects were lacking. Housing projects for the elderly could reduce social isolation, loneliness and even depression, but we do not know if such supposed effects are evidence-based. Further, it is very likely that nutrition interventions and substance abuse interventions during pregnancy will have an impact on the neuropsychological development of the child and on birth weight and preterm deliveries, wellknown risk factors in psychiatry. Over the last 15 years the Healthy Cities programme of the WHO has had a great impact on the health policy of many cities in Europe. A large range of social and environmental interventions have been implemented. Mental health promotion was however poorly represented in this project. Nevertheless, it is probable that Healthy City programmes have had a positive impact at mental health as well as a result of safer environments, housing projects and social inclusion of minority groups. I would highly recommend that efficacy and effectiveness studies in health promotion should use in the future a much broader scope in outcome measures, including mental health indicators.

Learning from failures and successes: Principles of Effect Management

Beside the successes, efficacy studies show failures as well. This means in the first place that we may not take for granted the efficacy or effectiveness of a programme just because it looks innovative, program providers are proud on their products, and such programmes are accepted positively by a local community. This is not a guarantee of effectiveness. Failures and unsuccessful programmes are valuable and crucial for the further development of prevention science, as long as we make them visible and study them carefully. Comparisons between successful and unsuccessful programmes help us to answer questions such as: What is the difference between effective and non-effective programmes, between successful and unsuccessful strategies of dissemination and implementation. What are the basic principles of effective mental health promotion? And for whom is by a preventive programme most effective and whom not or only marginally? What does such knowledge mean for example for the way we define our target groups and recruit our participants and how could such knowledge be used for improving quality of new or existing programmes, or for making new versions of a programme which are better tailored to the need of specific segments of a target population?

Studies on these differences in effect have identified a range of effect predictors in mental health promotion and prevention. My research team is working currently at the development of a comprehensive system of principles of effective promotion and prevention and guidelines for effect management. Some examples of such effect predictors:

- Take a **long-term perspective** for developing an evidence-based programme. The most effective programmes, which are currently available, have a developmental period from start until the moment of repeated efficacy of around 10 to 15 years. Given the large investment that is needed for developing and implementing effective programmes and the limited budget, it is crucial to set national and international priorities in mental health promotion.
- **Segment** problem and target groups to make more tailored interventions possible for specific subgroups. Tailoring increases the effectiveness of a program.
- Intervene **as early as possible** and focus at **sensitive periods**. Importance of interventions **early in life**, based on the knowledge of long-term developmental trajectories towards poor mental health and mental disorders. For example, to prevent serious conduct problems it is recommended to intervene already in preschool and early elementary years, instead of waiting until adolescence when risk factors are strongly interrelated and stabilized.
- Over the last decade there is a significant change from mono-component programmes to **multiple-component** programmes. There is evidence from many sources that

programmes are more effective when they addressing for example not only children but simultaneously parents, teachers, the school system and peers. Using a package of interventions with a combination of methods is usually more effective then a mono-component programme.

- **Addressing clusters of problems.** Prevention is frequently dominated by a specific disorder approach or at a specific unhealthy behavior. In such an approach we try to influence factors that are responsible for that particular outcome. However, epidemiological and evaluation studies have shown that different problems and disorders have frequently common risk and **protective factors**. Therefore, an alternative would be to focus at a combination of common risk and protective factors in order to produce multiple effects. Effect research shows that such multiple positive outcomes are found indeed. In addition, different mental health problems are related, show a high level of comorbidity and could concentrate themselves in certain groups or neighborhoods. In such cases, it is more effective and efficient to use a comprehensive community approach, as is used for example in the Communities that Care Program developed in the United States and adopted by several European countries.
- **Duration and dosage,** programmes who are too short run the risk to be not effective or to produce only time-limited effects. Several studies showed that, at least in children, spreading the same contact time over a longer period is more effective then offering the same contacts in a much shorter period (for example couple of months).
- **Reach the whole target population**
  One of the main problems in current prevention and promotion practice is their limited reach in the community. Efficacious tools are available but more effort should be spend to their large scale dissemination and implementation. More attention needs to be given to the development of infrastructures which are able to disseminate and implement evidence-based programmes. This is currently a serious bottleneck in many European countries.

Conclusions and recommendations

To conclude, there is ample evidence that mental health promotion and interventions to reduce the risk on mental disorders could be effective and cost-effective. On the other hand there is still a long way to go and political measures are needed to enhance the perspective at effective mental health promotion. To facilitate this process, I would recommend to:

- Choose a small number of priority areas, taking into account both the existing prevalence and burden as well as current perspectives for effective interventions. Good candidates are: school mental health promotion, aggression, depression.
- To make better use of the large range of existing, evidence-based interventions, this means facilitating their large scale dissemination and implementation.
- To develop a worldwide comprehensive overview on available evidence-based programmes. Support could be given to the current initiative of the Society for Prevention Research to design a worldwide Register and Advocacy system for evidence-based programmes. A strong European involvement is recommended.
- International collaboration is needed between Prevention Research Centres on the development of new evidence-based programmes, replication studies and the evaluation of their effectiveness in the community.
- To increase effectiveness we not only need efficacious programmes but evaluation research should also be focussed at the identification of important effect predictors and their translation in principles and guidelines for effect management that can be used in practice and policy making.

- A more efficient collaborative structure needs to be developed between the many organizations and international networks who are currently active in this field. Several current initiatives among others and the organizers of this conference and of the World Federation for Mental Health need to be supported. The establishment of an international Consortium Centre for Public Mental Health is an example of a recent WFMH-initiative.

Finally, in my visits to several European countries it became clear to me that a lack of national policy for mental health promotion, the lack of supporting national and local infrastructures and the lack of mental health promotion experts is a serious barrier for creating an effective prevention and to create the targeted balance between mental health promotion and mental health care.

Promotion of mental health for children and adolescents

John Tsiantis, Greece
Department of Child Psychiatry
Athens University Medical School

It is difficult to give a definition of either Mental Health or good Mental Health promotion. I would like to start first by citing what Stakes suggested on Promotion of Mental Health on the European Agenda (first draft document 1997).

Mental Health and mental well being are issues of everyday life. They are enhanced, produced - and reduced - in schools, streets, workplaces and homes. They are matters that should be of interest to every citizen and employer and to all sectors of administration (Stakes 1997). On the other hand Mental Health promotion focuses on strengthening and maintaining supportive factors and supportive environments to increase individual and community well being. It is not a "program" but a balanced approach to dealing with everyday realities that, all individuals and group or community members' face. The focus is on the determinants of health rather than risk factors.

MacDonald and O'Hara have developed a formula using a map of elements of Mental Health, with those factors, which both promote and reduce it for individuals and communities. It has been suggested that social policies strategies as well as public Health Services need to address issues and problems related to Mental Health on a number of levels. As well as working at the individual or "micro" level, Mental Health promotion needs to address those structural conditions and issues' at the «meso» «macro» levels which affect Mental Health. These actions cover the needs of individuals and communities and include various types of services on the level of primary, secondary and tertiary prevention. The framework within which Mental Health promotion activities may be offered need to address the whole population and not just individuals or groups who may/may not present Mental Health problems. (Mental Health Promotion: A quality Framework. Health Education Authority).

Several countries and organisations have been motivated to develop a quality Framework for mental health promotion. For example the Health Australian discussion paper on Mental Health promotion (Building capacity to promote the Mental Health of Australian 1996) identifies a population perspective for developing a Mental Health promotion framework. Health is the starting point - the overall aim of the work is to move towards the Health end of the continuum of Mental Health for all people.

When we discuss Prevention we denote the following three levels. Primary prevention seeks to reduce the number of new cases of a disorder, secondary prevention seeks to lower the role of established cases of the disorders in the population, tertiary prevention seeks to reduce the amount of the disability associated with an existing disorder. It should be also mentioned that the boundaries of Mental Health promotion and primary prevention may overlap. The same applies for primary, secondary and tertiary prevention in clinical practice or research.

When we speak 0f Mental Health promotion programmes for children and adolescents we should try to develop programmes which should start early in life especially if we consider

that infant Mental Health is the key for the prevention of the psychosocial health for the entire life cycle of the individual.

In discussing the programmes for Mental Health promotion one needs to bear in mind the following:
The Mental Health promotion programmes should address large sections of the community and the population at large. However, it seems that with the existing trends for cutting down the welfare state due to financial constraints, the burden to families is great but more so for the families in need. The latter implies that our intervention should establish priorities without ignoring the needs of the whole population. Moreover, we should be aware that an intervention program may stigmatise families or make them more dependent on others, even though its intent is to help them.

I will now cite some examples of specific areas of problems which need to be addressed by the development of specific projects. The problem areas I will cite seem to be priorities in several countries. However, we know that priorities differ from country to country and are dependent on several factors. These are:

- The rate of economic and social development of each country.
- Research evidence
- Levels of development of child Mental Health services and Public Health Services in general.

List of problems in child and adolescent mental health

1 Disadvantaged and children who live in poverty
2 Disabled children
3 Child abused and neglected children
4 Children of mentally ill parents
5 Conduct disordered children
6 Adolescents at risk
7 Substance abuse among teenagers
8 Adolescent pregnancy
9 Adolescent depression
10 Adolescent suicide
11 Loss in children and adolescents (Death, divorce)
12 School failure
13 Coping with physical illness
14 Bully/victim, problems among school children

The list could be enlarged but I think it indicates areas of needs in several countries. On the other hand research evidence across countries indicates that approximately 14-18% of children have moderate to severe Mental Health problems. Moreover, there are serious repercussions in the psychosocial development of these children as well as their educational achievement later in life (*Rutter and Smith 1995, Robinson and Rutter 1990)*. It is estimated that from these children with problems only a percentage of approximately 10% to 15% reach the existing Child Mental Health Services *(Cox 1993, Orford 1987)*. The latter applies to several

countries all over the world, even for those countries which have a good economical and social development. It is further argued that even if the above percentage was higher it would have been difficult to be managed by the existing Child Mental Health Services.

Similarly, it is known that even psychological disorders of childhood which are thought to spontaneously remit, have been found to have poor recovery rates of approximately 50% *(Cohen et al 1993)*. Moreover, early psychiatric disturbance seems to persist in later childhood. Approximately 2/3 of 3 year olds show significant disturbance when evaluated again at 8 or 12 years old *(Campel 1995)*. It has also been indicated that the rate of disturbance is higher for children coming from disadvantaged families living in inner city areas.

It seems to me that the development of Mental Health Promotion and prevention programmes are imperative in order to address the above mentioned rates and types of problems for children and adolescents. The structures through which these programmes could be developed are through the school system and the Public Health System more specifically through primary Health Care Services.

Mental health promotion through schools

It has been suggested that health promotion, mental health promotion and prevention in school age is important. Children and adolescents in school age make up about 15 percent of the population in post-industrial countries. It is a healthy group. However, from a life course perspective this short period is important. Disadvantage in this age seems to affect health during the remaining part of life. (Wadsworth 1997, Vagero 1997, Brembery 1998). Therefore, Mental Health Promotion during this period is important. The WHO initiative Health promotive school belongs to this strategy. More recently, a preliminary framework has been suggested for conceptualizing school based mental health problems where mental health promotion is included (Pheifer and Reddy 1998). This framework is called the Tripartite model of School based Mental Health interventions. This framework consists of three dimensions. The three dimensions are: the spectrum of mental health interventions, focus of the intervention, linkages with community service.

The Universal preventive interventions have as a target the entire school population.

The Selective preventive interventions have as a target a subgroup of school population who is at a risk to develop a behavioral or emotional disorder. This risk is significantly higher than the average, based in one or more validated risk factors.

The Indicated preventive interventions have as a target high-risk children and adolescents who are having minimal or detectable signs or symptoms foreshadowing behavior or emotional disorder.

The Treatment interventions: These interventions are designed to eliminate or reduce an episode or delay the recurrence of a behavioral or emotional disorder among children's who meet the full criteria of a psychiatric diagnosis.

The Maintenance interventions often referred to as after care services. These interventions are an important and yet often an overlooked component of a complete spectrum of Mental Health Interventions. The primary aim of these interventions is to sustain levels of functioning or clinical gains acquired during the implementation of treatment interventions.

Finally the Mental Health Promotion interventions for school age children represent interventions trying to build a sense of integrity, flexibility resilient, empowerment and self-efficacy (Cowen 1991).

I will now continue by focusing on early intervention programmes for children and I will finish by citing some results from an early intervention programme, which was implemented in 6 European countries through the primary health care services of the respective countries.

Early intervention

The importance of developing early intervention programmes was recognized in many countries at a very early date -perhaps as far back as the first years of this country- and took the form of welfare and child protection programmes. In recent years, significant progress has been made in developmental psychiatry and developmental psychology in areas connected with the mental health of infants and children. There have also been developments of research projects the last 20-30 years, which explore a variety factors that influence the development of children.

It would appear that the most significant factors are early relationships and interaction and, more generally, the quality of the parent/child relationship (D. Stern 1977, Clarke-Stewart 1998, Wachs and Cruen 1989, Klein et al 1993), together with the significance of parental, family and environmental factors (Rutter 1989, Sroufe and Fleeson 1988, Banet et al 1982, Klein et al 1993), the significance of stress, life events and traumatic experiences (which have a direct effect on children and parents, and thus also an indirect impact on children, Winnicot 1979, Little and Flarsheim, 1979), and the idiosyncrasy of the children themselves (Earls and Young 1987).

RISK FACTORS, PROTECTIVE FACTORS AND EARLY INTERVENTION

The factors which influence the normal development of the child, the most important of which have been mentioned above, have been the subject of numerous studies. From those, the risk factors fall into two categories -biological factors and environmental factors -and it is important that their presence in the child, the family or the social environment be taken into consideration when designing intervention programmes. It is also essential that the severity of these factors should be assessed, in view of the impact they can have on the design and implementation of early interventions programmes. It has also been proposed that a cumulative index composed of the existence and conjunction of more than one risk factor should be established (Sameroff et al 1987).

In view of the difficulty of projecting the degree of risk from the existence of a single risk factor, researchers have tried to understand why it should be that some risk factors have a better prognosis than others where some children, and not others, are concerned. This question has stimulated discussion and research on the issue of resilience and on the role which protective factors can play in cancelling out the risk factors. The results of this process of debate and research have had a significant impact on the design of intervention programmes and have clearly discouraged the tendency to concentrate on risk factors only and ignore the protective factors. Research, for example, identified typical factors, which concern the child and contribute to the child's resilience. These factors are: The child's idiosyncrasy, ability to cope with stress, the child's intelligence and self-esteem, and the quality of the supportive relationships which exist in the child's life.

It would seem that considerations of this kind have contributed to the beginning of a shift in the interests of developmental psychology from a static, child-focused approach to one, which is more dynamic and family-oriented. This approach has three essential components:

- The quality of the parent/child relationship.
- The degree to which the family provides the child with essential and varied cognitive, affective and social experiences together with an appropriate social and physical environment.
- The ways in which the family- and in extension social policy and service development-secures the conditions for the child's health and safety.

This approach, and the composite interaction of all the biological and environmental factors, which can affect the development of the child gives a central position to the family, with reference to the quality of the reciprocal interaction between mother and infant, to the family's response to the child's needs, to the experiences with which the family provides the children, and to the care taken over the child's health and safety. The quality of the reciprocal interaction between parents and infant would certainly seem to occupy a central position in this pattern (Clarke-Stewart 1998).

COMPONENTS OF EARLY INTERVENTION PROGRAMMES

In view of the discussion so far, it will be clear that early intervention programmes can adopt approaches which differ in accordance with the stress caused in the family, its members and their functioning, with the presence of biological or environmental risk factors or the outcome of reciprocal interaction among them, and with the counterbalancing action of protective factors, whether biological or environmental. Along general lines, however, the components of intervention programmes consistings of benefits, social support and information and services for families.

Needless to say, when developing intervention programmes, there must also be a system of services in the community structured in such a manner as to allow the implementation of integrated intervention programmes.

It would appear, however, that the most important components of all early intervention preventive programmes are as follows:

1. A supply of information and services provided for the family and the children by the members of the intervention team.
2. The development of a relationship of trust between the family and the members of the intervention team. This will facilitate the family in obtaining the information it needs about the different stages in development and the needs of the child as they change through those stages.
3. Counseling on questions of prevention, which should cover issues related to parent/child relationships, reinforcement of the parents' existing skills, and the ways to seek help in the environment of family and friends and from the community in which the family lives.

Approaches to early intervention programmes

Traditional strategies used by Child Mental Health Services in the area of prevention and promotion are individual psychotherapy, parent counseling, family, behavior therapy, medication and a variety of group work techniques. These approaches are very expensive, time consuming, most of them are poorly evaluated and the most important of all is that they frequently fail to reach the families with need. To put it in another way, high levels of need cannot be adequately

met because there have been reported problems of detection *(Bowman and Garalda 1993)*, service use *(Offort et al 1987)*, and service provision *(Angold and Costello 1995)*.

Consequently, Child Mental Health specialists have tried to develop over the years alternative strategies and approaches to tackle the problem.

The different strategies and approaches can be summarized as follows:

1. The use of parents.
2. The use of volunteers.
3. The use of existing network of public health services within the Community.

1. Programs that sensitize care givers recognize the central importance of parents for the health, well being and development of the infant and young child *(Rutter M. (1989))*. Factors that influence the quality of care have also been clearly demonstrated. They include parental mental health, interparental relationship and environmental stressors *(Cox A. 1993)*. Developmental guidance advice and support for parents have been at the center of the work for many years.
2. The use of volunteers or paraprofessionals who are helping families through their regular contact with them.

The first two approaches are schemes through which different parent training and support programs or voluntary family befriending schemes and parent counselling programs have been developed.

The third approach is the one which is based on the more effective utilization of the existing resources of the public health system in a country.

Early interventions and primary health care services

It is therefore suggested that if preventive action is to be practicable, it must be integrated into existing statutory services. Moreover, we should take into consideration that several European Countries – especially Southern Countries – do not have comprehensive specialized mental health care services developed in all regions but by and large they possess nationwide Primary Health Care services, providing the population with generalized access to maternal and child care. It is then surmised that preventive interventions have to be incorporated in the existing service structures if they are to survive the experimental phase of the implementation.

There are several projects being implemented in this area. Most of them involve the training and supervision of PHCWs. In most countries this task is implemented by health visitors who have a statutory obligation to visit infants and their carers. *(Appleton 1990, Nicol R. et al 1993 and H.Davis.)*

Similarly, Barker and Anderson (1988) have developed in Bristol a training package for health visitors which includes all the components mentioned above. This program has now been adopted quite widely in the U.K. Similar programs have also been conducted across the Atlantic in the States. Some of these are: The infant Health and Development program *(Brooks-Gunn et al 1994)*, which aimed at reducing the educational, health and behavioural risks associated with low birth weight. The program was implemented by home visitations by specially trained nurses. Another well known project is the prenatal infancy project, also known as the Elmeira project. In this programme home visits by nurses included an educational component for risk behaviours, parenting techniques, enhancement of social support and advice *(Olds et al 1994*,

Olds and Kizman (1993)). This programme was addressing the problem of physical child abuse and seems to have been successful. Another program is the Perry preschool project *(Schweinhart and Weikart 1992)*, which seems to have been highly successful and included preschool educational preventive interventions.

In general, most programs being developed with this philosophy have a preventive approach while others combine a preventive and a promotional approach.

The target of these interventions is the general population or the population at risk or both, they are care giver focused or child focused or both. They are home based, nursery school, or health center or hospital based.

One major issue regarding these programmes of early interventions is to evaluate the effects of the different interventions or the processes by which the changes occur. In relation to this *Rae-Grant (1991)* indicates that the maximum impact on outcome stems from programs with multiple components, beginning before birth, of long duration and home based. Peter Fonagy, in a recent review paper on preventive and treatment interventions concludes, that early preventive interventions have the potential to improve in the short term the child health and welfare of children while in the long term, children may benefit in critical ways behaviorally, educationally as well as in terms of social functioning and attitudes. He also suggests that these results should be qualified in the light of the following: 1) outcomes are selective, 2) many studies report unsuccessful high rates of refusal and most unfortunately it is most likely those in great need do not receive the required help 3) attrition is high 4) results are generally poorer with what appear to be high risk samples. However, work on child and sexual abuse and neglect seems to offer the most clinically significant findings. (Fonagy 1996).

In all the types of early interventions described so far, the care givers through the help they receive are better equipped to meet the needs of their children. This is achieved by obtaining information concerning child development. An implicit aim of such information is the activation of the young mothers attachment system through the provision of a stable, safe non-exploitative relationship with the PHCWs *(Searight et al 1989)*. The provision of factual information regarding child development quite often seems to form a subsidiary aim of prevention programs *(Trad 1992, Pfannenstiel and Honing 1995)*. It seems therefore that an important element in these types of interventions is the kind of relationships that parents develop with the professionals who help them. Luborsky et al (1986) suggest that while the therapist is a key source of variability, in accounting for the observed differences in treatment effects, the therapists experience or training accounts for a modest, proportion of this *(Lyons and Woods 1991)*.

I will now describe briefly and give some preliminary results from a multicentre EU/WHO program on the promotion of childrens' psychosocial development through primary health care services in six countries*: (Tsiantis et al 1996)*. The project was initiated under the auspices of the WHO regional office for Europe in a meeting in Athens in 1990, and it was funded later by the DG XII of the EU. Its initial phase was completed in two centers, which took role in the development of the programme namely of Athens and Belgrade.

There were several aims of the study. These were, firstly, to teach primary health care workers in contact with families with young children to recognize the importance of psychosocial factors in child development, and to train them to work with families in ways which promote the psychosocial development of young children; secondly, to strengthen health care workers' sensitivity to the psychosocial status of the child, and their ability to monitor progress in children's psychosocial development. In addition the effectiveness of the programme was

evaluated in its impact on health care workers' knowledge and attitudes, in terms of their contacts with the families, and in terms of the outcomes for children and mothers involved in the programme.

SAMPLE

The program was aiming to include 200 mothers and their infants in each participating centre in each country. One hundred in the experimental and another one hundred in the control Group. The sample was drawn from the normal population attending the anti-clinic being served by the PHWs and did not belong to a high-risk group.

TRAINING PROGRAMME

The training was organized by the Greek team and it is to produce a direct, specific and measurable effect on the attitudes, beliefs and activities of PHCWs with regards to everyday practice which intention is to broaden the focus and alter the style of practice used by the PHCWs. There are three training phases coinciding with the research phases. The two first training phases involve ten to twelve 3 hour sessions with each session including a theoretical and an experimental part and the third five 3 hour sessions. The total training is 65-87 hours in three years.

AXES OF THE TRAINING PHILOSOPHY

These are:

- The importance of acquiring the ability to adopt an approach whose fundamental component was empathy ensuring that early parent/child relationship develops in a climate of mutual pleasure and trust.
- To encourage the modeling strategy thus facilitating the mother to adopt an approach to interact with the baby at the cognitive, social and emotional levels.
- To alert the caregivers to their childrens needs and to encourage them to adopt problem solving approaches using the parents own resources when appropriate.

The Semi-Structured Interview

The interview schedule, which was developed by the Belgrade research team, aims at providing the PHCWs with an instrument which will guide and facilitate their contacts with families. The content of the semi-structured interviews is closely related to the content and timing of the training sessions. The issues covered in the interviews are as follows: pregnancy, the first three months of the child's life, four to twelve months postnatally and the second year of life.

EVALUATION OF THE PROGRAMME

Included the following:

- Impact of training on PHCWs knowledge and attitudes related to infant behavior and development.
- Impact on outcomes for children and mothers.
- Impact on practice as assessed by the delivery of the interview.

RESULTS

Although six countries were involved initially (Cyprus, Greece, Portugal, F.R.Y., Slovenia and Turkey) results are presented for four of these countries. A different design was adopted in Turkey and this makes the results non-comparable and while the study was completed in Slovenia, the results were analyzed separately.

Numbers Participating

There was some attrition for both groups. This has resulted in the final numbers being lower than the total target of 800 families for the four countries combined.

MULTIPLE CHOICE QUESTIONNAIRES

The Assessment of changes in the knowledge of PHCWs.

The assessment of the changes in the knowledge of PHCWs it was done through three multiple choice questionnaires which the PHCWs answered before and after each training period. The training period covered the three phases of the programme (pregnancy to 3 months, three months to 12 months, 12 months to 24 months).

The comparison was made between the experimental and the control group as well as before and after each training period in each of the two groups. We will present indicatively some results of the multiple choice questionnaire from all centers.

The figures given are the percentage correct on each questionnaire including only those PHCWs where there were both pre and post-test data available.

For all three questionnaires the PHCWs in the intervention and comparison groups performed comparably on the pre-test administered before the training.

This was also the case after training for the first and second questionnaires, although on the third the intervention group performed significantly better ($t\{35\}=4.2$, $p<0.000$) at post test. Also comparing individual's performance before and after the training demonstrated that health care workers in the intervention group scored significantly better on all three tests as a result of the training, while those in the comparison group did so only on the second post-test. **These results suggest that the training programme was effective in increasing the knowledge of health care workers, and sensitizing them to issues concerned with the psychosocial development of the child.**

PROCESS

The second stage of the evaluation was concerned with how the health care workers performed in their interactions with families, and this was assessed both by the outcomes of the semi-structured interviews, and by measures both by the outcomes of the semi-structured interviews, and by measures of how these were delivered. The semi-structured interviews were administered to the mother by the health care worker. There were essentially five different interview schedules that covered the six to eight contacts that each health care worker had with each participating mother. These different interviews covered pregnancy; 0 to 3 months; 4-7 months, 8-12 months, and 18-24 months.

For each of these interactions the health care worker also completes an 'interview diary' to record their perception of how the interaction with the mother had gone. In addition, on two

occasions-once during a visit in pregnancy, and during one of the first or second contacts-each health care worker was observed by an independent observer, while conducting an interview.

Semi-structured interviews

For the interview data the results for each country separately were compared for each variable of the interview for the intervention and comparison groups. In general, given the number of comparisons that were made, there were few significant differences between groups within the data from each country, and even fewer when data from different countries were combined. **It is relevant to note, however, that where there were differences they tend to favor the intervention group-that is the intervention group showed fewer problems, or reported more favorable attitudes, or behavior that would be considered more positive.**

For the pregnancy interview although there were individual variables that showed quite substantial differences between groups in some centers, there was little agreement between centers in the variables where differences were found, and there were no variables which showed significant differences between the intervention and comparison groups when data for all countries were combined. Certain variables however, did show significant differences between the two groups. There was also, consistency in that significantly fewer mothers in the intervention than in the comparison group had negative feelings about the baby. In all four countries reported that the baby had established a sleep rhythm (x^2=9,2, p=0,008), and significantly fewer reported any area of difficulty with the baby (x^2=4,3, p=0,002). Even when no significant differences existed, the general trend was that fewer mothers were in the intervention group than in the comparison group that:

1 Had negative feelings about their baby

Identified any area of difficulty with their baby.

Were more likely to express normal concerns, rather than other more negative

feelings, as being separate from their baby.

More mothers were described as reinforcing the baby's attempts at communication.
It is also notable that FRY (Fry) mothers in the intervention group were all described as having their expectations of the child fulfilled.

In general it was evident that a more positive picture of parenting existed in the intervention group. This difference was even more notable in the FRY Group.

INTERVIEW DIARIES

These were completed by the health care workers to indicate what contacts they have had with the family, what issues were raised, how they felt the interview had gone, what difficulties they had encountered, and what, if any further action was planned.

The findings taken together appear to suggest that the training made the Health care workers more painstaking and careful in their interaction with the mother. It also suggested that the effect of training was to make health care workers more aware of the way they behaved in their interaction with mothers and more self-critical.

Results will also be shown in some selective measures namely the Maternal-well-being as assessed by the Edinburgh post-natal Depression Scale and the Maternal coping by The Daily Hassles Scales. These results will be shown in the four countries and in Greece separately.

The maternal well being was assessed by the Edinburgh post-natal depression scale EPDS, (Cox et al 1987).

The EPDS was completed by mothers in the six weeks, twelve and twenty four months after birth during a home visit by an independent researcher. The EPDS assess the mother affective state.

The Daily Hassles (Crunic and Roth) assesses the stress (tension) that mother experiences regarding the frequency and the intensity which is due to the every day difficulties the mother has to cope with the upbringing of the baby. The scale was completed by mothers themselves during a home visit by an independent researcher in the twelve and twenty four month. These periods represent important periods in the development of the child and it is expected that may influence mothers capacity to cope with the child.

Edinburgh Post-natal Depression Scale

1) Four Countries
There were no significant differences between the intervention and control groups at any of the four time points. It was notable however, that there were significantly more mothers in the intervention group scoring above the cut off point (indicating poor mental well–being in Portugal at both 6 weeks and 12 months).

2) Greece
Mothers belonging to the intervention group were less depressed when assessed by the EPDS in all measurements (6th week, 6,12, 24 months). Moreover in the consecutive measurements the experimental group showed a steady decline overtime, whereas in the comparison group mothers mental state remained unchanged, initially and then become worse in the 24th month. The difference between the experimental and the control group was according to our hypothesis. On the other hand the difference was approaching statistical significance in the sixth and 12th month [$t(105)=-1.9$ $p<06$, $t(106)=-1.6$, $p<.09$] correspondingly whereas the difference was statistically significant in the twenty four month. [$t(101) = -2.05$, $p<.036$]

The high score in the EPDS in the comparison group in the twenty four months may be due to the high score in the intensity of the stress (tension) which this group presents in the Daily Hassles Scale.

Maternal coping-the daily hassles scale

1) Four Countries
There where no significant differences in the combined data relating to either frequencies or intensity at either age.

2) Greece
In Greece the experimental group reported lower scores in stress in comparison to the control Group in both the frequency and the intensity in the twelve and twenty four months. The difference is statistically significant in the scores of frequencies in the twelve months. [$t=232$, $p<01$ and the twenty four months in intensity [$t(100)=3.09$, $p<001$].

These results demonstrated that the PHCWs of the experimental group in Greece contributed to the improvement of the affective state and in the coping with every day stress of the mothers they worked.

DISCUSSION ON THE RESULTS

It appears that the training programme was successful in the first stage-that of increasing knowledge and awareness of development in children, as reflected in the responses to the multiple-choice questionnaires. The effects were not large, but they were consistently in the direction of increased knowledge, and this applied at each of the three stages of the training.

The second part of the evaluation, investigating whether this was reflected in practice, in how health care workers behaved in their interactions with families, was less clear cut. On the whole where there were differences between intervention and comparison groups they tended to favor the intervention group.

The differences found in Greece does not necessarily mean that the Greek team performed better. It may be an indication that one cannot find differences in the combined data from different countries for several reasons. Some of these are the cultural differences, the differences in training existing amongst the PHCWs in the studied countries i.e. Health visitors in Greece and FRY, GPs in Portugal, student nurses in Cyprus. There may be other differences that have not been identified. It remains a possibility that if the research had been either with a group of mothers who were very disadvantaged or in situations where the whole population could be considered needy that the impact of training might have been more evident in the outcome for children and their mothers.

Towards this direction we are now working in a study being developed in 5 different countries, namely: Cyprus, Greece, Finland, FRY, United Kingdom.

This project is called Early Promotion Project. It is funded by the countries involved and it is also being assisted by the EU through a Leonardo Da Vinci programme. The study uses primary health care professionals (PHCP) to address two highly important issues: early detection of conditions that may put an infant's development at risk and preventive intervention with children and families in need. The aim is to promote children's psychosocial development and to prevent psychosocial dysfunction by developing and evaluating a training program and a system for early detection and intervention to be used by the personnel involved in primary care. The service is designed to be flexible in response to need and to involve the network of primary health care services, their usual personnel and their clientele. Intervention will be applied according to the needs of recipient children and their families as estimated by PHCWs. The development and evaluation of the training program and service manual will ensure the survival of the methods beyond the experimental phase and facilitate access to the general population.

A rigorous evaluation procedure constitutes a vital component of the project. It consists of three inter-related parts:

1) Evaluation of the impact of training on the PHCWs;

2) Assessment of the quality of intervention;

3) Evaluation of the impact on child and family outcomes at 18 to 24 months of age.

Assessment of the programme's cost effectiveness also forms one of the goals, as well as an innovative aspect of the study.

CONCLUSIONS

In today's society children and adolescents face severe risks that were almost unknown even a generation ago. For example family, school and community violence, early sexual activity, the single parent family, frequent family disruptions and the economic crisis and the family disruptions that frequently follow – are but a few examples of the several stresses that challenge today's children and adolescents. Moreover, the societal cost of untreated mental health problems among the school children and adolescents is great. Such children and adolescents with untreated or partially or ineffectively treated emotional or behavioral problems end up with a poor school performance, high rates of delinquency, lowered rates of employment with little or no success finding employment after leaving school, and increased likelihood of involvement with the police, criminal justice, adult mental health and public welfare services. It also seems that with the existing trends for cutting down the costs for welfare state due to the financial constraints, the number of families in need is greater whereas the service provision of specialists mental health services is not adequate to meet existing needs.

It seems therefore imperative that all countries should try to develop mental health prevention and promotion programmes for children and adolescents. These programmes could be developed through the school system or the public health services especially in primary health care services. In order to achieve this it is necessary to develop programmes to serve the community in need, and to conduct studies which will refine existing methodologies for an effective utilization of the allocated resources.

Invited comment

Robert Jezzard, United Kingdom
Department of Health

Thank you Professor Tsiantis for your comprehensive and thought provoking presentation. I think you have successfully highlighted all the crucial elements that should underpin our approaches to the promotion of children's mental health.

May I also thank our Finnish hosts for inviting me to provide comment. These are very exciting times both for those who care about mental health but also more specifically for those who are concerned about the mental health of children. We can therefore be very grateful for Finland placing this high on the agenda for their European Presidency. The process began at the preparatory consultative meeting in Helsinki in 1998. Children's issues were included but I have to say, represented by a small groups of participants. We hope that after this conference there will be a greater appreciation of the need to raise the profile of children's mental health and to see that its promotion is a vital part of our efforts to improve the mental health of the whole population.

In the United Kingdom, mental health has in the past been described as 'the Cinderella Service' – and child mental health as the Cinderella of Cinderellas. Cinderella, you will remember was cast aside and neglected by her ugly sisters – but a fairy godmother came to her rescue. Child mental health is no longer forgotten and neglected as we now have a huge programme to improve our mental health services and for the first time our Government has allocated new money to improve the services for children and young people in England - £90 million over three years.

I know that this interest in the promotion of children's mental health is not unique to England and am delighted to hear about the initiatives occurring across Europe and the collaborative projects being established between different European countries. Such co-operation is vital to our understanding of the genesis of children's difficulties and also to the testing out of new ways to provide services.

Sir Michael Rutter and David Smith have provided good evidence for an increased prevalence of psychosocial problems in young people over the last few decades. In their seminal book, entitled 'Psychosocial Disorders in Young People: Time, Trends and Causes', they highlight how comparative studies across different countries and cultures helps to better understand the complex causal relationships, both environmental and biological, between risk factors and their impact on children's emotional, cognitive and social development. In addition we are also now gaining an appreciation of protective factors that serve to mitigate the effect of psychosocial adversities. It is often by looking at the different circumstances in which people grow and develop that we learn most about causation. Hence the importance I attach to these co-operative ventures across Europe.

There are a number of points covered by Professor Tsiantis that I would like to emphasise.

The promotion of children's mental health requires action at all levels. It is a matter for both social and public health policy and our approaches must incorporate whole population initiatives as well as targeted interventions. The evidence is now much clearer that single approaches are insufficient and that those that make a difference have multiple components.

Intervention early in a child's life or in the life cycle of a developing problem is also now recognised as essential if we are truly to make a difference. This may appear self-evident but it is only relatively recently that sufficient evidence has emerged to give us the confidence to incorporate early intervention into policy initiatives. But Professor Tsiantis made another important point. Interventions should be maintained over time. It is improvements in the mental health of children and young people that are sustainable that are most important.

The mental health of children and young people has tended to be seen, and still is by some, as the concern only of mental health professionals but Professor Tsiantis emphasises the point that we must make more use of existing networks within the community, in schools and in primary care particularly, and recognise also the part that parents, volunteers and young people themselves can play. We do not expect specialist chest physicians to be needed to advise on the hazards of smoking. Nor should we expect Child Psychiatrists and Psychologists to be the only arbiters of children's mental health. This should be the concern of everyone and everyone can play a part in creating the environment that best allows children to thrive and develop.

A month ago I participated in the European Conference on the Promotion of Mental Health in Schools – entitled 'From Ripples to Waves' and held in Helsinki. The conference brought together health educators, mental health professionals, teachers, nurses, and pupils. It was held in a school and for the first day, young people outnumbered professional delegates. Schools in Ireland, Belgium and Finland were linked together through the internet and both visual images from web cameras and 'chat room' conversations were fed into the conference process. Needless to say, some conversations were a little risqué, but they were predominantly informative and thoughtful. There were also a large range of workshops and young people participated in them all. It was a conference to remember and a conference full of energy and commitment.

As part of the conference process a resolution was created. The focus is on what schools can do. Some may not think the content is remarkable. Perhaps it all looks like commonsense. But it is remarkable for two reasons:

Firstly, this resolution was worked on by a range of people from across Europe and from a range of perspectives. It was subject to more than one revision at the conference in order that it could represent everyone's views. Young people contributed their ideas too. The languages of both mental health and also health promotion are not universal and the importance of children's mental health is not always appreciated. Nonetheless, we relatively easily achieved agreement about the issues that mattered most.

Secondly, it is remarkable because it illustrates so well, the obvious importance that the school environment, as one of the settings in which children's development is shaped, can have in promoting their mental health. Obvious to us all here perhaps – but we must remember that the articulation of this idea and its increasing prominence and profile in policy development is relatively recent.

I will finish with a cautionary note. Professor Tsiantis' research indicates that detecting change and demonstrating positive outcomes for mental health promoting activities is not easy. We still have much to learn about the research methodologies that are best suited to determining what works and there is much to be studied. We need to know what will make a difference that has an impact not only during childhood but on into adult life too. The promotion of mental health must start in infancy and continue through childhood and adolescence. Then I hope we can begin to have an effect.

The title of the Helsinki conference 'From Ripples to Waves' is a metaphor that we hope will

inspire all of you here to recognise that Finland's initiative is but the beginning and that the work must continue until we have indeed, made waves. The international advisory group will continue its work and is delighted to hear that the Portugal's new mental health association, PUERI, will be arranging a conference to continue our efforts to increase the visibility of child mental health across Europe.

Professor Tsiantis, thank you very much indeed for your presentation today. It was an important contribution, emphasising particularly the value of early intervention. Improving the mental health of children and young people will have an impact upon a person's whole life span. The promotion of children's mental health is not about childhood alone.

What are the challenges for good mental health among the elderly?

Lars Andersson, Sweden
Stockholm Gerontology Research Centre

A unique feature with gerontology – the study of ageing and old age – is its tendency to emphasize the *positive* aspects of mental health.

Methodologically, for instance, its affirmative view is witnessed through varied life satisfaction indices. Semantically, concepts such as "quality of life", "well-being", "happiness", and "morale" further underscore this positive orientation in the research and theoretical models. Notwithstanding the abundance of research on dementia and depression, the affirmative mental health focus on ageing and old age is a cornerstone in gerontology.

However, as a result of the concentration on life satisfaction, major mental health problems have been, in some cases, grossly passed over. Delving into this issue, it is imperative that we categorize mental health into (a) the psycho-social problems, where life satisfaction can be included, and (b) the psychiatric disorders, which covers a range of the more serious problems, though not exclusively the most severe.

Regarding the role of advanced age in mental health, a further distinction must be made concerning the chronological onset of mental disorders. Is a particular disorder a continuation of an earlier disorder or is it an entirely new occurrence? An advanced age mental disorder could be contracted by an individual who, historically viewed, has had little problems in life adjustment but who develops major mental health problems for the first time in old age. Depression, delirium, paranoia, personality changes, and dementia, for example, could affect individuals who previously led normal lives. The true picture, however, is not uncomplicated. Persons with hereditary dispositions for mental disorders may not succumb until late life stressors make their presence known (Gaitz & Varner, 1980).

Mental disorders that occur for the first time in old age often have a strong biological component and are seldom a continuation of previous problems. It is, for example, increasingly recognized that depressive symptoms in old age are associated with brain abnormalities. In this case, depression may be an early symptom in dementia. Having said that, it is important to emphasize that depression is also high among those with medical illnesses (Gatz & Zarit, 1999).

This presentation will open with a short section on mental disorders in old age, followed by issues of life satisfaction, and in particular, to factors related to ageism. Finally, mental health promotion and prevention in old age will be illustrated with a brief comment on the European Union's position regarding mental health promotion among the aged.

Mental disorders

It is not an easy task to estimate the frequency of mental disorders. Those who are affected usually refuse to participate in surveys. In addition, people do not seek help only from general practitioners and hospitals or psychiatric outreach units, but also from the social services, private therapists, the church, quacks, and family and friends.

With this in mind, it is generally reported that about 20% of the adult population shows symptoms of mental disorders that would meet the criteria of disease classification, and the lifetime risk may run as high as 50%. Most of these people are unknown to psychiatric care. This means that most elderly with a mental illness are undiagnosed and untreated. And if they are treated, the treatment is often inadequate.

Thus, it also follows that the absence of a diagnosed mental illness is not the same as good mental health. In particular, among the elderly, there are many individuals with severe mental health problems who have not been diagnosed.

Another problem in its own right is the high use of and often incorrect prescription of psychopharmacological drugs; the most common belonging to the class of hypnotics. It goes without saying that haphazard treatment with psychopharmacological drugs considerably lowers the quality of life.

Depression is perhaps the most common of old age disorders and responds well to a variety of treatments (Gatz & Zarit, 1999). But depressive symptoms in old age tend to be protracted and misinterpreted. This is probably due to the lack of diagnoses and the lack of active rehabilitation. The results are higher costs for the community, even with higher death rates among depressed elderly people.

Dementia is the main cause of institutionalisation and accounts for about 40% of all costs arising from care of the elderly. The prevalence of dementia increases from about 5% among people in their 70's to about 20% among people in their 90's.

Psychotic states are also common. They are characterized by delusions, misinterpretations, and hallucinations. Other symptoms are disoriented speech and disorganized behavior; each of which is difficult to interpret and understand.

Only a few studies of anxiety in the elderly exist. One reason for the lack of anxiety prevalence in *epidemiological* studies is the hierarchical diagnostic system. For example, a depression diagnosis would generally overshadow an anxiety diagnosis. Nevertheless – and in spite of the fact that risk factors increase with age – the occurrence of anxiety seems to be lower among elderly than among younger people. On the other hand, expressions of anxiety in old age may be misinterpreted.

Following Gaitz and Varner (1980), it can be argued that for many people, late life is a time when goals have been reached, and they feel satisfied with a life well spent; those who fear they have not achieved their goals may experience the anxiety of "time running out". Although goal-setting does not cease at any age, persons who carry high expectations into old age may encounter problems when accelerated losses and the onset of infirmity may limit productive activity. Old age differs from other life stages in that there is little future, something that has significant implications for those whose life review might reveal unresolved conflicts and guilt, as well as unfulfilled goals and needs. Such situations may be precursors of low life satisfaction, and possibly depression, in late life.

In order to cope with this situation, many use denial as a *defense mechanism*. Denial can interfere with the acceptance of ageing at all life stages, but especially in old age where one has to adapt to the losses that accumulate in the higher ages. Such denials hinder healthy adaptation to the reality of aging. The degree of defensiveness toward one's own ageing, then, may be a predictor of adaptability to old age (Gaitz & Varner, 1980).

Trauma in the psychoanalytic tradition is any experience which is mastered by the use of defenses. Trauma in this sense produces anxiety which can lead to a psychoneurosis.

Complications related to trauma may be depression, dissociative disturbances, paranoid reactions, social isolation and a nervous irritability with susceptibility to noise, insomnia and psychosomatic disorders. Each of these disorders is identifiable in old age, although not often placed in relation to anxiety.

Life satisfaction

A concept that has had an impact on gerontology for several decades is that of successful ageing - an idealization of ageing without decline. It is important to realize that individuals who approach successful ageing are part of a selected group of people who have managed to optimize their ageing and compensate for possible negative hereditary dispositions. Many, however, no matter how hard they would want or try to attain successful ageing, will never reach this ideal. And then there are other individuals who have lived a (too) "pleasant" or sedentary life, enjoying unhealthy food, having had no exercise, and using various stimulants whose bodies demand to be "paid back" in late life. Successful ageing is reserved for a biological "elite" who through a combination of nature and nurture have been endowed with "extraordinary" life-sustaining, successful ageing qualities. The hidden agenda behind successful ageing is, by most accounts, not to age at all! Or at the very least to minimize the extent to which it is *apparent* that one is ageing, both internally and externally. One way to succeed with this, at least partially, is to claim a division between the external appearance of the body and its functional capacities and the internal or subjective sense or experience of personal identity.

Many old people say they "feel young inside", which appeals to the common-sense notion that there is a growing discrepancy between the outward appearance, and the inner or subjective "real self" which paradoxically remains young. If our bodies must grow old we can at least retain our youthful spirit. One variation of this is to speak about the "ageless self", based on self-assessments in which the body remains "subordinate" and "invisible". The good news is that ageing does not seem to happen to us on the inside. At the same time, however, we are changed by the years we have lived, not only physically, but also psychologically, and the internal and external aspects of ourselves are inseparably bound. One may ask what actually is the "ageing process" - if the self is ageless (Andrews, 1999)?

But if and when people do say that they "feel young inside", what exactly do they mean? What could the opposite – "feel old inside" – possibly mean? Could it mean, for instance, to suffer memory lapses, or stereotyped feelings that rigidity is part of advanced age, or, to those who approach life with a preconscious notion that they do not wish to be old, could it be dismissed as something "not applicable"? The most probable explanation, however, is that the negative connotations of 'old' and 'old age', can result in a dissociation of oneself from the category of old age. This might be a very reasonable position to adopt, instead of claiming the inverse: "I'm old and I'm proud of it" (Andrews, 1999).

In recent years many researchers in gerontology have adopted the term agelessness. They argue that old age is nothing more than a social construct, and that until it is eliminated as a conceptual category ageism will continue to flourish. Others state that the concept of agelessness is itself a form of ageism (Andrews, 1999). When something is stigmatized, there are generally two ways to fight it. Either one tries to abolish the concept or connotations relating to it, or one tries to fill it with positive content as a counterweight. One may ask why attempts to speak about ageing in a positive light often result in a denial of ageing. This presents people active in the area with a particular challenge: we must find a way to locate and represent both the continuity and the change in the identity of elderly people.

Other models describe the process through which optimal adaptation to ageing works. Following Gatz and Zarit's article on "A good old age: Paradox or possibility" from 1999, Schulz and Heckhausen (1996) suggest a developmental theory of control in which they propose that old age is characterized by a decreased availability and use of primary control and an increase in secondary control. Whereas primary control is largely behavioural, secondary control involves cognition - for example, assigning values to alternative goals, estimating likelihood of goal attainment, and engaging in strategic social comparison in order to protect oneself. One model of how such cognitive adaptation can work has been presented by Baltes and Baltes (1990) as "selective optimization with compensation". Selection necessitates a concentration on areas of functioning that are of highest priority. Priorities are established by taking environmental demands into account and also by emphasizing the individual's areas of greatest expertise. Optimization refers to methods of amplifying resources, such as opportunities for practice. Compensation means substituting available competencies and techniques, including use of environmental aids, for prior competencies which have been lost or diminished (Gatz & Zarit, 1999).

Positive mental health

Generally speaking, the preponderance of mental health theories have, in reality, been theories of mental illness. However, Jahoda (1958) once presented a list summarizing criteria for positive mental health. She suggested six criteria: (1) sense of identity, including self-acceptance, self-esteem, and self-reliance; (2) investment in living and in realizing one's potential; (3) unifying outlook and sense of meaning and purpose to life; (4) autonomy, including self-determination with respect to demands from society; (5) accurate perception of reality and sensitivity to situations of others; and (6) mastery of the environment, manifested in interpersonal relationships, engagement in work and play, and ability to solve problems (Gatz & Zarit, 1999). There seems to be substantial agreement among all scholars, independent of branch or area of study, on the aspects comprising good mental health. The attributes most often listed are coping skills, optimism, mastery, self-esteem, adaptability, congruence between aspirations and achievements, feeling secure, responsibility, and deriving pleasure from life's activities.

In terms of mental health promotion strategies, these attributes are often directly translated into criteria for the improvement of well-being. Reasonable as this may seem in some cases, it might be considered a bit unrealistic and, by some, a far-fetched ambition aiming to change the personality. A more concrete and practicable way is to focus on, for example, the social network. When people receive support, and become integrated, several of the desirable attributes follow as bieffects.

Intervention

Mental health can be promoted through a variety of interventions, aiming, for example, at network building. Several decisions must be made in light of interventions. The fundamental question – whether to use a high-risk strategy or a population oriented strategy – needs to be supplemented by the question of minimum intervention (Kahn, 1975). One of the most crucial issues in treatment is whether to support autonomy or dependence.

The discussion of health promotion and prevention components brings to the fore a fundamental aspect of interventions, namely the conceptual level at which interventions should be applied. The behavioral scientist's conceptualizations, to some extent, resemble the physicist's search

for the elements of matter. Once a certain level containing a few components is reached, new findings lead to the unveiling of another level with more components etc. One example is gathered from Weiss' (1974) six components of the single entity loneliness, which have been merged into two basic categories: assistance-related and non-assistance-related, with the second category being divided into "self-esteem related" and "related to affectional ties".

With these conceptualizations as a starting point, an intervention could be based on any number of the six specified categories, or on either of the two or three more general concepts. At this point it is not relevant to debate whether a certain conceptual level is more basic than another. The point is rather to illustrate the intermingling of socio-psychological factors. In practice then it would be realistic to expect that if some components on one particular conceptual level are chosen as core concepts for an intervention, then other components on the same conceptual level might also be influenced through a common factor.

Nevertheless, a definite sensitivity is needed to determine the most appropriate level of specificity in conducting interventions. (Andersson, 1998).

Action

Mental illness costs more than any other group of diseases. The costs and the knowledge of what a lingering mental illness brings in terms of psychological and social suffering should be an imperative for health promotion and prevention, although proving that mental disorders can be prevented, especially in aged persons, is quite difficult. Beliefs about treatment of the elderly with mental disorders have historically been pessimistic. But by focusing on points of leverage, treatment can support areas of functioning that are still normal.

A key factor in health promotion is personal, active participation from the elderly themselves at all levels. This is also strongly emphasized in international declarations. The WHO/UNICEF Alma Ata declaration (1978) Article 4 states that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care".

What areas are most important for the various types of actions, for example interventions, or political initiatives? This presentation together with further suggestions from scholars emphasize these key imperatives:

Health promotion

Key factors in health promotion in late life:

- Promoting economic well-being in old age
- Combatting ageism
- Promoting autonomy and empowerment
- Promoting physical activity in the community and in institutions
- Facilitating social support, social integration and social participation
- Targeting specific groups for actions to reduce social isolation, such as the bereaved or carers

Prevention

General principles for a preventive approach to mental disorders in late life:

• Early diagnosis of and therapeutic intervention in both physical and mental disorders.

• Promoting the availability of primary care and psychiatric facilities that are attractive and truly usable by the elderly population.

• Reduction of chronicity by more appropriate and comprehensive discharge planning from hospitals and mental facilities, with continuity of care appropriate to the rapidly changing needs of an old person.

• Knowledge about psychiatric illness among the elderly should be disseminated to all who work in health and social care.

• Greater utilization and coordination of professionals from various disciplines (multi-disciplinary groups) who can intervene at all phases of the course of the disease.

• Social support groups comprising people who share a similar type of problem should be established.

• The curriculum for medical education must always include geriatrics and geriatric psychiatry.

• Mental health issues need to be more visible in media debates, aiming for less stigmatization of mental health problems.

EU

Mental health issues have been a rather neglected area in the European public health context. Support is found in the Treaty of Amsterdam, which furthers the case for health promotion. Lastly, to advance the development of a European policy which aims at increasing community-wide actions to promote mental health, support is also found in the WHO document "Psychiatry of the elderly. A consensus statement" (1996). Herein, it is mentioned, that mental illness in the elderly is a field that ought to be prioritized not just to help the *inflicted* but also to aid and assist *all affected* – that is to say the relatives, family and friends.

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Invited comment

Sirkka-Liisa Kivelä, Finland
University of Oulu and
Oulu University Hospital

Professor Lars Andersson covered many important aspects of mental health in old age, one of them being positive mental health and possibilities to promote mental health and to prevent mental disorders in old age. The high prevalence of mental disorders and the shortage of interventions to promote mental health were also mentioned. We both have a Scandinavian background, which maybe is the reason for my non-opposite views compared to those of professor Andersson.

Having similar ideas than professor Andersson I myself would like only to highlight some further aspects of mental health in old age and certain risks for disturbances of mental health.

Ageism

Negative attitudes towards ageing and aged persons are quite common in western societies. These negative attitudes affect the well-being of the ageing population in many ways. The first effect contributes to the self-esteem of the aged. If there exists strong negativism in society, the aged cannot feel themselves important participants in society.

Secondly, negative attitudes among middle-aged politicians lead to a lack of interest in the protection of the economic status, possibilities to participate, housing, adequate environments and social and health care services for the aged. The older population is nearly forgotten in making decisions. I am glad the agendas of the European Community have not ignored the older population.

Ageism is also an underlying background factor in the curricula of medical nursing and social personnel in universities and higher-level schools. These curricula do not stress education about ageing, older age, taking care of the aged and health population in old age, although the majority of the users of social and health care services belong to the young-old, old or old-old population. This shortage of education, in turn, affects the quality of services available to the aged.

There exist negative attitudes towards the aged. There are many stereotypical nonpositive attitudes towards mental illnesses. And, lastly, treatment and rehabilitation are usually thought to be more important than health promotion. All these facts mean that mental health promotion in old age is not prioritized in societies. It lies in a very low priority level.

My research team has found the prevalence of major depression to be about 3% among the Finnish population aged 60 years or above. The prevalence of depressive disorders with a less strong symptomatology compared to that of major depression was high, nearly 15%. Depressive disorders in old age are underdiagnozed, and what is more important, the treatment of depressed older and old persons is underdeveloped. There exist good opportunities for a recovery if an ageing or aged depressed person is adequately treated. The results of my own studies have, however, shown that the majority of the ageing or aged depressed persons are not adequately treated. The poor level of treatment is a common finding in European countries as Dr. Andersson told. One needs to be an important older person in order to get adequate treatment of depression.

Thus, there is a need to develop even treatment of depressive disorders, not only mental health promotion.

The prerequisites for the promotion of mental health in old age include free and safe physical environments where even disabled persons may move and maintain their social activities. Even here, negative attitudes may hinder the development.

I stress that one of the major points in promoting mental health in old age is to decrease negative attitudes towards the aged among middle-aged and younger populations.

Abuse in old age

Economic, physical, psychic and sexual abuse is one of the risk factors for mental health disturbances in old age. The aged may be abused by their family members or by outsiders. According to the results obtained by my own research team since the beginning of the 90's, 7% of women and 3% of men aged 65 years or over have been abused when aged 65 years or over. The majority have been abused by their own family members, and a smaller proportion by an outsider. These figures show that there exists abuse of the aged. The interviews of Finnish social and health care personnel made by myself during the previous two years give evidence to suggest that the incidence of abuse towards the elderly by outsiders has increased during the late 90's in Finland. The majority of the cases where the abuser is an outsider are economic, that is the aim is to steal money or other property from older persons either in their own homes or on the streets. Our society seems to be especially unsafe for the older population. Similar trends have been presented in European congresses on ageing.

Safe societies prevent economic, physical, psychic and sexual abuse towards the aged. The concrete promotion of safety includes a great variety of means ranging from legislation to information of the aged themselves. Physically disabled persons and persons with memory impairments are at greatest risk for abuse.

Physical and physiological factors

As professor Lars Andersson stressed, many kinds of physical and medical factors may disturb mental health in old age. Poor nutrition may be an underlying factor. Difficulties in shopping due to one's physical disabilities or to a lack of a car and the long distances between the shopping centres and the areas where older people live, are some reasons for poor nutrition. As these examples show, town planning affects even the nutrition of the older population.

Medicines may have harmful side-effects on mental health. Depressive disorders, memory disturbances and mental confusion may be caused by these side-effects. All of the many epidemiological studies made by my own research team and by other researches have shown the use of many kinds of medicines to be common among the aged. The extent of mental disturbances caused by side-effects of medicines or by the simultaneous usage of many medicines is unknown. I assume, however, that this is an extensive problem. It is also a problem which might be prevented by adequate education of physicians.

Relationships between mental and physical factors

There exist many different relationships between mental and physical factors. Not only physical factors affect mental well-being, but mental factors also affect physical well-being. A typical feature of old persons is that a minor disturbance in either mental or physical well-being may have severe consequences.

Depressive disorders are independent risk factors for physical disabilities in old age. Thus, a depressive disorder in an old person may lead not only to physical disability, but also to a need for home services and even to long-term institutional care.

My dear audience, I will illustrate the great vulnerability of old persons with one concrete example. When a socially active, nondisabled, nondepressed old person living independently falls during his or her social activities and sustains a hip fracture, the consequences of a hip fracture may be dramatic. The hospital treatment and rehabilitation may take a long time. The falling may lead to a fear of falling. The older person may limit his or her physical and social activities due to this fear of falling. The ultimate consequences may be social isolation, depression, lowered physical abilities and a need of informal and formal care.

Efforts to maintain the mental well-being of the older population do not only affect the mental well-being of the older persons themselves, but also have a variety of effects on the physical well-being of the aged and on their need of informal and formal mental and physical care.

Effects on family members

The mental disturbances of the aged have also dramatic consequences on the family members of old persons. Caring of a demented older person is an example. Living with a depressed old mother or father may affect the well-being of a middle-aged child. Thus, promoting mental health among the aged has positive effects on the well-being of middle-aged populations.

Experiences from mental health promotion

In order to encourage us all to proceed with mental health promotion in old age in Europe, I shall lastly tell you a good example from Finland. During 1984 and 1985 my research team made an epidemiological study of depression in old age in the Finnish municipality called Ähtäri. After this epidemiological study we further educated health and social care personnel and workers of nongovermental organizations and church to support the depressed aged and to promote mental health of the aged. We gave many lectures to the aged themselves and to the middle-aged and younger inhabitants of this municipality. The topics of these lectures included aspects of normal ageing, possibilities to prevent depression and to support depressed and disabled aged persons. We encouraged the development of social activities for the aged, especially for those who lived alone and were in a risk of social isolation. We called our programme "a community-based programme to prevent depression in old age and to support the depressed elderly". My research team made a second transversal epidemiological study about depression in old age in this same municipality during 1989 and 1990. What did we find? The results showed the prevalence of major depression to be similar in both of these studies. However, the prevalence of minor depressive disorders was clearly lower during the second study in 1989-90 compared to the findings from the first study in 1984-1985. This was not a controlled intervention. Unfortunately we had no control municipality where no community-based programme was implemented. However, I dare to suggest that the community-based programme did have effects on the mental health and well-being of the elderly. According to this experience my hypothesis is that quite a lot may be done with low economic resources to promote mental health of the aged. I hope this hypothesis will later be proven by controlled multiprofessional studies performed in co-operation with several European countries.

Mental health and employment policy

J. Agustin Ozamiz, Spain

University of Deusto

The social changes we are living with are much more extensive than those experienced by people living at the start of the industrialisation period. It took the international scientific community more than 100 years to understand and explain the social, economic, psychological and organisational influences of those changes. European Welfare has been developed primarily from that understanding. 200 years ago, slavery in America and servants in Europe were the main work force. High rates of unemployment, job insecurity, employment instability which means low level working contracts, are symptoms of this social change, in addition to an increase in extreme poverty and social exclusion, a widening margin between rich and poor, and a higher incidence of suicidal, sociopathic and aggressive behaviours.

As the Employment and Social Affairs Division of the EC has stated (1) the industrial changes have a wide range of effects on workers. The characteristics of this development are:

- The internationalisation of business and markets.
- The changing structures of companies and production processes.
- Technological change.
- The decline of employment in traditional industries, and the generation of new sectors associated with new technologies and with services.
- The changing structure of the work force itself, as the proportion of young people in Europe declines, and the proportion of those aged 60 and over increases.
- The positive impact of more women in work, and of their increasing influence in positions of power and responsibility.
- The growth of part-time work (much of it undertaken by women, whose wage levels generally still lag some way behind those of men in comparable jobs), and the disappearance of employment for life - arrangements.

Unemployment is one of the main problems in Europe, the average unemployment rate in Europe is about 11%, but precarious employment is becoming increasingly common. For example, in Spain, although the unemployment rate has decreased in the last years from a rate of 22% in 1995, nowadays 35% of the jobs could be said to be precarious, as well as 90% of the contracts signed during 1998 and 1999.

The theory of Marie Jahoda (2) about the needs a job should fulfil -leaving economic matters aside- might also help us to understand the influence of work on mental health. According to her, employment has the following "latent functions":

- To impose a time structure on the day.
- To permit regularly shared experiences and contacts with others.
- To link an individual to goals and purposes that transcend his/her own.
- To define aspects of personal status and identity.
- To enforce activity.
- To provide security.

In other words, we could say that employment helps us build our perception of time and space, the axes around which our cognitive system is organised.

There is also evidence of negative effects on mental health of poor working conditions. The burnout syndrome is one of the most studied phenomena in this field. Abundant research is also available about the problems caused by shift work, work which is boring and tedious, and stressful situations at work. Several studies have also demonstrated changes in psychiatric morbidity associated with changes in work status.

The "Tokyo declaration" (3) acknowledges that it is stated that, the growth of neuroscience and stress science has furthered our understanding of the links between work structures and processes, the way in which these are perceived and appraised and the resulting interaction between the central nervous system and other organ systems to promote or compromise workers´ health.

A consistent relation has been proved to exist between unemployment and minor psychological disorders. Interesting meta-analyses of the consequences of unemployment for health have been made by Peter Warr (4) and Anne Hammarström (5). As a conclusion we could say that unemployment is connected with the following negative outcomes:

- Lack of happiness,
- Lack of satisfaction in life,
- Lowered self-esteem,
- General distress,
- Anxiety,
- Depression.

Of course, personal resources, emotional as well as economic and social, are crucial in coping with a period of unemployment.

According to Fryes (6) are evidences that unemployment can put at risk the mental health and psychological well-being of other groups too: 1) members of families of unemployed people (children, spouses, other family members); 2) people on employment with some training schemes, 3) those left in organisations after others have been made redundant; 4) those who are trapped in psychologically distressing or dissatisfying jobs by mass unemployment; 5) those who unemployed or not, live in the communities dominated by mass unemployment.

Some British studies (7) suggest that unemployment is the social indicator most frequently related to deprivation and consequent need for health service provision. There are also studies, which show that employment instability is becoming, in some circumstances, more harmful than unemployment, and instability also generates mental problems. (8)

Studies on social prospectives for the next decade foresee an increase of mental diseases in general. The progressive increase in mental illness which has been observed in recent decades, not only in Europe but also in USA, is predicted at an even more accelerated rate. Indicators of mental health problems such as suicide rates, self-destructive behaviour, drug-dependencies, aggressiveness, and demand for care, continue to increase despite organisational improvements in health care networks.

Another aspect of the consequences of unemployment, one that I consider crucial for people with long term mental heath problems, is that, in the majority of cases nowadays, unemployment leads to social exclusion and poverty.

Around 2% of the population within the EU are estimated to live in a situation of extreme social exclusion.

1. European employment policies

As stated in the report of the EC's "Key Concepts" Project I consider that "Mental Health and well-being are basic resources for everyday life. Mental Health, social integration and productivity are linked: well functioning groups, societies, organisations and work places are not only healthier, but also more effective and productive.

Significant mental pressures are created by changes in working life. A central challenge is how to combine technological development, organisational innovation and the requirements of mental health protection."

Companies nowadays are the organisation of knowledge (9), where we put our mental energy -and not so much our physical energy- at stake: work places demands on our mental, communicative, psychological and interpersonal skills. An appropriate and satisfying work environment safeguards our mental health and can even improve it. On the contrary, in extremely competitive and turbulent work environments where co-operation is practically non-existent, it is highly probable that this will lead to an increase in the incidence and the severity of mental health problems.

We should become aware of the fact that the production system has been subject to some substantial changes. It is no longer the one found in the industrialisation period.

The European Commission's 1996 Employment in Europe report, reviewing job gains and losses over the last decade, confirmed that throughout the Union there were job losses in agriculture and manufacturing, and gains in services. It also identified two groups of service industries:

- medium growth (making only modest contributions to job creation) - banking and insurance, public administration, transport and communications, and distribution;
- High growth (making more substantial contributions to job creation) - health and social services, business and personal services, education, and tourism.

This year the Council of the EU has adopted a resolution about employment guidelines based on the following four pillar structure: 1) improving employability, 2) developing entrepreneurship, 3) encouraging adaptability of businesses and their employees and 4) strengthening the policies for equal opportunities between women and men;

Among other considerations in this resolution preamble, the Council considers that employment policy is the top priority of the European Union.

The headings of this resolution are:

I. IMPROVING EMPLOYABILITY

Tackling youth unemployment and preventing long-term unemployment

Transition from passive measures to active measures

Encouraging a partnership approach

Easing the transition from school to work

Promoting a labour market open to all

II. DEVELOPING ENTREPRENEURSHIP

Making it easier to start up and run businesses

Exploiting new opportunities for job creation

Making the taxation system more employment friendly

III. ENCOURAGING ADAPTABILITY OF BUSINESSES AND THEIR EMPLOYEES

Modernising work organisation

Support adaptability in enterprises

IV. STRENGTHENING EQUAL OPPORTUNITIES POLICIES FOR WOMEN AND MEN

Gender mainstreaming approach

Tackling gender gaps

Reconciling work and family life

Facilitating reintegration into the labour market

Every Member State of the EU has already developed these Council guidelines in their own National Action Plans, and will be revised according to these guidelines.

The European Commission is already tackling several of these issues in its different action programmes, but a key question is the integration of these issues and their implications for the promotion of mental health. One issue is the protection from social exclusion. I shall now consider some new possibilities in the contexts of these actions

2. Key questions in a strategy of promoting mental health within employment and unemployment.

In the aforementioned context of the current and future situation of employment in the European Union, it will be useful to define the priorities to be taken into account in the sphere of mental health promotion. This concerns not only the content of the goals, but also the processes that may help to develop and adapt those goals in different European regions.

In practice, if we are to develop a strategy for the promotion of mental health in the sphere of employment policy, we should distinguish four aspects:

- Mental health at work
- Unemployment and mental health promotion
- Re-entry into paid work
- Employment rehabilitation of people with long-term mental problems.

2.1. Mental health at work

The production system has undergone not only quantitative but also qualitative changes. The human production force can no longer be described as 'physical', as used to be the case earlier in most industrial companies. Nowadays, it is rather our knowledge, our mind and mental energy, our social skills and emotions within human relations that count when we work. More than 50% of the work force in the EU is employed in the service sector; even in other sectors, business is carried out through enterprises of knowledge.

Consequently, we should realise that, precisely in terms of production and quality, mentally healthy people are the best success predictors of the production systems. Crucially, our mental

health is increasingly at risk as a result of problems such as uncertainty and bad organisation at work. Unions, employers and employment agencies should realise the importance of these matters.

When evaluating companies, the owners take results as the only indicators of success. The structure of a given organisation is the factor responsible for yielding positive or negative results. The crucial variable -an intermediate step between the organisational structure and results- is the human motivation for work; and, in the field of the organisation of knowledge, this motivation cannot be encouraged by using material incentives alone. The meaningfulness of work has a substantial influence on motivation.

It is obvious, nevertheless, that the meaning of work changes from culture to culture, and between different periods of history. As Fourgous and Lambert (10) point out, the major motivator at work in the post-industrial society is not sharing a profession but belonging to a work-team or a production project. It is basically the feeling of being part of an effective and safe company that encourages motivation nowadays.

It is along these lines that the European Fund for Quality Management points to satisfaction at work as one of the nine criteria by which to assess organisations when it comes to issuing them a quality certificate. The criterion of satisfaction at work includes questions such as effectiveness in communication, motivation, involvement, individual and team acknowledgement.

In the Luxembourg declaration on Work Place Health Promotion (WHP) in the EU, adopted by the European Network for Workplace Health Promotion on 28 November 1997 to improve employee's health, it stated the following:

WHP is based on multisectoral and multidisciplinary co-operation and can only be successful if all the key players are committed to:

- Management principles and methods, which recognise that employees are a necessary success factor for the organisation instead of a mere cost factor.
- A culture and corresponding leadership principles which include participation of the employees and encourage motivation and responsibility of all employees.
- Work organisation principles that provide the employees with an appropriate balance between job demands, control over the own work, level of skills and social support.

WHP can reach its aim "Healthy people in healthy organisations" if it is orientated along the following guidelines:

- All staff has to be involved (participation).
- WHP has to be integrated in all important decisions and in all areas of organisations (Integration).
- All measures and programmes have to be oriented to a problem-solving cycle: needs analysis, setting priorities, planning, implementation, continuous control and evaluation (project management).

2.2 Unemployment and mental health promotion

As mentioned above, this is one of the most important aspects of the matter on which the social agents should focus. We are conducting, (with the financial support by the DGV/F3), a project called Unemployment and Mental Health which focuses on the negative impact of unemployment on Mental Health.

This project will develop European strategies aiming at

- Improving the mental health and well being among individuals, families and communities affected by unemployment
- Raising awareness among the different stakeholders about the multiple links and complex interactions between mental health/well-being and unemployment
- Effective marketing of the results and recommendations produced by the project.

To achieve these goals all relevant actors and parties have to ensure and strengthen

- Effective ways of support, consultation and counselling, including self-help measures, for unemployed persons and organisations/employees in difficulties
- Effective approaches to develop work environments in a way that takes into consideration the special needs of the ageing employees, the disabled and of persons with mental health problems in order to prevent their marginalisation and exclusion from work
- The search and support for innovative actions (models of good practice) in the field
- Enhancement of co-operation between different actors and stakeholders
- Support for dissemination of innovations in the field.

Unemployment affects the whole society, and therefore it is mandatory that all mental health promotion measures within the field of unemployment and mental health take into account the needs of at least five different groups of stakeholders such as

1) Families, friends, and other social networks

2) Employers, unions

3) People working in health and social services including the third sector

4) Administration, governments, politicians at regional, national, and international levels

5) Media and influential institutions in modeling social values and attitudes.

According to the preliminary recommendations of the Project "Unemployment and Mental Health" several activities are needed:

- The governmental organisations need to be allowed to react flexibly and rapidly to changing situations
- The officials communicating with the unemployed should be instructed to be more responsive and the official information channels should be developed towards more humane approaches
- The NGO's involved must be encouraged and empowered to disseminate good practices and innovative solutions which may inspire people to participate more in their activities
- The special needs of the unemployed in different age groups must be recognised by stakeholders in all sectors of this field
- Individuals affected by unemployment should be encouraged to maintain and develop their skills during the period of unemployment and be able to acquire a positive image of the future re-employment
- Special attention needs to be paid also to the problems arising in the families of the unemployed while the family members are highly likely to suffer from the impaired situation as well
- The different actors should be required to initiate further co-operation where increased sensitivity and respectfulness towards each other's views is expressed
- The people currently unemployed must be seen as a reserve possessing a vast amount of positive resources and skills that may be transferred into future productivity once the employment situation further improves.

It is needless to say that employment and unemployment are strongly interdependent. Realising the fact that full employment is hard to achieve, it should nevertheless, be a serious objective of the labour market policies of all Member States and be strongly implemented in the Community level policies as well. This calls for strengthening the national initiatives as well as for active surveillance by the organs of the European Union (e.g. the Parliament and the Commission to monitor the development and implementation of the outlined measures and procedures).

2.3. Re-entry into paid work

Re-entry into paid work can be considered as psychosocial stress, specially if the unemployment period was associated with mental health problems.

For these people, uncertainty could very well generate insecurity with severe psychological consequences.

Places of work should become more secure environments if we want a mentally healthy and competitive population, a community with ever-growing solidarity and high levels of mental health. This is also the way in which these matters are understood by the EU, as stated in the green Paper 'Co-operation for a New Work Organisation', published in April 1997(as supplement 4/97 of the EU Bulletin):

"We must find some balance to cope with the turbulence and uncertainty generated by the change; balance among young workers and old workers; balance among workers with different levels of instruction and training and, most of all, balance among flexibility and security, flexibility and safety."

The employment authorities should develop strategies to cope with these requirements.

German researcher Thomas Kieselbach (11) who has studied interventions to counteract health effects of unemployment concludes that schemes which integrate elements of employment, qualification and psychosocial guidance under the perspective of a close relationship with industrial reality have the strongest beneficial impact with regard to re-employment and psychosocial stabilisation of the participants.

According to him the most urgent needs for preventive measures are:

- Integration of psychosocial or socio-pedagogic counselling and guidance as basic elements in qualification and reintegration schemes.
- Creation of specific reintegration schemes for very long-term unemployed.
- Professional support for self-help initiatives at counselling the unemployed.
- Concept of "social convoy" of occupational transitions: Outplacement- replacement-inplacement comprising advice on legal, financial, labour market, retraining and psychosocial matters.
- "Social guarantee" to work or the right to enter a qualification scheme after a certain period of time in order to prevent the development of long-term unemployment.

These kind of programs must also take into account the following research findings: unemployed people with higher levels of employment commitment, more financial problems (both objectively and subjectively assessed) and with less security are at greater risk of more severe mental health problems than job seekers with lower employment commitment, less financial worries and more security.

Interventions which combine increasing commitment to paid employment and more vigorous job seeking with the threat of withdrawal of financial support combine stressors probably multiplicatively and maximise the likelihood of more negative mental health consequences of unemployment. (Fryer and Payne)(12)

2.4 Employment rehabilitation of people with long-term mental problems

Considerable experience has been accumulated on what strategies are efficient in the vocational rehabilitation of people with long-term mental problems. Those based on paid employment have proved much more effective than the classical occupational activities developed in the traditional psychiatric services

In the last 10 years, two strategies developed through the HORIZON programme are being implemented with some success:

- Supported employment,
- Social firms.

Supported employment is defined as paid work in a variety of settings, particularly regular work sites, especially designed for handicapped individuals traditionally unable to take part in competitive employment, and who, because of their disability need intensive ongoing support to perform in a work setting. This commitment to both time-limited training and long -term support services distinguishes supported employment from traditional vocational placement models. Outcome reports from supported employment projects for persons with severe mental problems have been cautiously optimistic.

Supported employment strategies must be based on, among other things, social and interpersonal communication skills. They should also take note of work atmosphere, trying to find communicative people with whom secure ties could be established, and who could be able to understand and listen to those with mental problems. Positive attitudes towards mental disease are, therefore, vital when working on these strategies.

Six years ago, around 400 social firms dedicated to people with severe mental problems were estimated to exist all throughout Europe. According to the CEFEC association, the objectives of these programmes are:

- To create permanent jobs,
- To offer payment in accordance with (or based on) agreed tariffs, so that those employed can be financially independent,
- To create a greater or lesser degree of market orientation and competitiveness.

One of the most recent and successful undertakings is the ACCEPT project developed within the HORIZON programme.

What we now need is to share our experiences and good practice; adjust the legal aspects of each member state; develop these strategies as much as possible; and solve specific problems such as the loss of social benefits when a salary is received, low as this salary might be. According to the CEFEC association: "only in France and Germany is there an obligatory quota system, i.e., businesses that do not employ their full quota of disabled staff, have to pay a levy to a public agency. This levy is used to fund schemes aimed at providing vocational integration and the money can also be accessed by social firms, to create new jobs, for example. There are quota systems in a number of other European countries, too, though they seem less efficient because there is not the same degree of compulsion as in Germany and France."

In the report of the Project supported by de DGV of the EC "Training and employment for people with a Psycho-Social disability" co-ordinated by the ERC-WFMH, it is recommended:

- A wide-ranging programme of **training and work opportunities** to enable beneficiaries to have a real **choice of options** suitable to their skills and interests, without being coerced into work which will cause their mental health to deteriorate. The programmes to be financed by redirecting parts of current mental health budgets towards employment and creating links to mainstream employment support/creation and economic development programmes. These to be evaluated at an organisational and national level and the finding disseminated and shared at national and European levels.
- Linked to the skills improvement programmes – co-ordinated presentations across the media **of positive images** of people who have had mental health problems as skilled workers and managers in modern industries. These to be directed at employers, Trade Unions and the general public and be designed to challenge established negative stereotypes of survivors of mental illness.
- Support should be sought for a programme of comparative research in Member States and across the world, to find practical ways enabling **welfare benefits** systems to help people return to work without taking unacceptable risks with their livelihood, and which can be flexibly reactivated when cyclical mental health problems recur.
- Linked to the above – research to provide **cost/benefit data** for programmes of training, rehabilitation and employment which take account of increased tax revenue and savings to welfare budgets both at national and European levels. This is vital if a case is to be presented to national governments suggesting that there are economic advantages in getting people disabled by mental health problems off benefits and into work.

3. Suggestions for European strategies

I shall now suggest some strategies for ensuring that employment policies, and mental health promotion actions are developed in a co-ordinated way by the Member States of the European Union.

3.1. There is a strong need for co-operation and agreement on a common action programme between the different networks related to the subject (WHPN, MHE, UMH, CEFEC, ADAPT….). One of these networks should take the responsibility of the network co-ordination.

3.2. To adapt these strategies to the different European contexts is essential to guarantee success. That is why it is suggested that, at a regional level (at least in the most deprived regions), each member state establishes an agency which will co-ordinate health service, education, employment and social welfare in order to develop programmes for mental health promotion in this field, as well as to evaluate the implementation of the suggested programmes.

3.3. The EC should emphasise the need for common indicators in different EU member states, to follow up and evaluate the development of employment policies. Co-operation between the networks, agencies and Universities to build useful, reliable and valid indicators of Mental Health promotion programs and employment policies. To this end, it will be necessary to develop a common conceptual framework for good practice in employment and mental health to evaluate it.

3.4. The advances that the EU is making in employment policies must be complemented by the suggested strategies for Mental Health Promotion. To match these strategies and policies some effort should be made, as a matter of priority, designing the appropriate actions for such an aim.

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Information society, social inclusion and psychosocial well-being

Henry Haglund, European Commission
Information Society Promotion Office (ISPO)

The European profile for the information society

The Information Society for Europeans should be built on the core values of European social and cultural heritage, equity, social inclusion and diversity. Social exclusion based on age, gender, race, disability, unemployment or any other reason is not acceptable. Additionally the European way should reflect strong commitment in relation to environmental issues and be operational in international context promoting European values in developing global frameworks. The Europeans should also try to establish a sound balance in between economic and social aspects in implementing the Information Society.

The Information Society is for us all and Europeans have the right to demand for welfare, quality of life, possibilities for active participation in the society, universal access to information and communication channels, privacy and security. Also issues like consumer and citizen rights in the Information Society have been raised.

A balanced European approach to IS should be built upon broad societal consensus and by partnerships bringing together different skills and expertise.

The Importance of social inclusion

Modern information and communications technology offers a wide range of opportunities for Europeans to be better equipped to face the future challenges. The Information Society offers enormous opportunities to improve the way in which Europeans live and work. These opportunities are strongly visible in the recent action plans of the European Commission. The Green Paper People First identified a set of common principles, based on the ideas and values, to guide public policies for the Information Society. According to these guidelines public policies should, among other issues:

- improve access to information
- enhance democracy and social justice
- promote employability and lifelong learning
- achieve and enhance equal opportunity between men and women
- promote inclusion and support people with special needs and those lacking opportunities to improve their position
- improve the quality and efficiency of public administration.

As it can be easily seen, many of these guidelines directly or indirectly refer to improving the living conditions and quality of life of older people, disabled, those with mental problems and those for some other reason in danger of isolation and social exclusion.

Within Europe there is a growing pressure to find solutions for the people in danger of being socially excluded. The disabled and especially the older people represent large and growing

segments of the European population. According to recent estimates more than 80 million fellow Europeans belong to these segments today and their proportion is growing.

These segments will be, year by year better informed and also willing to be in charge of their own lives, thus representing an increasing political pressure for the decision makers. Independence and better quality of life belong to the key issues raised. Older people will be more active and they also represent a growing role in the consumption market thus opening a field for innovative new services.

It often seems that Information Society and related technologies are regarded as an ideological frame and a toolbox to take care of the segments of older people and disabled with less cost and trouble, still somehow trying to guarantee a satisfactory level of basic services and treatment. These people may so easily be classified as a burden, an overhead that should be taken care of with straightforward efficiency. Under heavy financial pressures within public services this may be understandable but, taken as a general guideline not acceptable and ethically justified. Too easily it is forgotten that these people represent an enormous source of knowledge, experience and strong driving force to actively contribute in the society. We should not ignore this opportunity of unlocking this potential.

We have human responsibilities and obligations to follow in providing equal respect and opportunities for all of us. They are as an example referred to in the United Nations Standard Rules concerning the Equalisation of Opportunities for Persons with Disabilities. I can recall a wise old remark that a prominent indicator of the level of a culture is directly reflected in the way children, older people, those disabled or those in distress are treated in the society. We should always pay respect, not to put on additional pressure, and provide new opportunities on voluntary basis, not by force.

Modern information technology and networking may provide help in several ways:
- by establishing contacts between people directly
- by establishing contacts between people in distress and those providing assistance
- by establishing networks between professionals and volunteers to exchange information and experience.

All these aspects are of great potential value when trying to find good working models for help and assistance.

European Commission initiatives and actions

The measures and actions available to develop and promote the European Information Society may be grouped in three categories: (1) regulatory actions, (2) research & development, and (3) awareness raising and promotion.

DGV ACTIVITIES

According to its mission statement. DGV, the Directorate General for Employment and Social Affairs, has the prime responsibility, within the European Commission, for ensuring that the objectives derived from the social policy advances of the Amsterdam Treaty agreed in June 1997 (Article 137) are met.

Among many other issues the Treaty offers specific provision for the Union to promote incentive measures to combat social exclusion. The actions include co-operation with non-governmental organisations and associations formed by the socially excluded and the elderly, co-operation

with charitable associations, and preparatory actions to encourage co-operation between Member States to combat social exclusion. As a result of a call for projects in 1998, 40 projects were selected. The project descriptions are available on the Internet via the EUROPA server (http://europa.eu.int).

THE 5TH FRAMEWORK PROGRAMME FOR RESEARCH AND DEVELOPMENT

The 5th Framework Programme provides a European platform for supporting research and technological development as part of Community research policy, and effectively constitutes a four-year strategic plan. The thematic programmes included are the following:

Theme 1: Quality of Life and Management of Living Resources

Theme 2: User-friendly Information Society (IST Programme)

Theme 3: Competitive and Sustainable Growth

Theme 4: Energy, Environment and Sustainable Development.

The Information Society Technologies (IST) Programme is managed by DGXIII, the Directorate General for Information Society. The strategic objective of the Programme is to realise the benefits of the Information Society for Europe both by accelerating its emergence and by ensuring that the needs of individuals and enterprises are met. Information is available through Internet (http://www.cordis.lu/ist).

The IST Programme Key Action no 1 refers to *Systems and Services for the citizen*. The aim is to foster the creation of the next generation of user-friendly, dependable, cost-effective and interoperable general-interest services, meeting user demands for flexible access, for everybody, from anywhere and at any time.

Specific work areas cover (1) professional health care and personal health systems, (2) providing support to citizens with special needs, including the disabled and the elderly, (3) administrations to provide on-line support for the democratic process, access to information and services, (4) environment, and (5) transport and tourism.

As R&D priorities the following issues are mentioned: (1) "design-for-all" products, systems and services, including improved participatory design methods, multimodal terminals and universal interfaces, (2) adaptive systems, including communication tools for persons with special requirements, mobility support services, both at home or in the wider environment, robotics control systems, (3) multimedia applications for supporting daily living and social integration at home, work, education, transport, leisure, etc,, social support and intervention networks, and new methods of service delivery.

PROMISE (MULTIANNUAL COMMUNITY PROGRAMME TO STIMULATE THE ESTABLISHMENT OF THE INFORMATION SOCIETY IN EUROPE)

The PROMISE Programme is managed by the Information Society Activity Center ISAC of DGXIII. The Information Society Promotion Office ISPO is a service unit within ISAC.

The main objectives of the Multiannual Community Programme to Stimulate the Establishment of Information Society (1998-2002) are the following:

1 *To increase public awareness and understanding of the opportunities, benefits and risks of Information Society development.*

2 *To optimise socio-economic benefits of Information Society development by promoting synergy*

and cooperation for widespread access and familiarity in the use of services provided by Information Society services and applications.

3 *To enhance the role of Europeans and the European visibility within the emerging global Information Society.*

The awareness raising activities have to be well targeted and planned in order to achieve optimal results. Co-operation with national and other liaisons should be strengthened with partners having the mission to act as information distributors, multipliers and change agents within their region or area of activity. Specific actions are also necessary to win the public acceptance for Information Society services among citizens.

The actions are strongly focused on the objective to reach a strong penetration of Information Society services usage in everyday life in Europe. The Information Society is powered by new and renewed services available through information networks. Strong emphasis is given to the issues concerning service production, distribution and usage.

Understanding the factors and their interrelations behind successful service production, either on commercial basis or in form of free public service, is crucial and best practices in this area need to be identified. A interdisciplinary approach is necessary covering issues of technology, economy, social and societal aspects, education and training and people's patterns of behavior, values and motivation. The opportunities and services of Information Society should be accessible to all Europeans. Special attention is given to avoid polarisation to those fully equipped and skilled to benefit from the Information Society services and those lacking these facilities and abilities. Additional information is available through the ISPO server (http://www.ispo.cec.be).

SELECTED ISPO SUPPORTED ACTIVITIES

The Information Society Promotion Office ISPO has during the past years provided partial funding for several initiatives promoting the Information Society. A number of them have clearly set their objectives to combat social exclusion. The following case stories represent a small selection of these.

The Herzogsägmuehle case

Herzogsägmuehle is a welfare organisation of the Protestant Church and belongs to the Association for Internal Mission in Munich and Upper Bavaria. It is part of the small town Peiting, situated about 55 miles west of Munich. The village community of Herzogsägmuehle consists of about 1700 people, 1000 of whom are residents. Herzogsägmuehle is a place to live. The main principle of this community is to provide a place for those that are, at least for a certain time period, unable to live and work elsewhere in the society.

The Herzogsägmuehle community offers its customers such services as therapeutic education for children and young people, training and vocational rehabilitation, housing and working opportunities for people with handicaps, social psychiatry and special care and assistance for people in particular living situations, suffering addiction or growing old.

The Herzogsägmuehle community has also opened its own Internet Café, open to the inhabitants but also to other people living in close neighbourhood. The Internet Café has served well as a tool for opening new relations and for bringing together local people.

The ILSE (Independent Living for Seniors) initiative

ILSE is an innovative cross-cultural initiative involving both Finnish and Dutch experts. Its aim is to utilise the welfare, building construction and information technology know-how and best practices available in both countries to provide conditions for independent living for senior citizens.

In the Netherlands significant progress has been achieved in standardisation of accessibility and "seniorenlabel" criteria. Cost efficiency in building construction can also be mentioned as an acknowledged Dutch strength. Finnish strengths include utilisation of telecommunications and information technology, telematic applications for healthcare and social services, strong attention to environmental considerations, and the educational requirements of home care personnel.

The ILSE framework was used for workshops taking place in the Netherlands and Finland in 1998. In addition, an ILSE Seminar and exhibition has been held this year in the Hague providing Dutch and Finnish companies and organisations to exchange information on new solutions. The ILSE partners are eager to share their experience with other Europeans as well, and thus the initiative has the potential for a significant European contribution.

The Inspiration Society initiative

The Inspiration Society initiative aims, through ICT technologies, to provide a tool to help people develop their skills for creativity, self-expression and for improving their sense of self-esteem. The 1st European Inspiration Society Workshop took place in Paris in early December 1998. The general motivation for the workshop was the conviction that the Information Society should be a more, not less, inclusive society. The dangers of exclusion are present and should be abolished.

The workshop participants, representing six EU Member States, gave a strong support to the idea of promoting the Inspiration Society and to the initiative to establish a European Inspiration Society Network with the aims to: (1) exchange expertise, (2) explore and define the state of the art on its domain of interest. (3) anticipate future developments, (4) make initiatives for future action, (5) be a forum for developers, researchers and research institutions interested in Inspiration Society, and (6) organise meetings and workshops.

CONCLUSIONS

During the last few years a number of EU Member States have produced Information Society related national strategies or programmes. As a general rule it seems that the issues included in existing national strategies and programmes do not differ very much from each other. Naturally there are differences in scope and priority settings but agendas are still much alike in terms of employment reflections, need for education, application areas to be promoted etc.

Still, it seems that rather seldom the specific issues related to dangers of social exclusion are well addressed in depth. Whether these aspects are included in the information society development plans or not, seems to depend on the weight these issues have generally in the national development agendas. Fighting social exclusion is a matter of general policy.

However, the vital issue is the success in putting the strategies and programmes into action. These concrete action plans have to be prepared individually taking into account the local/regional/national circumstances. Information exchange, learning from best practices and

experience achieved elsewhere are important and provide valuable working material for consideration, but do not necessary ensure success.

It is also worth to underline, that the process of having a regional or national Information Society strategy serves well as a tool for producing overall regional development plans. The Information Society strategy work brings together not only technologies but also many other issues, such as social and societal, legal, economical and cultural aspects. The work is a reflection of the real life, in all its dimensions. Let us keep our approaches broad enough and let us to keep everybody on board.

Thank you for your attention!

Telematics and substance abuse prevention – possibilities and problems

Teuvo Peltoniemi, Finland

A-Clinic Foundation and Prevnet Euro

One can attempt to build a temporary or a longer lasting better world - **a utopia** - with the help of religions, political movements, arts and literature, but also, which brings us to our theme – through the use of chemicals like alcohol and drugs, or by different sicknesses of the mental kind. Utopia is also an especially suitable term for the Internet. Like traditional utopian ideas (Peltoniemi 1988, More 1516, 1998), also the Internet is anarchic, egalitarian, and impossible to control. New kinds of utopia are enabled by the virtual worlds provided by telematics, the Internet, mobile phones, virtual reality etc. If the term utopia suits telematics well, so does its antithesis, **dystopia** which has been used in literature to refer to societies where individuals are oppressed by means of technology and drugs, like in Orwell's 1984. While the date has now fortunately passed the threat itself is one to be kept in mind. It comes as no great surprise that telematics has been seen as having the potential for providing us with unlimited prosperity and wellbeing or, as a competing vision, as marking the beginning of the end for mankind.

The information society is nothing more and nothing less than a new way of dealing with the human striving towards utopia. That is why ICT - information and communication technology - has the same three characteristics**, a good method, a symbol, and a potential harm**, that the great utopian ideologies do. When trying to assess what the information society and telematics have to offer to those of us who work with mental health or substance abuse issues, all these three sides must be taken into consideration. This has been done implicitly in the important EU document "Building the European information society for us all" (1996) where most aspects of the role of information society and telematics are discussed in depth.

Social and psychological distance and anonymity

There is one particular feature of ICT which is of utmost importance for telematic solutions in substance abuse and mental health work. This is the possibility of letting people regulate the **social and psychological distance** with the help of telematics.

It has been suggested that the new information and communication technology is impersonal, cold and inhuman as compared to "real" human relations. This is the common argument of some professionals in social work and health care who consider telematic methods inadequate and consider face-to-face meetings as the mode of action to use in these fields. It can be pointed out, however, that in reality a large part of social and health work takes place over the phone and through letters. This issue is rarely seen in the context of another important question on human behaviour and service seeking: the wish for **anonymity**. (Peltoniemi 1997b)

Even though the impersonal nature of telematic methods is often listed as a disadvantage it can be an advantage as well. This, in addition to the easy operation procedure, is probably one of the reasons behind the explosive growth of e-mail, IRC groups, and short text messages.

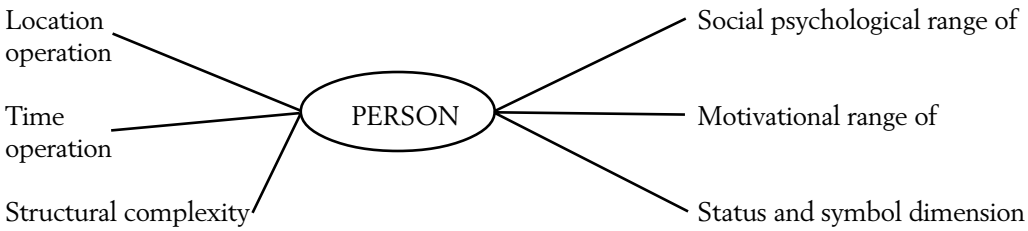
This question concerns interaction between people. We often seem to forget the variety of ways in which people communicate in different situations and cultures and at different times.

This oblivion is often connected to the rather simplistic pseudo-psychological idea that all problems will be solved if they are just "openly discussed".

The wish to regulate the social and psychological distance is easy to see in our everyday behaviour. We often make a phone call when a personal contact feels too difficult or otherwise unwise. In an anecdotal bit of information from Sweden, it was reported that sickness absences increased markedly when it became allowed to leave a message on the answering machine instead of having to report the absence over the telephone to an occupational health carer.

If we take an example from ordinary life, many of us like to first stroll around in a fashion shop for a while and then ask the sales persons to help. We like to obtain our own territory where we can orient ourselves to the situation. To put it short, telematic methods let people have more freedom in most areas; enlarge their territory. In a virtual world these areas can even be independent of each other, unlike in the three-dimensional, real word. Opportunities provided by telematics for drug and alcohol work are presented as an overview in Table 1.

TABLE 1. The differences between the real and the virtual world



The virtual world allows more freedom of action in terms of e.g.

- Time
- Location
- Autonomy
- Integrity
- Attitudinal range
- Cognitive resources
- Anonymity
- Motivation
- Social capacity

In this context it is easy to see the usability of services that give the client a chance to regulate his/her social and psychological distance in substance abuse and mental health work. Pal (1999, 1428) for instance, advocates the use of e-mail because "patients want to know more than they can obtain from the normal clinic based consultation, and they might find contact on the information super highway *less intimidating* than face to face dialogue with their doctors."

The advantages and disadvantages of ICT

It is interesting and important to note that with ICT the advantages and disadvantages are often different sides of the same features. When the degree, environment, intention, approach or target changes, a harm can become a benefit. For instance many are afraid that ICT will divide people into class A and B citizens. It is true that the use of telematics is distributed

unevenly and that there are big differences between countries, generations and genders. Hämäläinen (1997) suggests, however, that in many cases, if used proactively, ICT can be the best tool against exclusion for various reasons.

At least the aspects listed in the next table can be analysed from both perspectives. Some of them will be dealt with in more detail later on in this paper in regard to their importance in substance abuse and mental health work. The list is presented here only as an overview (Table 2).

TABLE 2. The advantages and disadvantages of ICT.

Instrumental nature
- efficacy, effectiveness
- cost-benefit - financial burden
- no alternative - no need
- threshold lowering/lifting
- easy access (time and place), public access - de-tolerance of delay
- target group - wide - specific
- richness of information - information anxiety/ information stress
- online, up-to-date - quality of information, needless information
- systematising work
- electronic data only - hard-copy - paperless office
- decentralisation of services/ causing unclear hierarchy

Democracy and ethics - legal and ethical questions
- anonymity, privacy, intimacy - data security
- self-help, citizens' own influence - treatment unavailability
- elites/masses - marginal groups, children, elderly, handicapped, unemployed

Human needs
- social contact - anonymity
- easy feedback, teletraining - impersonal, group counselling
- change in people's use of time: rigid/flexible time schedules
- work procedures and work roles
- leisure time/ work time
- interactive/ automatized contact
- engineer's dreams only - opposition to change
- generation gaps: youth/ older generation
- television - phone - e-mail
- interactive - non-interactive media

Telematics in substance abuse and mental health work

The Ottawa Charter of 1986 defines health promotion as a process enabling people to increase control over and to improve their health (Lehtinen, Riikonen & Lahtinen 1997, 31). The use of new information and communication technologies in health promotion has many advantages when evaluated using such criteria as cost effectiveness, simplicity, ease of access and anonymity. A seamless service chain can be developed using. Telematics can help and systematise treatment

methods. ICT makes it possible to contact a large number of people with reasonable costs. Information and communication technology can empower people and increase their ability to help themselves. (Building the European... 1996)

Even though many of the methods in alcohol and drug prevention have been borrowed from other disciplines there has not been much interaction with the technical sciences. The use of the new ICT in substance abuse prevention has so far been limited although in recent years such applications have been suggested. Sloboda (1997, 14) stresses the many advantages of the new technology especially in mental health promotion, alcohol and drug work and with other sensitive matters.

Even though the utilisation of telematic methods in drug and alcohol prevention and treatment has not been very extensive, examples do exist. The first telematic solutions were probably the crisis and hot lines that are now standard services in social and health care in most countries. Closer to ICT come automated, tape- or computer-based phone systems, the first of which were probably the Dial-A-Fact phone in Toronto, Canada (Schankula 1983) and AlcoPhone in Helsinki (Peltoniemi 1986).

Interactive computer-assisted drinking screening programs have been developed by for example the ARF in Toronto (Skinner & Allen 1983). Self-assessment tests can systematise client work in a neutral way and give the client written response and descriptions of his drinking habits in comparison to the general drinking habits. This kind of interactive computer programs and games are now quite common in many countries (e.g. Hester and Delaney 1997).

The idea of regulating the social and psychological distance has been tested for example in an American study (Huber et alia 1996) where members of a counselling group communicated trough anonymous e-mail messages even though they were located in the same premises. Therapists reported that clients were more frank and that written messages seemed to have a stronger effect than verbal exchange and suggested that this technique may especially help men with alcohol or relation problems as well as introvert delinquents.

Prevnet Euro

The possibilities of the Internet, support phones, computer programs and videoconference training in drug and alcohol work were tested in a series of pilot projects of Prevnet Euro - a five country project coordinated by the A-Clinic Foundation and financed mainly by the DG5 Drug Programme. The work concentrated on creating the contents and structure of cheap and simple computer technology and cross-cultural telematic interfaces. The emphasis was especially on approaches that can lower the threshold of contacting the prevention and service systems and that increase exchange of information between professionals.

All the Prevnet partners, from Finland, the Netherlands, Spain, Sweden and the UK, participated in the development of a data base on telematics, a Guidelines (Tammi & Peltoniemi 1999) and a video conference meeting system. In Finland and Sweden the main product is the DrugLink information and self-help platform. In Prevnet Sweden one of the end products was a self-evaluation program, "Lifestyles". NIGZ in the Netherlands provides an extensive service, Alcoholvoorlichting, for the young in both Dutch and English. Prevnet UK publishes a net magazine, Drugworld, for the young, as does Prevnet Finland ("Hemmo"). Drugworld as well as the Finnish DrugLink have already won awards of excellence.

The Finnish Drug Link

The main platform for telematic substance abuse work of the A-Clinic Foundation is DrugLink (Päihdelinkki). It contains a large data bank of information bulletins on addictions, available in print form, through automated voice menu controlled phone service and on the Internet. There are also Swedish language versions of DrugLink both in Finland and in Sweden. An English version is being prepared.

Self-help tests are provided for alcohol, drugs, gambling, smoking and excessive Internet use. The test applications give case specific recommendations for possible further action based on the results. In the DrugLink web counselling service the staff of the A-Clinic Foundation answer anonymous questions.

The use of DrugLink has been quite extensive and it has actually exceeded all expectations. The average number of users has been 130 a day and the average stay on the DrugLink pages has lasted 23 minutes which is more than would be spent on a typical superficial surfing visit. In the process, DrugLink has increased the number of out-patient clients of the A-Clinic Foundation by 25 %.

Net dependency

One of the main disadvantages of the Internet is its addictive nature. Computer games can be very dependency inducing (Mustonen 1998). There are many people who play the virtual card game Solitaire, the most common PC game, for long periods per session even at work. Internet addiction is a logical addition to the list of dependency problems treated organisations like the A-Clinic Foundation.

A number of net addicts has come to the attention of the A-Clinic Foundation through both DrugLink and the local units. It is still difficult to evaluate when one's use of Internet within the limits that could be regarded as "normal". This is why self-assessment tests on Internet addiction are perhaps even more important than with alcohol or drugs.

It seems that the net addicts' relation to the Internet is more social than is the case with average users of the net for whom the instrumental nature of the net is more important. (Young 1998) Addicts use Internet chat arenas, multi-player games and e-mail quite a lot. In this way the Internet really is a **virtual space** for net addicts, an expansion of normal social relations. This is also a benefit. Basically there cannot be anything wrong with the idea that people meet online instead of through more traditional means. I personally know at least two women who have got married or have found a permanent relationship through net contacts.

Virtual reality

In a Chinese story an artist paints a picture of a house so real that he can finally open the door and enter the house to vanish for good or, to use a recent term, move into **virtual reality**. Many things and behaviours allow us to catch a glimpse of a virtual world. We can step into a virtual world through chemicals, movies or books, even if these only stimulate a few senses. The human imagination fills in the gaps.

In telematics the term virtual is used in a very vague and broad sense. More strictly it means artificial stimulation of all five senses by means of a computer. At some point this could perhaps even be done through direct manipulation of the brain without any wires and electrodes. From this perspective virtual reality is technologically still in its infancy. Not all senses can yet be involved in the experience and what can be done is still rather primitive, as for example heavy gloves and a helmet are needed.

A concrete example of how virtual reality and the real world already overlap are the driving computers where GSP satellite positioning is combined with online maps. The driver always knows where he is and the map can even be projected on the windshield and thus be matched with the surroundings. At least in Tokyo already now the car driving assistant computer is a blessing because of the ancient odd system of allocating names and numbers to streets and houses.

As a little example of what the virtual world may bring us later on is the toy of 1997 - Tamagotchi. It is a virtual chicken that requires all the care, feeding, cleaning and playing a living bird does. Tamagotchi is a good example of the three main features of ICT. It is at the same time a means, a symbol and a problem. It became extremely popular without any marketing efforts which tells us that it was the first representative of a threshold invention. It was a gimmick good enough to combine a machine and human like behaviour. And again human imagination takes care of the rest.

In the future it will be possible to seamlessly mix the real and the virtual using new technology. We can live in a world where the real and the imaginary mix totally and in such a way that there is practically no hangover or other kinds of punishment to follow. Most people will probably use virtual reality in the same way than we now use movies or books, just as a brief trip away from reality. But surely there will also be those who like virtual reality so much that they do not want to come back to the dull realities of ordinary life, especially if they are marginalised people. It is possible that this **complete addictive behaviour** takes over all partial virtual experiences that we can now achieve with substances or other means. This may develop into a real challenge for the prevention and treatment of addictions.

Control of Internet

Many see the Internet as a conduit for drug dealing and, indeed, there is a lot of drugs-positive material. It is easy to find material on the use, availability and production of drugs (Internet and illegal drugs 1998, Peltoniemi 1997a). There has been serious discussion, also within the EU, on whether the Internet should be better controlled (Parental Control… 1999).

The control of the Internet may, however, be very difficult if not entirely impossible. In health education the belief sometimes surfaces that exaggeration, half-truths and even incorrect information and scaring tactics are justified by the good purpose. This can hardly be considered correct. In Prevnet Euro a different approach was chosen. The project's Internet pages offer balanced high-standard information on drugs to provide people with the necessary tools so that they can decide for themselves. There are even links to some of the main pro-drugs pages.

This policy was also referred to in the Finnish statement at the UN Special Session on Drugs in New York, in June 1998, when minister of Interior Jan-Erik Enestam informed, how "materials are being produced in several European countries to be used to balance inappropriate or false information on drugs" (Enestam 1998). This policy also emphasises that because informal guidance by parents is difficult, the society should help families with this task. (Parental Control… 1999).

Another reason that makes the control of the contents of the Internet very difficult is the fact that with many sensitive questions such as sex, drugs etc it is impossible to reach a consensus in any one country let alone within the EU or world-wide. One may recall how contradicting views exist on drug policy in the European Parliament.

Telematics and social norms

It is easy to see that ICT is now very symbol loaded. It is most often presented as a utopia, a means for reaching everything that is good, a sign of success and of future. On the other hand there are those who believe in a more dystopic vision and claim that ICT is the final tool in excluding a part of the population from the main front of life.

In an American study 18 % of the population eagerly accepted new technology, 48 % were cautious experimenters and 34 % were against it (Rosen & Weil 1995). In Finland the attitudes towards information society are more positive than in EU countries on average. (Nurmela 1997).

The different attitudes are probably based on differences in infrastructure. Today in Finland, there is at least one mobile phone in 75 % of all households, a computer is available to 63 % either at home, at work or at school, and access to the Internet is available to 42 % of the population. (On the road... 1999).

It is quite likely that the symbol value of ICT diminishes as the infrastructure of telematics improves. Then also the views of what is acceptable and normal will change. A good example is provided by two news items from a newspaper last summer. The first one was about how in the UK radio disturbance transmitters had been installed in some train carriages, blocking the use of GSM phones. The other one was about GSM sub transmitters being installed in trains carriages in Finland to improve the field of mobile phones.

Of course it is not only a question of attitudes, personality features or technophobia, but of a much wider combination of matters (Rantanen & Lehtinen 1998, 33). Taking a critical attitude, the fear of new technology or the fascination of it are really different sides of the same matter, of a kind of an adaptation process.

The message is clear: mobile phones and the Internet will follow the same track as phone and television. The first users of ICT are norm breakers, they are either admired or hated, often both at the same time. Then the exception becomes normal, most exaggerated forms diminish and emotional reactions decrease.

Technology, contents and training

In criticisms of telemedicine it has been stated that in the beginning the driving force behind the development was technology itself, not its applications (Ohinmaa et alia 1997). If the objectives for the use of telematics are not clear we will not get the results wanted as new technology in itself is not enough. As Dr. Vappu Taipale (1998), the Director General of Stakes, stated at the UN Committee for Social Development: "The importance of information society will me measured on the bases of the contents outcome. A real challenge is to get rid of the instrumental-orientation and concentrate to increase the level of contents."

Another important aspect to be strongly emphasised is the need for training of professionals. In Prevnet Euro especially the use of video-conferencing was tested. Evaluation study data was also gathered using mostly video conference connections. Teleconferencing has now reached a point where the standards and cost of equipment make personal teleconferencing possible. This has often been the stage where real development begins. Another test takes place right now as we have a video conference connection to Prevnet Jellinek in Amsterdam.

Prevnet Euro experiences

Many of the experiences of Prevnet Euro and other telematic project in substance abuse and mental health work have been discussed above. The suggestions derived from Prevnet Euro can be summarised as in the table 3.

TABLE 3. The suggestions of Prevnet Euro.

1. Both advantages and disadvantages must be taken into account as they are often two sides of the same coin.
2. Contents must come before technology.
3. The citizen's point of view must be the starting point.
4. Telematics must give people themselves greater freedom to regulate their social and psychological distance.
5. Both direct and indirect services are needed.
6. Networking, assessment and help methods by people themselves and their peers must be provided.
7. Training is necessary for utilisation of telematics to the full and to overcome cultural and generation gaps.
8. Services must also be provided for marginal groups.
9. Support and treatment services for net addicts and, in the future, virtual addicts must be organised.
10. Democracy and equality are long-term goals.
11. Local, regional, national and international services must be networked and integrated.
12. Follow-up, evaluation, self-learning and self-systematising must be built into the systems.
13. Access must be easy, simple, instant and cheap, that is, of a low threshold.
14. There must be a seamless service chain and integration of telematic and traditional services.
15. The main goal of the level of quality is the best possible service.
16. The financing of anonymous services must be organised centrally as the clients cannot be identified and allocated to any particular financing system like their home municipalities.
17. The services must be innovative and provide added value, e.g. invent new working procedures that would be impossible with traditional means.

The last point is important. Many virtual reality solutions are of this nature and some cannot even be imagined yet. Therefore ICT innovations must be carefully scrutinised and adapted to the service of social and health care if they contribute to the general goal of advancing the well-being and health of people.

Future development

Currently, Prevnet Euro services are mostly informative and preventive. Self-help tests, the DrugLink anonymous consultation service and support phones suggest that telematics can also be used in the treatment of addictions and related problems. There is already a plan with some of the Prevnet Euro partners for a *virtual clinic* where treatment, research, inter-professional consultation and training would be added to the existing telematic services. The idea is that a seamless telematic service chain would be combined with traditional face-to-face services to create an integrated system.

The link between the abuse of alcohol and drugs and mental health problems, suicidal behaviour and other psychosocial problems is well known. Thus an increase in the consumption of alcohol

and other substances also leads to an increase in the incidence of related problems. This calls for a unified alcohol, drugs and mental health policy and a close cooperation of different services.

There is a need to integrate not only vertically but also horizontally. The technical platform of the virtual clinic should be general enough to also be applicable in related topic areas. In the final version the platform should be integrated to general social and health care telematic systems to provide an easy, user-friendly and effective interface available to all citizens on local, national and international level.

In the Finnish statement at the UN drug session in June 1998 it was announced that this autumn, Finland will organise a meeting "on information and communication technology which could be applied to drug prevention." It was a reference to this conference and especially to the workshop 6 "Telematics in mental health promotion and substance abuse prevention", which is also the end seminar for Prevnet Euro. The arena of this speech reminds us of the fact that the new ICT and especially the Internet are global and transnational in nature. Thus it is to be noted with pleasure that organisations from all the 15 EU member states have already joined the application for an extensive Prevnet Telematic Network to continue the work of Prevnet Euro.

All the material referred to suggests a course of development which demands that we make the slogan *information society* become reality also in alcohol and drug prevention and treatment. One thing is for sure: the question is no longer whether we should use information society or Internet in our work. The point of no return has been passed long ago. Now the question is whether we will be developing the ways in which ICT is utilised in our work ourselves, or whether others will do it for us.

I started by referring to telematics as a new way towards utopia, and really, there is a great potential in ICT to take us much closer to utopia than traditional methods ever allowed. Therefore let us go together. This time the method allows us all to stay in command, not just follow the leader as in traditional utopias.

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Round-table: wider partnership for promotion of mental health

Peter Lehmann, Germany
European Network of (ex-)Users and Survivors of Psychiatry (ENUSP)

Promotion of mental health and prevention of mental disorders by empowerment

IS THERE A PSYCHIATRY-POLICY WITHOUT MEANINGFUL PARTICIPATION OF (EX-)USERS/SURVIVORS OF PSYCHIATRY?

To have ten minutes so speak is an honour, compared to total exclusion of users, ex-users and survivors of psychiatry in former years until the beginning of this decade, when the European Network of (ex-)Users and Survivors (ENUSP) was founded. To have only ten minutes makes me rather angry, because so many things, I as the representing person of the (ex-)users and survivors of psychiatry who are the subject of the conference, can't say in the short time: for example human rights' violations, non-stigmatising non-psychiatric approaches as examples of good practice in preventing mental disorders and promotion of mental health: like the user-controlled Berlin runaway-house or Hotel Magnus Stenbock, a user- and survivor-run project in the Swedish Helsingborg – institutions which are more effective and – by the way – cheaper than psychiatric institutions.

Empowerment is the key word that best shows the central interests of (ex-)users and survivors of psychiatry. »Empowerment«, a special term coming from USA, can be understood as »self-authorisation«. (Ex-)users and survivors of psychiatry should have or regain the authority over their own life, get access to information and money and speak with their own voice. Empowerment is the basis of prevention of mental disorders and promotion of mental health.

Speaking more about terms: The term »user of psychiatry« refers to people who have mainly experienced psychiatric treatment as helpful. The term »survivor of psychiatry« in turn refers to those who have mainly experienced psychiatric treatment as being a danger to their health.

These definitions are often misunderstood: to »survive psychiatry« does not mean that psychiatrists are being accused of trying to intentionally maltreat or kill people. But it does mean that diagnoses such as »schizophrenia« or »psychosis« very often have a depressing and stigmatising effect, leading to resignation and chronic hospitalisation. And it means that drug-effects such as neuroleptic malignant syndrome or tardive dyskinesia or dystonic or epileptic attacks can be a danger to health and life, which have to be survived. Believe me, I know what I am speaking about.

To speak from ENUSP means to focus on its several added values inclusive the broad representation from different organisations in East and West and in the different national states. ENUSP, an autonomous and democratic organisation, includes organisations from all European states, even those that are to join the EU in coming years.

The meaning of the inclusion of (ex-)users and survivors of psychiatry became clear also with the conference "Balancing Mental Health Promotion and Mental Health Care. Joint WHO / European Commission Meeting", Brussels, in April 1999. Also one representative of ENUSP was invited beside approximate 70 psychiatric workers and other ones. The necessity of the inclusion of (ex-)users and survivors of psychiatry was expressed by the rejecting reaction to complete all given suggestions regarding common goals and strategies to advance mental health promotion and care.

Only after a strong criticism (nobody had dared it to affirm the position of ENUSP) and under friendly support of the European-Union-representatives Mr. Alexandre Berlin and Mr. Horst Kloppenburg some of our proposals have been added to the consensus-paper:

- the active inclusion of (ex-)users and survivors of psychiatry to psychiatry-policy
- the promotion of self-help-approaches and non-stigmatising, non-psychiatric alternatives and
- above all the freedom of choice to strengthen human rights.

To repeat: nobody of these famous and 'progressive' psychiatrists in Brussels had dared it to affirm the position of ENUSP.

Human rights' violations in psychiatry mostly are only recognised by (ex-)users and survivors of psychiatry. If here would be more time, I would speak about complete psychiatry laws, which were developed from political parties in co-operation with (ex-)users and survivors of psychiatry for example in Germany, even if not accepted by the parliament – laws which in particular contained the legal security of advance directives for the protection of the right of self-determination and human dignity. We want certainty of the law also for us. Human rights are not divisible. (Ex-)users and survivors of psychiatry have to have the same rights as so-called normal patients.

One example, how co-operation could work, is the acceptation of a resolution of World Network of Users and Survivors of Psychiatry (WNUSP) in Santiago, Chile, September 1999, by the general assembly of the World Federation for Mental Health. As spreading laws and courts' decisions on forced outpatient treatment with psychiatric drugs gives (ex-)users and survivors of psychiatry deepest concern and produces desperation and depression in many cases, because to destroy the human right of self-determination and to rob somebody of his or her own safe room to live, creates paranoia and other mental disorders. WNUSP's resolution to WFMH, when accepted, gives hope to lower the danger of further spreading of forced outpatient treatment and its consequences, new and enhanced mental disorders. When the resolution was accepted: »Because of concern about the spread of forced psychiatric procedures into the community, resolved that WFMH supports the position of WNUSP in opposition to involuntary outpatient commitment«, there now is the possibility to co-operate on international and national levels to prevent the human rights' violation of outspreading forced treatment.

In 1997 ENUSP has made a lot of co-operation-suggestions, when we were asked for a statement to the draft »WHO Quality Assurance in Mental Health Care«. You can read the proposals in "Current Opinion in Psychiatry", No. 1 in 1999, where the commentaries to the Declaration of Madrid are published. I cite one proposal to enhance quality of care:

It should be acknowledged by psychiatric associations and/or by reforms of the law that advance directives (made during non-doubted states of normality) about wanted and unwanted treatments have to be respected.

By the way: ENUSP prepares an international workshop on this topic. We ask you to support the financing, concerning the designation of legal possibilities for advance directives in the different countries as well as reaching people who want to support our efforts for improvement of the legal situation of (ex-)users and survivors of psychiatry.

At last again our central interests and goals regarding the development of psychiatry-policies, promotion of mental health and prevention of mental disorders:

- Inclusion of (ex-)users and survivors of psychiatry and acceptance of their treasure of experience on all levels of decisions, administration and education and research
- Protection from unwanted medical manipulations
- Freedom of choice as a characteristic of quality of care
- Development of alternatives to psychiatry for (ex-)users and survivors of psychiatry who made bad experiences with psychiatry or who doubt the competence of medicine to solve psychological problems of social nature
- Financing of self-help and alternatives by splitting the available money.

I am very sad to tell you at this European meeting on Promotion of mental health and social inclusion, that the European Commission decided in 1999 not further to support ENUSP, which makes it very complicated for us to exchange information and even have a well-functioning desk to make co-operation optimal. We hope for your support to change the situation again.

Financial contributions to psychiatric institutions, organisations and congresses should be made dependent on a meaningful participation of (ex-)users and survivors of psychiatry. Meaningful participation means that (ex-)users and survivors of psychiatry are integrated in planning processes, are supported financially to participate, are integrated in all meetings and decisions on the basis of equal opportunity and can speak more then ten minutes in meetings and congresses.

»Psychiatric services belong to the users«, Mr. Eero Lahtinen from STAKES said at the »Joint WHO / European Commission Meeting« in Brussels in April 1999. (Ex-)users and survivors of psychiatry should be included effectively into all topics.

At first glance this proposal may seem expensive and rich of conflicts. However, self-help and empowerment as means for promotion of mental health and prevention of mental disorders in particular – in view of sinking public funds and increasing efforts for equal opportunities – are justified not only morally, but also help to guarantee mental health and the prevention of mental disorders. ENUSP and the organisations, which are organised in ENUSP, are ready for co-operation. Please use our offers.

Solja Peltovuori, Finland

European Federation of Associations of Families of Mentally Ill People (EUFAMI)

I start my presentation with a concrete act. I have with me a EUFAMI petition, that has at the moment 47.186 names from all over Europe. This petition is addressed to the political decision makers and health-care professionals. As a EUFAMI representative I'm very happy to give it to all of you who are attending this conference. The actual statement supported by all these people is: "Europeans should by right have access, when required, to prompt, effective, high-quality and up-to-date mental health care and services".

EUFAMI message is that, just as we are very willing to work in the area of mental health promotion, we are naturally equally interested in the area of mental health services. Our wish is to have a balanced combination of both approaches. The petition and the concern that it is clearly demonstrating, is also to show you that EUFAMI is a valuable, active partner of the European level. We have at the moment members from sixteen countries and believe that we represent at least 50.000 families coping daily with mental health problems.

I now will take the opportunity to bring you news from the third European EUFAMI congress, that was held in Stockholm, by coincidence almost a warm up -meeting for this EU-conference in Tampere. The Stockholm conference title was: The caring future… starts now! About 300 people attended. The main themes that were dealt with were: children of people with mental ill health, family support and self-help and codes of good practice for psychiatric illnesses. The conference was a great success with a new Stockholm declaration published. The conference results will act as guidelines for the future activities and efforts in the field of family work.

For some time now, EUFAMI members have been campaigning in certain areas in their respective countries and also more and more on the European level. The topics have dealt with reducing stigma, self-help and empowerment, legislation and codes of good practice, and active involvement in research activities e.g. family participation and early intervention in psychosis.

One of our main interests has been the development of networking and partnerships. There has to be different levels of co-ordination (e.g. different resources), co-operation (e.g. working together with concrete projects) and communication (deeper understanding) dealing with values and changing practices. With this type of active role, Eufami has a many tools for mental health promotion to work with many different partners.

I thank you for your attention and end my short presentation here, so that there is also time for questions and comments from the audience.

More information available from the EUFAMI web site: www.eufami.org.

Vivian Barnekow Rasmussen, Denmark
WHO Regional Office for Europe

"WHO has a policy framework on a very deep theme that is called Health for all by the year 2000. It has a lot of targets and quotations and those targets will not be filled by the year 2000 that's for sure. So it's useful to see a paper that has been developed and its called "Health 21 - Health for all in the 21st century".

So this is our framework for working for the next 20 years or so within the World Health Organization. To get to the health for all by the year 2000, it is focusing on determinants of health and also much broader, because it is focusing on the fact that social and economic determinants are very important in any kind of health area. So this is why I'd first like to assure you that there is a very very deep interrelationship between socio-economic development of the country and the region, and the health development in the same area. Another part of WHO and the new framework is focusing on partnerships, but let us start by looking at the target which is dealing specifically with mental health. So it's Target 6 on the 21 point targets and the headline is improving mental health. By the year of 2020, people's psychosocial wellbeing should be improved, and better comprehensive services should be available and

accessible by people with mental health problems. And let me just highlight two of the areas that are in context in this target. First of all, the prevalence and adverse health impact of mental health problems should be substantially reduced, and people should have an increased ability to cope with stressful life events. More attention is paid to the promotion and protection of mental health throughout life, particularly in socially and economically disadvantaged groups. And the third one to highlight is living and working environments are shaped to help people at all ages to gain a sense of coherence, build and maintain social relations and cope with stressful situations and events. And it is obvious that these areas won't become entirely a matter of the health sector only.

Another target which also includes the issue of partnership in the 21 targets is Target number 14 which talks about a multisectoral responsibility for health, and debates that by the year 2020 all sectors should have recognized and accepted their responsibility for health. This includes the fact that we should not in the health sector only seek to put our footsteps on our sector into our legislation, but we should also manage to put footsteps or footprints of health into social and economic regulations and legislation etc. And let me try to look at the areas that focus to comment this target. Decision makers in all sectors should take into consideration the benefits to be gained from investing for health in their particular sector, and orient policies and actions accordingly. The promotion and protection of public health are used as essential criteria when choosing policies and strategies both in business and in public sector. Governments and parliaments give higher priority to policies that contribute to health promotion and protection, and undertake health audits across all sectors. More attention is paid to the individual and collective responsibility in education, information and research activities in order to build awareness of competence in and accountability for health.

Another target I will focus on this presentation is Target number 20 which is mobilizing partners for health, and it should be at the heart of all of us to deal with here - partners for health. So by the year 2005, implementation of policies for health for all should engage individuals, groups and organisations throughout the public and private sectors, and civil society, in alliances and partnerships for health. And I will highlight the following areas: health sector should engage in active promotion and advocacy for health, encouraging other sectors to join in multisectoral activities and share goals and resources. Structures and processes should exist at international, country, regional and local levels to facilitate harmonised collaboration of all actors and sectors in health development. All sectors and actors in health identify and take into account the mutual benefits of investment in health. International solidarity for health development is strengthened, using the European structures for intergovernmental co-operation and action.

Added to this, I could mention that in 1997 at the international health promotion conference in Jakarta, where one of the five priority areas incorporated in the resolution was also partnership - and let me just read out a few lines from there. The headline was "consolidate and expand partnerships for health." Health promotion requires partnerships for health and social development between the different sectors and all health components in the society. Existing partnerships need to be strengthened and the potential for new partnerships must be explored. Partnerships offer mutual benefits for health through the sharing of expertise, skills and resources. Each partnership must be transparent and accountable and be based on agreed ethical principles, mutual understanding and respect.

So if I go into the specific area of mental health and mental health promotion, I shortly focus on developing in January this year (1999) and specific partners are mentioned such as of

course collaboration with the European Union, of which examples have already been seen through their meeting in Brussels couple of months ago and also in this conference here. If we go down to networks, I would like to mention examples of networks that should be looked at as allies and partners when we talk about mental health and mental health promotion in Europe. I would say that of course this list is not full, this is just examples of partnerships that could be actively engaged. So one is the Advisor Group on mental health, another one is the European Task Force on mental health promotion, a European multi-center study on attempted suicides, WHO has a long series of collaborating centres in the area of mental health and I think that in the last meeting 25 collaborating centres were presented, in all their different fields of mental health and mental health promotion.

And finally, but not lastly, collaboration with non-governmental organisations which is essential, and one is of course Mental Health Europe. Next speaker will discuss partnerships and the necessity of partnerships within the health sector and across all sectors. I should also need to emphasise the necessity of partnerships outside the public sector: partnerships with the private sectors are essential as well. Thank you very much."

Katherine Weare, England
University of Southampton

PROMOTING MENTAL HEALTH IN CHILDREN AND YOUNG PEOPLE: THE NEED FOR A WHOLE SCHOOL APPROACH

The health promoting school approach

To date much work on the mental health of children and young people has been concerned with the needs of troubled and troublesome pupils, those with special needs and emotional difficulties, and those whose behavioural problems disrupt the school community. Of course a concern for the vulnerable is vital, but such work is more effective if it is based within a broad and positive focus on mainstream schools, on the whole school population, and on teachers as well as pupils.

This paper argues that, to promote the mental health of children and young people effectively, we need to take a whole school rather than just an individualistic approach, and attempt to make the whole school into the kind of place where all, teachers as well as pupils, can be mentally, emotionally and socially healthy. This 'health promoting school' approach sees the school as a holistic, ecological, and inter-dependent organism (Parsons *et al*, 1997). In the health promoting school approach, the totality of school life is examined and understood, including what has been termed the 'hidden curriculum' of the norms, values and of school life. All aspects of school life are seen as potentially relevant and inter-related, including not only the taught curriculum, but also the school ethos, relationships, management structures, and the physical environment. The health of teachers is of concern, as well as pupils. Looking even more widely, the school is seen as part of its wider community, reaching out to and supported by parents, local health services, and other agencies, involving them in programmes and interventions, while in turn contributing to the life of the community. Such an approach is being realised through networks across the world, particularly in Europe, where the European Network of Health Promoting Schools (ENHPS) is now to be found in some forty countries. Evaluations show that it has been a highly effective catalyst in developing health promotion in schools (Parsons *et al*, 1997), including mental health promotion (Weare and Gray, 1994).

The need to take an eco- holistic approach is well supported by evidence from research on school effectiveness (Durlak 1995). Areas are crucial include staff development and training, curricula, methods of assessment, pupil ability groupings, teacher-pupil relationships, and parental and community involvement. There have been a wealth of studies into what kind of school environments and climates are the most effective both in inducing learning and promoting mental and emotional health in schools.

Four key elements have consistently shown to be crucial to all aspects of school life and achievement, including the promotion of mental health of pupils and teachers: they are supportive relationships, a high degree of participation by staff and pupils, clarity, and the encouragement of autonomy. Each of them separately, and even more so when found together, clearly leads to better academic achievement and interest in the subject in pupils, better teaching by staff, and higher morale and lower absenteeism in both parties (Moos, 1991; Wubbels, Brekelmans and Hoodmayers, 1991). These studies have also demonstrated that the assumption that there has to be a conflict between the traditional academic goals of the school and the goals of mental health promotion is incorrect. The opposite is in fact the case: the same conditions are conducive to both types of goal, and both types of activity tend to support one another.

Relationships

The importance of warm and supportive relationships to both learning and mental health is well supported by empirical evidence. Studies have consistently shown that the quality of relationships in a school is an essential factor in producing high levels of staff and pupil morale and performance. For example, a meta-analysis of 24 studies suggested that pupils learn more and have higher attainments, enjoy learning and are more motivated, and attend better if their teachers are more 'understanding, helpful and friendly' (Wubbels, Brekelmans and Hoodmayers, 1991). A meta-analysis of 12 sets of classroom research across 4 countries in the 1980s (Haertel, Walberg and Haertel, 1981) showed that better achievement on a variety of outcomes, both cognitive and affective, is associated with classrooms with 'higher levels of cohesiveness' and 'less social friction'. Conversely schools that are unsupportive and have poor relationships have been shown to induce depression and absenteeism in staff and pupils (Moos, 1991). Poor relationships between pupils and staff and between teachers and their colleagues is one of the most commonly cited causes of staff stress, while high levels of support, particularly from the head teacher have consistently been shown to reduce the likelihood of teacher 'burnout' (Sarros and Sarros, 1992).

Rogers (1961) suggests that three key competences underpin our ability to make relationships across a wide range of social contexts: they are the capacity for empathy, genuineness and respect. He maintains that the higher the levels of empathy, genuineness and respect that the teacher gives to the students, the more the students will learn. The same applies to staff: the more they feel understood and liked, the more effort they are likely to put into their work and supporting the life of the school. So the type of school ethos that is most appropriate promoting both health and learning is one in which the school as a place where each person feels that they belong, feels cared for, valued and safe, which facilitates their growth and which empowers them to 'be all they can be'. The key principle of equity demands that all be freed from oppression and fear (WHO, 1997b), and so the promotion of a sound school ethos and healthy relationships means that schools need to take vigorous steps to prevent violence and bullying, an issue on which there now a wealth of well researched work on which schools can draw (Rigby, 1996; WHO, 1997a).

Participation

There is overwhelming evidence that the level of democratic participation that the school encourages is a key factor in producing high levels of both performance and satisfaction in both teachers and pupils. In a now classic study of 12 British schools, Rutter et al (1979) found that schools that were more effective in terms of pupil learning outcomes were also more likely to consider teachers' views and represented them fairly, and involve teachers in policy formation. A study by Little (1982) found that where staff were involved in designing and evaluating teaching materials and teaching them to one another they were more motivated and committed than when they were teaching programmes that were given to them to teach. Byrk and Driscoll (1988) found that teachers who worked in schools that were more 'communal', in terms of having shared values and a common agenda of activities, were more likely to be satisfied with their work, be seen by students as enjoying teaching, to have high morale, and be absent less often. Meanwhile students in more 'communal' schools were more interested in school and had better achievement. Throughout such 'communal' schools disorder, absenteeism and school dropout rates were lower.

So a key strategy for mental health promotion in schools is to ensure that its organisation, management structures and ethos are empowering and encourage participation. Empowerment and participation takes many interlinked and mutually supportive forms: they include consultation of staff and students, a democratic, 'bottom up' approach to decision making, and open communication. The role of the headteacher in an empowering school is as facilitator rather than a despot, the leader of a team of staff rather than the apex of a rigid hierarchy, a team that genuinely collaborates with pupils and parents in the running of the school, is responsive to their needs and wants, and attempts to create a sense of common ownership of the school's processes, policies and decisions. Such schools see themselves as accountable to parents, to pupils, to local education authorities, and to the local community. Pupils' parliaments, parents' councils, and school planning groups that include members of the local community are just some of the ways in which empowering and democratic intentions can become reality.

Clarity

The third key element in the effective school is clarity, which is another word for transparency, often put forward as a central value in the health promoting school (WHO, 1997b). Clarity involves people experiencing structure and boundaries, knowing what is expected of them and what they can expect of others, understanding what their role is, and what the norms, values and rules of the organisation are. Without such clarity people cannot feel safe enough to operate effectively or to give one another warmth and support: the world becomes frighteningly boundless.

The need for clarity in human relationships and organisations has been proven time and again by a great deal of research: basically people do not relate to one another or work well in climates with high levels of ambiguity and uncertainty. In the school context, several meta-analyses have shown that students learn more and have higher attainments, enjoy learning and are motivated, and attend better if their teachers show clear leadership and are certain of what they are doing (Wubbels, Brekelmans and Hoodmayers, 1991). Studies have demonstrated that pupils achieve better, both cognitively and affectively, in classrooms with higher levels of goal direction and less disorganisation (Hartel, Walberg and Haertel, 1981). Rutter *et al* (1979) found that pupils do better in more structured schools in which they receive more praise and positive rewards and where staff had high expectations of them. Teachers too do better where goals are clear (Little, 1982), being more highly motivated and more effective in their job

performance. Clear feedback about the quality of their performance to pupils and to teachers, so long as it is supportive, is strongly associated with satisfaction and effectiveness (Moos, 1991).

So a further key strategy for schools is to ensure that they are providing a secure environment in which children and young people can trust. To induce effective learning, schools and teachers need to know clearly what they are aiming at, how they intend to achieve it, on what evidence these approaches are based, and why they believe it is a good idea. It follows that those who would promote mental health in schools need to set about the task with the same degree of organisation, clarity and structure as is given in effective schools to the transmission of core values, to discipline and to the teaching of traditional subjects. Mental health will not be promoted through vague and woolly approaches (although this does not imply that they must be taught through traditional didactic methods, as we shall shortly see).

Schools need to have explicit policies that relate to mental health promotion built into their school development plan, in the curriculum, the environment and in terms of family and social links. They include policies on issues such as relationships, decision making, discipline, bullying, racism, sex education, and home school relationships, all of which have an important part to play in shaping the overall health promoting context. Such polices need both strong management support and to be 'owned' by staff, pupils, parents if they are to succeed in practice.

Autonomy

The goal of empowerment is not compliance but autonomy, by which is meant self determination and control of one's own work and life, thinking for oneself and being critical and independent, while able to take full responsibility for one's own actions. So the final fourth feature which is essential if the mental health of school members is to be genuinely promoted is the encouragement of autonomy.

Research has consistently demonstrated that pupils learn better across the board, including in their academic subjects, and are happier at school, if the goal is for them to think for themselves and to work as independently as their age, stage and personality allows. To summarise the results of several meta-analyses, it clear that students learn more and have higher attainments, enjoy learning and are motivated, and attend better if their teachers allow high levels of student responsibility and freedom (Wubbels, Brekelmans and Hoodmayers, 1991). Pupils respond where the degree of organisation and structure is suited to their age, stage and personality (Greenhalgh, 1994). Younger, less mature and more introverted and anxious pupils children need higher degrees of structure and organisation but still benefit from being given as much autonomy as they can handle, and by being gradually encouraged to work with more independently. Older, more mature and more confident pupils can handle higher levels of individual choice and autonomy. So teachers need a strategy for gently pushing the learner towards ever greater independence, while providing a secure base for their explorations. As pupils mature, programmes can to an increasing degree become pupil lead.

Autonomy is a vital issue for teachers too. The degree to which teachers have control over their own work, and have leeway to make their own decisions has been shown to be fundamental to their emotional and social health and to their performance in general. Studies across a variety of occupations have shown that higher levels of staff autonomy have a wide range of benefits, including decreased stress levels, lower absenteeism and higher morale (Shaw and

Riskind, 1983). Tuettemann and Punch (1993) found that lower levels of stress were associated with higher levels of influence and autonomy. Those further up the hierarchy of the workplace who have greater control over their environment tend, contrary to common sense expectations, to have lower stress levels than those lower down, despite having a higher pressure of work: for example a study of head teachers showed that they tend to have lower stress levels than those who work for them, while a study of female, younger and more junior teachers found they had higher stress levels than their male, older and more senior counterparts (Hui and Chan, 1996). Where staff lower down the hierarchy are allowed more leeway to make their own decisions, the high demands tend not to lead to stress (Moos, 1991). Autonomy even appears to be linked to physical health benefits, a major study by Marmot *et al* (1997) showed that lower levels of heart disease were found in those with more control over their work than those with less.

Mental health promotion needs a balance between the four elements

In practice each of the four key elements of supportive relationships, participation, clarity and autonomy tend to reinforce one another and are far more powerful when used in combination: for example, teachers who feel more supported are more likely to set clear goals for their students (Moos, 1991). Many of the studies of the various factors have found it more helpful to cluster them and to look at them together. Indeed some researchers have suggested that we cannot understand any of these features in isolation (Marshall and Weinstein, 1984). So, research on school and classroom environments strongly supports the need for an eco-holistic approach.

Promoting mental health in schools involves a balancing act between the four elements, in which each has to be present in the right proportion. Too much emphasis on warm and supportive relationships, participation and individual autonomy without clarity can lead to a 'laissez faire' environment, in which people have an unrealistic sense of their own personal importance, everyone competes, no-one knows what the rules and boundaries are, and little is achieved or learned. But an emphasis on clarity alone leads to an authoritarian, inflexible, over regimented and autocratic environment, in which people may know the rules but may not care about following them, and can feel unvalued and alienated. The third way that achieves the right balance between these extremes has been described as 'democratic'. It is one in which people feel cared for, part of the organisation and able to act with a degree of personal control, but know that too that there are clear boundaries, that they are but one among many, and their needs have to be set alongside everyone else's. Such 'democratic' environments have been shown to produce the best balance between productivity in terms of task performance and the quality of relationships between participants (Lipitt and White, 1970).

Empowering classroom methodologies

Although younger children in particular need the consistency and security of a regular classroom routine, on the whole most of us respond better when varied methods of teaching and learning are used. There is strong evidence that approaches to social and emotional learning which use a range of methods are more effective than those with a more limited repertoire, and that the need to employ variety is particularly strong when teaching adolescents and adults (Greenhalgh, 1994). Using a wide range of methods of teaching and learning helps people to generalise their learning, by giving them a range of contexts in which to practice their competencies. It also helps the teacher to construct a range of learning experiences that can meet the different learning styles that learners have, and helps learners themselves develop a wider repertoire of approaches to learning. Activities include, for example, clarifying beliefs and values, reflecting on learners' emotions, practising assertiveness skills, and developing critical abilities. Such

approaches are highly active and participatory, involving group work, role plays, games, simulations and structured discussion. Projects which attempt to develop mental and emotional health in schools have invariably used such active and participative methods (Weare and Gray, 1994; Lantieri and Patti, 1996). There is good evidence for the value of this approach: Elias and Allen (1991) showed that discovery learning was more effective than normal programmes for helping pupils generalise their social and emotional learning.

The needs of teachers, and teacher education

Schools have traditionally focused on pupils, taking the health and well being of their staff for granted. This has never been a sensible assumption, and we know how many teachers suffer particularly from stress, and often feel undervalued, by school senior management, pupils, parents and society. Teachers cannot be expected to be enthusiastic about health promotion if they do not feel their own health is being promoted: they need constant support, from staff development programmes, from positive and helpful appraisal, and most of all by having a voice in all aspects of school management and organisation. They need to be strongly valued, and to be given active and positive help to promote their own mental health and well being.

Involving families and the community

In line with the new inclusiveness, schools are generally making far more effort to involve parents in the life of the school than has traditionally been the case. In many cases, such involvement is highly supportive of the social and affective wellbeing of the school. For example, initiatives which attempt to curb bullying and violence in schools invariably make the involvement of parents of bullies, victims and other children their first priority at every level of the intervention, from dealing with the immediate incident to seeking support for the wider school policies and actions that are trying to tackle the problem (Olweus, 1995).

The school is one of the agencies which is often seen as having a role to play in regenerating and sustaining a sense of citizenship, community and public responsibility. Democracy, citizenship and community involvement are central to the health promoting school idea. The vision of the health promoting school outlined in the official documents is one in which the health promoting school concept is understood by all in the community, including those agencies which are directly concerned with the school, and embedded in their philosophy and practice. There is close congruence between the goals of the school and the local community, with the community being included in school plans and closely consulted about how both sides can achieve cooperative working relationships. Members of the whole social mix in the community participate in the life of the school, bringing the contribution of the various social, cultural and religious groups, the public services, businesses, and the local media into school life. Community representatives are found on the school boards and committees that plan the various activities that relate to health promotion, and indeed all aspects of school life. The school receives support from local health and education authorities, and local media, and is an integral part of a wide range of formal and informal local networks. Pupils spend a considerable part of their time outside the school, giving and receiving from the community.

Successful examples of such two way involvement can be found, including community links that are specifically designed to foster mental and emotional health. The ENHPS has been instrumental in catalysing several examples of such positive links between school, parent and the community. For example, in ENHPS schools in both Belgium and Northern Ireland parents and the local community have become involved in a wide range of aspects of school life, while at a school in Denmark, pupils established a swimming pool, cycle tracks and a club for young people in the local community (WHO, 1997).

Giving special help to those with emotional difficulties

Taking a whole school approach does not remove the need for special help for vulnerable and difficult children and young people. However it is cheering to note that the kind of actions which a school needs to help those with special needs and behavioural problems are exactly the same as those it needs to take in any case to promote the mental, emotional, and social health of all pupils. For example, effective interventions begin early, work on pupils' self-esteem, give them plenty of personal support, guidance and counselling, teach them social and life skills, involve peers and parents in the process, and create a positive school climate. The school can give positive and appropriate help to those who are troubled and troublesome by balancing the need to be inclusive with their need for special help, starting early once a need has been identified, being positive about achievements and cultures, and teaching social and emotional skills carefully and explicitly. If such special measures are carried out within the overall supportive framework supplied by health promoting schools, they are considerably more likely to be effective than if they are applied only to those pupils in specific difficulties.

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Implications for the future

Rachel Jenkins, United Kingdom
Institute of Psychiatry

Background

The European Network on Mental Health Policy was established in the European Community in 1995. It includes members from all EU Member States and aims to strengthen mental health policies in Europe, exchange experiences between Member States, take action to promote mental health and prevent mental illness, plan special programmes for different target groups, and to stimulate joint research and development activities. Some of its achievements so far include:

1. the preparation of an influential EC-funded report *Key Concepts for European Mental Health Promotion* in 1997;
2. the major international 1998 Consultative meeting *Mental Health Promotion on the European Agenda*, which aimed to promote dialogue between Member States on the European Mental Health Agenda, to seek and develop new ideas and develop proposals for European Mental Health Promotion in six priority areas;
3. the groundbreaking joint World Health Organization/European Commission meeting in April 1999 in Brussels on *Balancing mental health promotion and mental health care*.

What has become clear from these developments is that mental health promotion and mental health care are complementary parts of the spectrum of necessary interventions to achieve good mental health outcomes for the population. Both approaches are essential elements of a comprehensive mental health strategy and a balance should be realised between them, stressing an intersectoral and a multidisciplinary approach. Thus, the joint meeting in Brussels recommended that the EC and WHO should focus on a series of priority issues in their respective programmes as a basis for joint action, and that the European countries, while respecting the principle of subsidiarity, would pay attention to these priority areas. The common goals and strategies which were identified in the joint meeting included

- enhancing value and visibility of mental health,
- increasing the interchange of knowledge and information on mental health,
- developing mental health policies,
- defining priority settings, target groups, and target conditions,
- development of primary and secondary care,
- tackling inequity,
- developing evidence-based guidelines for good practice,
- human resource strategy,
- research and development,
- legislation emphasising choice, confidentiality and human rights.

Now, this work has culminated in mental health, for the first time ever, becoming an EU Presidency theme. Thus the 1999 Finnish Presidency for the EU includes this European Conference on Promotion of Mental Health and Social Inclusion. Besides the plenary sessions, there have been six workshops running through the conference. The topics of the workshops were identified in the Consultative Meeting in 1998. Each workshop topic is of great importance

and has synergy with the recommendations of the joint WHO-EC meeting. The priority areas for the workshops were as follows:

- Enhancement of the value and visibility of mental health,
- Development of mental health indicators,
- Promotion of mental health of children and young people,
- Promotion of mental health in old age,
- Working life, employment policy and promotion of mental health,
- Telematics in mental health promotion and substance abuse prevention.

Components of mental health policy

Before turning to the specific workshop recommendations, it is helpful to consider some general issues such as what do we mean by mental health, what are the causes of mental ill-health and mental illness, why is the burden of mental illness so great, and what is the place of mental health promotion within general mental health policy.

So what do we mean by mental health? Positive mental health is essential to our ability to achieve a positive sense of wellbeing and to our ability to achieve a belief in our own worth and the dignity and worth of others. It includes the ability to initiate, develop and sustain mutually satisfying personal relationships, as well as the ability to cope with adversities. Positive mental health is important in its own right, and it is a resource for individuals, communities and the nation.

Mental ill-health and mental illness can be caused by a wide variety of factors including individual psychological and physical factors such as heredity, nutrition, physical health, chronic illness, trauma, early childhood experiences, etc. Individual social issues such as life events, chronic adversity, lack of social support and supportive relationships, family environment and living environment may be linked to mental ill-health alongside with wider societal issues such as poverty, unemployment, poor education, poor housing etc.

The burden of mental illness is very great. It arises from individual suffering, disability, mortality, loss of economic productivity, poverty, family burden, intergenerational burden (cycles of disadvantage, intellectual and emotional consequences for children) and reduced access to and success of health promotion programmes and prevention and treatment programmes.

There is a rapidly increasing evidence base for the effectiveness of programmes for mental health promotion. Some of these programmes have been shown to

- increase psychosocial resilience in children, adolescents and adults (which protects them against mental and social problems),
- reduce risk factors in prenatal period, family life, and school and work environments,
- reduce depression, aggression, drug and alcohol abuse,
- diminish consequences of mental ill-health, such as family violence, youth delinquency, productivity loss, and inequity.

The specific details of overall mental health policy will vary according to the needs, culture, circumstances and opportunities of each individual country but the main issues to be considered include national components, support infrastructure and service components.

National components which need to be considered include
- the national strategy to promote mental health, and to reduce morbidity and mortality,
- policy links with other government departments (housing, employment, education, etc.),
- legislation,
- mechanisms for implementation and accountability, and
- the funding streams.

Support infrastructure includes
- the mental health information strategy,
- the research and development strategy and
- the human resource strategy.

The service components which must be considered include
- mental health promotion in schools, workplaces, in the media, and in the community,
- primary and secondary care to do primary, secondary and tertiary prevention,
- good practice guidelines,
- health service links with social services, schools, employment services and criminal justice system, and
- health service links with NGOs.

All of the above are relevant to national governments, most are relevant to WHO, and some are relevant to the EU.

Workshop recommendations

The following technical workshop recommendations are the product of 18 months deliberation culminating in the discussions of the last two days, and are one outcome of this conference. The final conclusions of the conference will be formed from the synthesis of the technical recommendations and the political debate and form the basis of the discussions in the European Council.

Workshop 1 (Enhancing the value and visibility of mental health) concluded that the EU should have an explicit mental health strategy in the field of public health policy. Such policies should explicitly consider that mental health and social inclusion are essential for living a full life and working, that there is incontrovertible evidence of the great social and economic burden of mental disorders, and that we have a rapidly increasing knowledge-base of effective action on promotion and prevention. The workshop therefore concluded that the EU should encourage

- general cross-sectoral action on mental health promotion and prevention,
- specific mental health activities,
- public health policies which include mental health,
- comprehensive mental health information systems on mental health and health promotion (see workshop 2), and, very importantly,
- options for co-ordinating with WHO, other international agencies and NGOs.

Workshop 2 (Development of mental health indicators) considered that the key issues are
- what do we want to know (needs, interventions, unmet needs, outcomes and target monitoring);

- where should we get the data from (for example, routine data, national surveys);
- how do we ensure quality of indicators and instruments; and
- how do we ensure quality reporting and interpretation?

The workshop concluded that we need a common system for mental health monitoring which
- is integrated with a general EU health monitoring system;
- is collected and further developed with attention to comparability and validity,
- is acceptable for cultures, Member States, users and carers;
- uses both routine service use data and population survey data; and
- is easily accessible to citizens and users, for example by telematic means and websites.

Workshop 3 (Promotion of mental health of children and young people) argued strongly that we need to raise awareness of mental health and wellbeing of children and young people, using a developmental, child-centred approach in all sectors and in all policies, covering the whole population. There should be supportive preparation for parenthood, and for active parenting, and we should increase the overall focus on vulnerable children and young people.

In order to achieve these goals we should
- make better use of existing research on good practice in mental health promotion from education, health and social fields;
- ensure adequate funding for new research on child mental health;
- develop and test EU indicators of positive mental health and mental health problems; and
- support and further develop learning environments (in and out of school) for children, young people, teachers and carers.

Workshop 4 (Promotion of mental health in old age) concluded that we need to
- increase knowledge, competence and skills of social and health care professionals, NGOs and carers;
- reduce risk factors including isolation, poverty, disability, malnutrition, abuse, pain, drug side effects by special programs for risk groups;
- provide community based mental health promotion programs for all elderly people,
- disseminate good practices; and
- widen our research programmes into risk factors, recognition, prevention, treatment and care by transnational research projects.

Furthermore we should establish a Network on Promotion of Mental Health in Elderly People for research, information, dissemination, monitoring and training.

Workshop 5 (Working life, employment policies and promotion of mental health) considered, firstly, that employment is central to mental health and social inclusion and that the workplace is an essential setting and medium for mental health promotion. Moreover, many people with severe mental illness are employable and specific support systems are needed for unemployed people and their families.

Therefore, we should
- bring together the mental health promotion and equality agendas;
- take a holistic approach;
- ensure appropriate cross-reference between policy areas; and
- include the voice and expertise of disabled people.

It may also be necessary to modify EU employment guidelines in order to include more occupational transitions in the guidelines, to add life-long learning and personal development, and to include disabled people in Equal Opportunities section. The National Employment Action Plans should include consultation with NGOs, and link to other national policy areas and be implemented by government as an employer. The workshop also recommended collaboration between EU and WHO, an update and dissemination of WHO and ILO guidance, and specific work with employers to incorporate the promotion of mental health within the concepts of corporate responsibility.

Workshop 6 (Telematics in mental health promotion and substance abuse prevention) concluded that we need to

- support professionals in appropriate information and communication technology (ICT) skills and applications by training, intersectoral co-operation and exchange, and by identifying best practices,
- support and include users and communities in ICT by easy access, networking, socially inclusive ICT-based arts, ICT-based mental health promotion and prevention, and by re-integration into employment by developing ICT skills.

There is a need for research on the social and cultural impact of ICTs on well-being, on the cost effectiveness of ICTs in mental health promotion, and on the ethical dimensions of telematics. It is important to promote awareness and dissemination of ICT by the media, by appropriate European networks and by work places, schools, and local communities.

Final conclusions

As well as their separate and individual conclusions and recommendations, a number of common themes or messages emerged from the workshops which are important enough to be summarised here:

- Mental health is not just for the professionals
- Mental health needs to be across policies, across sectors and across all levels
- The mental health and social inclusion policy of the EU should incorporate user perspectives and participation along with that of mental health professionals, and have clear links to local community activities
- There is no health without mental health.

Global perspectives on mental health

Gro Harlem Brundtland
Director-General, World Health Organization

Madam Minister,
Distinguished Delegates,
Colleagues,
Ladies and Gentlemen:

It is a great pleasure to be here in Tampere in beautiful Finland - and to meet with this important gathering of mental health promotion experts. Thank you all for joining in what needs to develop into a significant movement for mental health.

Let me thank Minister Eva Biaudet and the Finnish government for hosting this meeting - and for their determined efforts to put mental health right at the core of the agenda of the European Union. We need determination like this if we are to make a lasting difference for the millions and millions who have the right to expect that societies and policy makers start taking mental health seriously.

Before I took office as Director-General of the World Health Organization, I was determined to address mental health as a priority. I had seen how hard it had been to strengthen mental health policies in my own country, Norway. I had started to see some of the vast neglect that people with mental health problems faced in developed and developing countries alike. It was very clear to me: Mental health must rise to a more prominent place if we are to live up to our mandate of promoting health and human rights.

That is why I very much welcome that the ministers of the European Union and its partners share this commitment - and that all of the dedicated people in this room now come together and can give input to the policy decision-making process at a European level. WHO is there to back and support this process and we are proud of saying that we are in this together.

My task today is to share with you a global perspective of the debate on mental health promotion. When I look out of the window from my office in Geneva and beyond the glorious snow-capped mountains of the Alps, what do I see?

Three features dominate. First of all: We are living in a world of rapid change. Even in the calmest and most prosperous corners of the world, people are facing a breath-taking pace of newness. From new technology to new jobs to new fashions in entertainment and culture, we are all being swirled along in what may well be the most rapid global transformation anyone has ever seen.

In the Eastern European states, the collapse of communism has led to an even faster pace of change. In large parts of the developing world, urbanization, rapid economic development and environmental degradation are forcing billions of people to face a future so different from the life when they grew up that few of their acquired skills are able to assist them with their new challenges.

Change is in itself not a negative thing. After all, the human quest for progress is motivating much of our behaviour. And, much of the change we see today is for the better.

Yet with change also comes insecurity, unpredictability and apprehensions deeply rooted in the human mind. Although some people thrive on change, most of us cope with it less easily. Let us keep this in mind.

The second dominant feature I see is poverty. Over the past decades, the world has seen great progress on many fronts. Great technological breakthroughs. Large groups getting better off. Yes - what most of the media makes us see is richness, abundance, and expensive lifestyles.

But in spite of the spectacular growth we have seen in parts of the world since 1970, more than three billion people - that is half of the world's population - still remain poor and live on less than two US dollars per day. Of these, 1.3 billion live on less than one dollar a day. Population growth may have increased these figures to four billion and nearly two billion respectively by 2025.

Of even more cause for concern is the prediction that most parts of the world cannot count on a substantial per capita income growth in the years to come, and that inequities prevent much of the growth we do expect from reaching the poorest.

My colleague James Wolfensohn and his staff at the World Bank recently launched a study called "Voices of the Poor", where they asked 60,000 men and women in 60 countries to share their realities, their hopes and expectations for the future.

One of their findings is that the poor seek much more than an increased income. They seek a peace of mind that comes with good health, a sense of community, safety and predictability. They seek the freedom to influence their own lives and to make choices. In short, they seek a sense of well-being that often follows higher income, but is not necessarily a part of it.

The word well-being is a key one. When we talk about mental health promotion, we are quick to stress that what we are aiming for is not only the absence of mental disorders. We want to ensure mental well-being, a state in which individuals can realize their abilities, can cope with the stresses of life, can work productively and satisfactorily and make a positive contribution.

Obviously, poverty, both real and relative, is a great obstacle to such mental well-being. The world has set a target of halving the number of absolute poor by 2015. That is a very tall order. It can be done - we need no magic pill to make it - we have all the knowledge to secure nutrition, basic health care, immunization of all children, clean water and basic education for all. But it will require real political will. Agencies such as WHO can help and support this process by mapping out concrete interventions that will make a real difference. We need a portion of decency on the part of the richer countries to pay a fair share to bring the excluded billion on board. Only four out of the richest countries – the Netherlands, Denmark, Norway and Sweden – live up to their obligation of providing at least 0.7% of their GDP for development assistance. The average is falling towards a record low 0.2%. This is – in my view – a shame, and all groups in civil society committed to development should hold their leaders to account.

The third feature I see is a process of ageing. Over the coming decades, we will see a great demographic shift in developing as well as in industrialized countries. There are currently about 600 million people in the world aged 60 years and over, and this figure is expected to rise to 1020 million within the next 20 years - a 70% increase in that age group compared to a less than 25% increase in the world's population as a whole. By 2020, approximately 70% of the elderly population will be living in developing countries.

We are talking of a demographic and social transformation of our societies. There will be changes, opportunities and challenges. One of the challenges comes from the fact that the risk of mental disorders increase with ageing.

Already, of course, we are acutely aware that mental illness is a serious health problem. Today, as many as 300-400 million people worldwide are estimated to be suffering at any given time from some kind of neurological or psychological disorder, including behavioural and substance abuse disorders.

Mental disorders account for 12 % of the burden of all disease in 1998. It is one of the dominating causes of years lost to disease, something too few people realize. The share was greater in high income countries at 23%, than in middle income countries at 11%. This overall figure is expected to increase to 15% over the next 20 years.

We must all help take these figures to the media - bring it to the people. Many will be surprised. But we should not shy away from communicating these facts - we have to do it as part of the vital process of rolling back the many taboos that deter prevention, treatment and care.

Major depression is ranked fourth among the 10 leading causes of the global burden of disease, which includes the developing world. By 2020, it will have jumped to second place if the projections are correct. This statistic of course does not include non-clinical depression reported by a person who proffers to being depressed today, and who consequently does not function well or work that day.

Major depression is linked to suicide. Most people who commit suicide are also clinically depressed. If we take suicide into account, then the burden associated with depression increases quite significantly.

One of our main enemies in our work against depression and other mental disorders is the imbalance of recognition between mental problems and physical ones. The figures are on the table, but there is still no recognition of the magnitude of the burden of mental disease. There is a lack of recognition, of awareness, and of action. Insurance companies discriminate between physical and mental disorders. Labour policies are less open to welcoming people with a history of mental disorders than those with physical ones. And still, mental health is not getting the level of resources that the magnitude of the burden warrants.

With this discrimination follows stigma, which complicates access to those who need help, treatment, care and prevention. Stigma creates a hidden burden of mental problems, which should be added to the burden we can measure. Only when we address the stigma and discrimination together will we be able to make real progress.

Stigma can be reduced by openly talking about mental disorders in the community, countering the negative stereotypes and misconceptions surrounding mental disorders, and ensuring the existence of legislation to reduce discrimination in the workplace and in access to health and social community services.

What does all this add up to? Some great challenges, is the short answer.

WHO is facing these challenges. In Beijing next month I will announce WHO's global mental health strategy. It will be centred around three words: advocacy, policy, and cost-effective interventions. Let me share the essence of our message:

Advocacy means raising the profile of mental health on the political, health and development agendas of governments and international organizations. In this effort, you are our allies.

Policy means integrating mental health into the health sector as part of countries' health sector reform. This means making clear recommendations for management, financing, and legislation to ensure that mental health becomes an integral part of health systems. I believe the EU can help in taking this agenda forward.

Cost-effective interventions mean ensuring that mental health services are incorporated in the use of all levels of health services, ranging from primary health care to support for families and other social services.

The implementation of cost-effective interventions for treatment, prevention and promotion is urgent. We need to document and disseminate specific cost-effective strategies which are targeting specific major diseases such as depression, schizophrenia and epilepsy.

It is not enough to promote mental health in the status quo. We must strive to anticipate future changes and prepare people for these changes before they happen, so they are able to cope with them, and hopefully to thrive on them when they come.

Take the work-place. In its effort to cope with the competitive pressures of globalization and the demands to bring down the high figures for unemployment, Europe is bracing itself for some radical changes to its labour markets. This could hopefully lead to lower unemployment, with all the positive consequences that would have for mental health.

But it is also likely to lead to less security in the work-place, less predictability and, for many, a sense of alienation and powerlessness. We need to anticipate these trends before they take effect, and we need to devise ways to minimize the stress that such changes could cause.

European collaboration - your core business - could be of great value. Not all trends arrive in all countries at the same time, yet the problems of change are often similar in many countries. There is great scope for a Europe-wide cooperation in the field of "mental health change management" - in a sense which goes beyond the borders of the European Union.

We need to reach out. Mental health professionals have a responsibility to go outside their own group and talk to politicians, to law-makers and to other professionals. Sometimes we tend to forget our roles as responsible citizens. Let us recall the words of Rudolf Virchow written 150 years ago: "Medicine is a social science and politics is nothing but science on a large scale." This has been my own life-time experience.

To be effective, public health professionals must learn to work at the heart of the political process with their elected political leaders. This is especially true when it comes to the fight against poverty: both absolute poverty as we see it in much of the developing world, but also the crippling and stigmatizing relative poverty which stains the achievements of European progress over the past decades. Unless we work to reduce poverty, we cannot hope to see the full fruits of the school programmes, the work-place programmes and the public campaigns we devise.

Rapid change for the worse, as we have periodically seen in our neighbours to the east over the past decade, is an especially fertile breeding-ground for mental illness. It is no coincidence that nine of the ten countries with the highest suicide rate in the world are in Eastern Europe.

These countries need our support.

Over the past few years, we have seen how war, violence and conflict have hit parts of Europe. We have seen how civilians rather than soldiers are the targets in these conflicts, and how psychological terror, rape and atrocities are systematically used to traumatize whole populations.

Many of us believed that the traumas caused by war, economic crises and collapsed social structures were a thing of the past, buried for good in the rubble after the Second World War. Yet, over the past decade, these horrors have reappeared on our doorstep, and in many cases, we have been forced to face them in our own neighbourhoods.

Let me tell you a story from my own country.

One late autumn day in 1995, a family of refugees arrived in a small village in central Norway. This family had witnessed how most of their own village's population in Bosnia had been massacred, and they had been maltreated for months in prison camps. The husband, who had also served against his will in the army, had suffered a mental breakdown and was periodically psychotic and suffered from paranoia and deep trauma. Taking a chance, the local physician and the municipality's psychologist went against the medical advice from Bosnia, which said the man needed hospitalization.

A year of close follow-up and dedicated work by the local doctor, the refugee coordinator and the local authorities had stabilized the family. The man had an internship in a local factory, the woman learned Norwegian and was included in local social activities, and the children functioned well at school.

Then the War Crimes Tribunal in the Hague wanted them to witness against the officers who had ordered the massacre in their village. This threw the man straight back into illness, with new psychotic spells and crippling attacks of anxiety. Again, the local physician chose not to go the way of the mental hospital. Instead he helped the family face their real problem - the traumas from the war. After a number of anguishing months, the family chose to testify at the Hague. By doing so, and by carrying it out, the man of the family managed to pull himself out of his own mental illness.

Today, the family lives a normal life in this village: they work, they are integrated into the local culture, and their mental health condition lies, according to the local psychologist, among the better half of the village's population.

What do I want to illustrate with this little success story? First of all: we must not leave the promotion of mental health to the psychologists and the treatment to the psychiatrists.

Mental health work is a process that starts with the individual in the family and continues through the work place and the local community to the public health infrastructure. It is no secret that the local physician is the person who first and most often encounters mental health problems.

The experience from the Swedish island of Gotland confirms of course that physicians can play a crucial role in mental health work. The Gotland study showed that when physicians were trained to detect early signs of depression, the suicide rate was reduced considerably. In the case of our Bosnian refugees, the local physician played a key role, but also the understanding of mental health problems by the refugee coordinator, the other support staff, and even the mayor of this small village played an important role in restoring the mental well-being of this family. In the end, it was a totally external factor - the therapeutic effects of truth and justice - which made the biggest difference, a factor that lies totally outside our realm of influence.

The second lesson I would point to is the futility of arguing the importance of mental health promotion versus mental health treatment. I really believe this perceived conflict is a false one. As you know, WHO and the EU arranged a conference on the balance between the two in Brussels earlier this year. Our view is that there should be no contest between the two. They should complement and reinforce each other.

There are weaknesses in our mental health services that need to be addressed, also here in Western Europe. However, we certainly must put a lot of emphasis on mental health promotion.

One doesn't have to travel far before the issue of improved care for mental disorder patients

becomes of acute importance. Europe still has over 100 very large psychiatric hospitals, and many of these are in a poor condition and often provide inhumane and outmoded care. The issues of effective treatment, access to drugs, and violations of human rights for mental illness patients need to be fully addressed.

But even worse: One-third of the world's population has no access to even the most basic psychotropic drugs. It has been estimated that only 35% of the people suffering from depression in countries with established market economies receive treatment. In other countries, such as sub-Saharan Africa and China, treatment rates for depression are as low as 5%.

So far I have highlighted what we already know. Nevertheless, we are in need of more good epidemiological information to assist us in defining focused policies and planning appropriate interventions. I therefore warmly welcome Minister Biaudet's call for a joint effort to develop a European mental health information system to map not only detailed information on mental health disorders, but also to collect data on mental health systems, activities, and on the concept of well-being.

For our part, WHO is now in the final planning stages of Mental Health Survey 2000, a large initiative which aims to obtain empirical data that will assist us in deciding how best to deal with the increasing burden of mental disorders in different parts of the world.

Mental Health Survey 2000 will assess mental disorders in comparison with physical disorders in 19 countries worldwide. Relying on modern epidemiological tools, WHO will gather real life data on both mental and physical disorders and disability, work loss, risk factors, service utilization and medications. This data is essential for WHO to monitor world health and develop evidence-based information for policy.

The more we know about the past and present, the more we learn about the future. Predictions are that the future will bring an exponential increase in mental problems. Some reasons for this I have already outlined.

Beyond doubt: mental health has to be given increased attention in our societies, by health authorities, politicians, policy-makers and decision-makers.

WHO intends to respond to this challenge and is prepared to assist Member States to develop evidence-based and effective strategies, both for health promotion and for treatment. I would hope that many of you here today, and the countries you represent, will contribute with your expertise, with your best practices and with direct assistance to our colleagues in Eastern Europe as well as in developing countries.

Minister Biaudet, ladies and gentlemen,

We need to focus on change.

When it comes to health promotion we must emphasize the role of the non-professional players in the field of mental health, and we must see mental health promotion and mental health services as parts of a continuum, not as opposite and conflicting poles.

In the picture that emerges out of these factors, one element stands out. That is the role of the family. Both in mental health promotion and in treatment and care, the family, often extended by the closest community network, has a central role to play. This, of course, is nothing new, and much of our work already focuses on the family. Still, we need to fully recognize the crucial role the family plays - and we also need to recognize that the family needs support. Much of the burden of caring for the mentally ill, or for preventing those who are in danger of becoming ill, is left to the family without providing the support, information and recognition they need to cope with this considerable burden.

I would like to commend EUFAMI - the EU Federation of Family Associations of Mentally Ill People - for its 1995 "Barcelona Manifesto", which outlines the needs and perceived rights of the family of the mental patient. WHO will keep its recommendations in mind in our work.

I hope and believe that this meeting will be an important step towards greater European cooperation and dialogue on mental health issues. WHO is committed to working with the European Union to achieve our mutual goals and mandates.

But on that road we must not just address the mental health issues and problems of Europe. It is not only a moral issue, but is in our enlightened self interest to assist the rest of the world to develop cost-effective, equitable and humane ways to promote mental health and care for the mentally ill. That, I have always believed, is part of Europe's responsibility – and opportunity.

I am confident we can do this. And therefore I invite politicians, technicians, humanitarians, social activists and colleagues in health to strengthen our working relationships, working together to improve the mental health and well-being of all peoples.

Thank you.

Ministerial panel discussion: Future challenges of European mental health policy

Dominique Gillot, France
Secretary of State for Health and Disabled People

Dear Ministers,
Dear Colleagues,

I am very happy to speak to you today on the subject of mental health which I have at heart and I thank our Finnish colleague for granting me the possibility to do so. As you know, in the field of mental health, France has a long history as it has distinguished since 1848 between mental patients and other patients in terms of covering the cost of their treatment by a groundbreaking law in force until 1990.

The context has obviously evolved and a reflection is currently taking place in France to reassess the field of mental health and its framework. Indeed, society places more and more demands as far as psychiatry and mental health are concerned, asking to cater for what it cannot deal with or assimilate alone at any rate: these days, exclusion, drug addiction and sexual deviances are part of this framework.

The action programme of my Ministry as regards mental health has three main lines:

1. Firstly, continuous improvement of mental sickness care by striving for a better quality of life for those in long-term observation. This also means reinforcing the rights of those committed for psychiatric reasons: a project of law on the patients' rights is in preparation. This text will apply to all those hospitalised, including those committed for psychiatric reasons, be it of their own free will or without their consent.

2. Secondly, it is important to commit to a policy of mental health promotion. I have at heart to move from a policy which was based too long on health care only to a real public health policy which includes prevention. This leads our country to develop four lines of work:

- Better communication on mental health. Since mental illnesses are considered frightening, they are often denied, often rejected. Most often, psychic suffering isolates. Preventive actions and preventive care are thus delayed while administering continuous care becomes complicated.
- Making available a system of study and of epidemiological information in the mental health sector.
- Creating a favourable environment for the improvement of psychic well-being. This depends, of course, on the social environment as a whole: living conditions, education, employment… Conducting a mental health policy thus results ideally from the co-ordinated and concerted action of numerous partners in both the social and the health sectors. All of the professionals of psychiatry are required to undertake mental health promotion actions in partnership with the other local operators.
- Developing targeted programmes. Certain forms of psychic suffering result more from a local dysfunction than from actual mental pathologies which they may precede. Four priorities have been identified on the national level:

- suicide
- juvenile violence
- psychic suffering of excluded people. Every region in France is required to establish a "regional plan to improve access to health care of the most underprivileged". Their realisations are co-ordinated on the national level.
- drug addiction.

3. Thirdly and lastly, it is important to improve the quality of mental health care.

Any improvement in health care implies developing guidelines covering the cost of the treatment and accreditation standards. It also involves a continuous reflection on mental health professions in connection with the two previous objectives: the place of the psychiatrist, the role of the general practitioner, of the psychologists, of the nurses and of the social workers.

These problems are common to us in Europe and I am convinced that we have to exchange our experiences as this is enabled today by the initiative undertaken by the Finnish presidency in order to launch a common analysis and intervention framework.

In this respect, initiatives such as the joint Commission/WHO meeting of April 1999 on "balancing mental health promotion and mental health care" and, indeed, the present conference which we are attending are part of this search for definition of the various fields of intervention.

As for European action in the field of mental health, our approach has to be an ambitious one while respecting the competencies of the Member States.

The work of this conference has proven the importance of a common observation system and, first and foremost, the possibility to agree in order to define simple indicators in this field. Such a consensus has to enable us to compare the situation in our different countries and to highlight the priorities of our national and, when needed, European policies.

Another element of a European mental health policy with a manifest European added value is that of research.

We particularly lack elements on the most effective strategies in the field of mental pathologies. To give an example, treating the various forms of anorexia which affect two percent of young women aged from 15 to 25 is being approached empirically by practitioners, and work related to medium-term patient follow-up is underway with the help of the European Union in order to assess the effectiveness of the various treatments used. We have to reinforce initiatives of this kind.

I have taken on purpose this example which deals with mental health and eating and which thus joins the themes chosen by Finland and France for their respective presidencies as regards health care.

After the information system and research, the possibility of exchanges and of co-operation between the EU countries appears to me as another promising way to act within the Community. In this respect, the development of European networks, be it between professionals or non-governmental organisations, is an enrichment for the benefit of each and everyone.

I shall by the way closely follow the European examples of successful policies to fight youth suicide which is a major concern and a challenge for us and for numerous other countries to accept. A national suicide prevention programme was launched in France in 1998 with the objective of reducing the number of annual deaths due to this cause to below 10,000. Can one imagine an advanced society with increasing suicide rates without this being a concern for the political authorities? I know that many countries present today have also established national suicide prevention policies: Finland, Norway, Sweden, Denmark, the United Kingdom, the Netherlands, Germany. A first analysis shows that the indispensable common denominator of these programmes has been the political will.

Our political will as regards suicide is strong, let us know how to pursue it and extend it to other fields of mental health!

Finally, a new way is opening up for us as regards European action. The entry into force of the Amsterdam Treaty offers us indeed more possibilities to act in the field of health care. It leads the way to taking into consideration mental health as an objective of all the policies in mental health and in other fields as well.

Other policies, whether they deal for instance with culture, environment, employment or social questions, have an impact on mental health. Decisions made on the communal level as regards agriculture or industry without taking into consideration their social and health consequences weigh sometimes heavily on individuals and families and may have an impact in terms of suicide and depression. The new Treaty compels us to think about these problems, and this will require preliminary work in order to determine the best methods for reaching this objective.

Our new Member of the European Commission in charge of health care and of consumer protection, David BYRNE, has declared that "mental health [should] merit consideration as a focus of future actions", particularly in those "conducted within the framework of a programme of Community action on health promotion, information, education and training". This makes me very happy and I hope that the propositions he will make can be realised under the French presidency.

Of course, these European actions are of help and assistance to national or local mental health policies. Indeed, the difficulties we have encountered in this field are often influenced by local factors and especially by cultural ones, and mental health policies will be all the more effective when they created and put to work as close to local realities as possible.

But I believe in the usefulness of a European action in shedding light on our national choices. This is why we will be happy to host the meeting of the project laid down in order to establish the mental health observation system in France in 2000. We are also studying the possibility to organise an exchange meeting between the regional services of European countries as regards experience gained in the fight against youth suicide.

I would like to conclude by pointing out that, in mental health more than in any other field, Man is in the heart of the action and to quote this phrase by Jean Monnet about Europe: "We are not forming coalitions between States, but union among people."

Thank you for your attention.

Els Borst-Eilers, The Netherlands
Minister for Health, Welfare and Sport

Ladies and gentlemen,

I should like to start by thanking my colleague for her hospitality and by complimenting her on her courage to put mental health on the agenda during the Finnish presidency. This takes persistence and, above all, faith. It is our job to ensure that their faith is justified.

It is high time we paid greater attention, in an EU context, to the mental health of the people of the European Union. Like it or not, we must confront the fact that mental problems bring in their wake social, individual and all economic costs that call for a common approach. I want to spell out some of the facts for you.

- The expectations are that depression is well on the way to becoming the number one illness in Europe.
- In European societies the total annual cost of psychiatric illness amounts to between 3 and 4% of GNP.
- In the Netherlands, 30% of the people on incapacity benefit suffer from mental disorders.
- And mental problems obviously also cause a great deal of personal distress and difficulty for the people close to the sufferer.

Ladies and gentlemen, the mental health care sector is facing a number of challenges on the eve of the twenty-first century. I would like to talk about the most important of them. They will sound very familiar to some of you. They apply, after all, to most of the countries in the EU.

The three themes I want to discuss with you today are also to be found in the Mental Health Care Policy Document that I published recently. They are the fundamental principles underlying the policy that we shall be pursuing in the Netherlands in the future:

- How to provide an appropriate response to the growing demand for help?
- How to promote the further socialization of care and at the same time prevent this from leading to social exclusion?
- And the third challenge is how to make the mental health services a much more evident presence in tackling a number of social problems.

Let's consider the first of these themes-how do we deal with the increasing demand for help? This is primarily about how to allocate the existing resources such that the people most in need of care are the people who actually get it. Another important aspect is, of course, to put a brake on this growth by trying to limit or even to prevent mental damage. Prevention, early detection and identification are important means to this end. One of the policy spearheads in my country is the recognition and prompt treatment of problems at a young age. I have also set up a National Mental Health Committee, whose task is to analyse the causes of the growing demand for help.

I turn to the second issue-how can we promote the socialization of care while at the same time preventing social exclusion? The nature of the demand for care has changed over the last few

decades. Many people with a chronic psychiatric problem want to be able to remain part of the community. In my country this means an ongoing shift away from institutional care towards care in the community-without this leading to disproportionate burdens on families, communities, the police and the legal system. Good housing, an adequate income, the prospect of a job or training and accessible general facilities are crucial to prevent social exclusion of patients receiving this type of care.

The third challenge to make the mental health care sector a much more evident presence in tackling a variety of social problems, such as incapacity for work as a result of mental problems (caused by, among other things, workplace stress)-one of the themes that were discussed in the workshops over the last few days-the problem of detainees with mental disorders in our prisons; the problems of abuse, isolation, and poor housing and living conditions. Many of the contributory causes of psychiatric problems (such as pressure from the immediate environment, stress at work, noise, fear of street violence, inadequate housing, child abuse, unemployment, loneliness and sexual abuse) are outside the immediate area covered by the mental health care sector, but their consequences-which can sometimes be very serious-most definitely manifest themselves in the mental health care services arena. The mental health care sector cannot solve these problems itself, but it can draw attention to the effects of trends in society and the implications of proposed government policy in these areas.

Ladies and gentlemen, I am in favour of devoting greater attention to the mental health care sector in a European context. I take the pragmatic view that, by sharing our expertise and by drawing one another's attention to best (and if possible evidence based) practices, we will be able to arrive at a more effective and efficient approach to mental health problems and their prevention in the future.

In this context, we should also be considering setting up joint research programmes in the years ahead, for instance on a subject like incapacity for work on mental grounds. It is of the utmost importance that we create reliable international statistics about the prevalence of mental problems, about mental health indicators, about the uptake of care services and about the effectiveness of interventions in the mental health care sector. A European monitoring system for mental health indicators is indispensable in my view, and it would also be worthwhile investigating the possibility of establishing a European forum for mental health research. Obviously there would have to be the greatest possible harmonization with existing European institutions.

I also think it important that, if we take decisions in the EU, we should examine the effects they may have on the mental health of EU citizens. In this connection, I should like to draw a parallel with "health protection" as a criterion for assessing some European regulations. In other words I want to advocate investigating the possibility that "mental health protection" should in future be made a part of the broader concept of "health protection". There must be an awareness- not just at national level but at EU level too - that, for example, economic decisions can have a knock-on effect on the mental health of the people. As Ministers of Health, I think we can make a contribution to the creation of that awareness. I also see an important role in this area for client organizations, because clients, as consumers, should be involved in all international themes.

The final reason for devoting more attention to the mental health care sector in the European context, as I see it, is that Europe's internal borders are becoming increasingly open.

To sum up, I would like to see mental health given specific attention in the future European health action programme, for which-I hope-the European Commission will shortly be making proposals in line with article 152 of the Treaty of Amsterdam.

The specific actions I have in mind follow on from the Commission's earlier proposals in a Communication on Public Health: gathering epidemiological data on mental health, compiling data on best practices. The health monitoring programme approved by the Council of Ministers-now up and running-would be the best place to collect this data. Secondly, influencing the determinants of mental health.

Lars Engqvist, Sweden
Minister for Social Affairs

Madam Chairman,

Being healthy is one of the most important priorities in life. Being healthy also means being mentally healthy and free from substance abuse. Good health allows people to live active lives, to work and to be able to participate in various forms of social intercourse. Equality in health must therefore be an overall objective for a future European mental health policy.

I also believe that to be successful, health-promotion strategies must be a part of an overall welfare policy for which all sectors of society share responsibility. Counteracting unemployment, abuse and violence, and improving the conditions of vulnerable groups will be necessary if we are to succeed in improving people's mental health.

All the evidence suggests that mental health will be an increasingly significant factor in the context of health and welfare development within the EU member states:
- we have successfully eradicated a number of common diseases
- living conditions for ordinary people have improved
- pressure at work and stress are on the rise
- for the first time in the history of modern societies such as Sweden, younger generations will not have entered a welfare cycle at a higher level than preceding generations. High unemployment poses a growing threat to health. The risk of mental illness and substance abuse increases when young people are unemployed and have no prospects.

On 20-22 January next year, Sweden will be hosting the first meeting of all WHO mental health collaborators in the WHO European Region, with a view to intensifying efforts to set up a pan-European network on mental health. This meeting will provide a broader forum for our deliberations and conclusions here in Tampere.

Many studies point to an overlap between problems with drinking or drug use and mental problems. Rates of alcohol or drug problems in mental health treatment samples are always higher than rates of alcohol or drug problems in a comparable sample of the general population. Similarly, the incidence of mental problems. in alcohol or drug treatment samples is invariably higher than that of mental problems in the population as a whole.

Associated with mental disorders, alcohol abuse and drug use area wide range of impairments in social contexts such as employment, family life and everyday social interaction. These im-

pairments increase the likelihood of divorce, unemployment, conviction for crimes and spouse and child abuse.

Improving mental health and reducing the damaging effects of alcohol abuse are not concerns that involve EU member states alone. With EU enlargement firmly on the agenda, these issues are likely to have even greater repercussions on future public health work within the EU.

Thus there is every reason for us at EU level, to focus our attention on the significance for both society and the individual of mental health promotion and prevention of alcohol abuse and drug use. When EU health ministers discussed their priorities for coming public health work in June this year, I raised the issue of alcohol and emphasised that, from a public health standpoint, the EU needed a strategy for alcohol. The new public health programme provides an excellent basis for such an endeavour. Comprehensive strategies on alcohol and the promotion of mental health are - and must be - challenges for the EU if we are to improve the quality of life of every European citizen.

Gisela Stuart, United Kingdom

Parliamentary Under-Secretary of State, Department of Health

I am delighted to be here. You deserve congratulations on two points. Firstly, for the generous hospitality during the conference and secondly for recognising the importance of the mental health agenda.
This conference has brought together a distinguished group of experts and interested parties. It allows us to share discussions on a broad range of complex and multi-sectorial issues, and above all allows us to explain and share good practice. But most importantly, this conference gives us an opportunity to significantly increase both the awareness and the visibility of mental health. It should be a key objective of governments nationally, and at Community level, to consider collectively what further action can be taken.

Let me explain this through my own country's experiences. In Britain, at any one time, one adult in six suffers from one or another form of mental illness. What is more startling, is that as many as one in five children and young people also suffer. To look at this in another way, mental illnesses are as common as accidents. Their difficulties range from depression to rare but severe mental illness such as schizophrenia which affects fewer than one person in a hundred.

Besides the immense suffering endured by the individuals and their families, mental illnesses in the UK cost over £32 billion each year including £20 billion costs in employment and social security benefits. We've heard today from Dr Brundtland about the steps being taken by the World Health organisation globally to address mental health. This is encouraging, as it often seems that communicable diseases attract a disproportionate amount of resources. At the regional level, the WHO European Regional office in association with the International Federation of Health Funds will be hosting a meeting in London later this month about the social and economic impact of depression. The World Bank has estimated that 10 per cent of the world's disability is due to depression alone and events like the one in London further raise awareness and encourage the development of creative approaches for securing improvements.

Mental illness is more common than is generally understood. Many people are anxious or fearful of its consequences and suffer stigmatisation and discrimination. Despite the relevance and importance of mental illness it does not receive the attention it serves. It deserves to be given much higher priority in order to have any impact on levels of understanding and appreciation of its impact.

During the summer we published a public health strategy called "Saving Lives - Our Healthier Nation". This places mental health as a priority area together with cancer and coronary heart disease. It sets population health targets not only to increase the length of our citizen's lives but also to increase the years they are able to live life to the full. Hence, our understanding is that mental health is more than a lack of illness. To be successful we need to assess and respond effectively to the many problems associated with poor mental health. To assist us in this task we undertook our first national psychiatric morbidity survey. We collected data on prevalence, risk factors and associated disability. Household, institutional and homeless samples were taken. The survey covered depression, anxiety, psychosis, alcohol and drug misuse, and highlighted areas where the need was greatest. We await the results of a similar survey of children and young people.

We live in the age of the Information Society and we need to share our ideas on how we can best improve the lives of our citizens and cope with the problems that are before us. I would like to share with you now the way in which my country is tackling mental health problems. Only this September we launched the first National Service Framework for mental health. This framework focuses on the mental health needs of working age adults in England. It sets standards to drive up the quality of care in local mental health services and to reduce unacceptable variations in local health and social services, and above all, to measure performance. The framework outlines the strategies to attain the standards and sets performance indicators against which progress can be measured.

The Mental Health National Service Framework focuses on 5 key areas, mental health promotion, primary care, effective specialist services, caring about carers and the prevention of suicide.

Just to highlight one area, our government says health and social services should improve their mental health promotion and prevention services to reduce social exclusion, and combat discrimination and hence promote their social inclusion.

Looking at mental health problems, they can arise from a range of adverse factors associated with social exclusion e.g. unemployed people are twice as likely to have depression. The most depressing thing is that children in poor families are three times as likely to have mental health problems as children in well off families. Black and ethnic minority groups are diagnosed as having higher rates of mental health problems than the rest of the population. Refugees are especially vulnerable and people with physical illness have increased rates, too.

We are looking for progress for people sleeping rough, people with alcohol and drug problems, those in prison and people with disability. We will also take action by asking local health agencies to develop local health improvement plans and we will take action to prevent discrimination against people with mental health problems.

Performance will be measured at national level and measured by national psychiatric morbidity survey and via the local health improvement programmes. These programmes focus on schools and workplaces, health settings as well as voluntary groups. This framework recognises the need to evaluate services and focuses on primary care as well as the need to co-ordinate health and social section.

Action will be taken outside government too. Projects run by charities and volunteers play a valuable role in raising awareness about mental illness and reducing stigma. One project run by "Depression Alliance" concentrates on employment, publishing packs to give advice on the prevalence of disorders and guidance on their management. It is our belief that joint working with other agencies is the best way to achieve high standards.

We also take the welfare of children and young people very seriously. We are committed to early intervention and have both mental health promotion and prevention high on our agenda. Children and adolescent mental health services will receive an extra investment of £90 million over the next 3 years.

There is one particular programme, Sure Start, I would like to draw your attention to which aims to transform the lives of younger children through better access to family support, advice on nurturing, counselling, and early education. The aim is to work with parents and children to promote the physical, psychological and social development of pre-school children and particularly those who are disadvantaged, to ensure that they are ready to thrive, to help families to function better and children to access education better. Support is available for parents to care for their children to promote health and development before and after birth, encouraging stimulating and enjoyable play and improving language skills.

We are also taking steps to improve school health standards. Here we are adopting a whole school approach, working on a range of themes. These include strengthening personal, social and health education to address physical and emotional health and well being (including bullying,) healthy eating, exercise and safety.

These initiatives along with protecting the welfare of children in need will all contribute to the prevention of subsequent mental health problems in children and in adults. This is an ambitious programme.

We are determined to bring about change that is achievable and challenging. Our national programme will be enhanced and become more effective through action at international level. The EU public health framework and the WHO programme Health For All policy will provide scope for raising awareness and exchanging good practice.

We want to enter a period of growth to achieve the gains which are there to be made. Working together with all international, national and local agencies can provide our citizens with safer, sounder and more supportive mental health care. We agree that there is no health without mental health.

Finally in the light of this conference we look forward to considering what can usefully be taken forward by the European Health Council.

Francisco Ventura Ramos, Portugal

Secretary of State for Health

In 1995 the Portuguese government decided to include mental health (MH) as one of the priorities of health policy. In fact, we realized at that time that it was important to include mental health. That we had to improve the conditions of living and the dignity of the patients who are institutionalized in psychiatric hospitals; that we had to enhance the quality of mental health care, creating new services, more comprehensive, and more community based; that we had to prevent mental disorders and to promote mental health in a planned and systematic way.

When we have taken this decision we were inspired by the values on which are based our political actions, the values of solidarity, social development and social inclusion.

We are also able to take into account a valuable contribution which emerged from a large national debate on MH, that took place in 1995, with the participation of representatives of all sectors involved in MH, professionals, users, relatives, NGOs and the support of experts of international organizations, some of whom I'm happy to see here today in this room.

In this context, the government established a strategy with three main goals:

1. To define and implement a national mental health policy, with clear objectives at the levels of mental health care and mental health promotion.
2. To create new legislation covering the most relevant aspects of MH.
3. To integrate in the Ministry of Health and in the Regional Health Administration specific desks for the coordination of MH programs and activities.

Through the development of this strategy some important advances have been achieved in the last four years:

- A new MH law has been approved in 1998. This law defines the main goals of MH policy, the rights of people with MH problems, including the regulation of compulsory treatment and establishes the principles of MH services Organization.
- A specific law regulating in more detail the services organization has been also approved in the current year, defining the structure of the community services and the principles on which the replacement of psychiatric hospitals must be based.
- Several new community services and rehabilitation programs were implemented all over the country.
- Improvements have been introduced in the MH National Information System.
- NM targets were integrated among the general health targets, namely the decrease of suicide rate and the improvement of the recognition and treatment of depression at the primary care level.

Among the measures that have been taken in other sectors which are relevant to MH, I must emphasize the joint cooperation of Health and Social Security Systems supporting the implementation of psycho-social rehabilitation projects to people with MH problems; the support to vocational training programs and to the creation of social enterprises.

The Government has also taken several measures to support people living in a situation of vulnerability and social exclusion, which benefit also people with mental health problems. These include the Security of minimal income, programs of social and vocational integration, a national program against poverty and specific programs for risk groups - children, elderly, drug addicts and HIV patients.

I'm glad to stress that some European initiatives, mainly in the area of employment were extremely helpful for the success of the measures I've just mentioned. However, the Portuguese Government strongly believe that the development of a MH strategy within the EU will be needed to the full implementation of national MH policies of the different member states.

Moreover, I'm sure that it can also have a very significant impact in many other countries.

This strategy must, of course, be centered in the community public health of the EU; but it must include as well actions in other sectors which are relevant to MH - namely social, education, employment and justice sectors.

To attain these ambitious goals we'll have to face many difficult, but also exciting, challenges.

Among these, I would emphasize the exchange of experiences in MH promotion, the defence of human rights and citizenship of people with MH problems, the development of MH indicators and the integration of MH in the health monitoring system of the EU, the support to research in MH at the European level, the development of programs supporting employment and social integration of people with mental disabilities, and educational programs.

It will be not an easy task. But, as Fernando Pessoa, the Portuguese poet, wrote, "everything is worth while if the soul is not too small".

Through the organization of this Conference and through the implementation of many other initiatives at European level in the field of MH, Finland has supported all of us to put our souls together in the defence of a better MH throughout Europe.

On behalf of the Portuguese government, I would like to express our gratitude to the Finnish government for all you have done to give MH the place it deserves in the European Agenda.

I can assure you, Madam the Minister, ladies and gentlemen, that during the Portuguese presidency we'll do our best to ensure the continuation and progress of the excellent work done by Finland.

Thank you.

Closing of the conference

Eva Biaudet, Finland
Minister of Health and Social Services

Dr Brundtland, Distinguished Ministers, Honourable Delegates, Ladies and Gentlemen,

First of all, I'd like to thank you all most sincerely for your very active participation in the discussions. We have spent three very intensive days here in Tampere, and it is now my great pleasure to have this opportunity to look back at those days and review the results attained.

To start with, the visibility of mental health has been brought to the forefront in a very important way by this conference. We also held enlightening discussions about future strategies and received recommendations from the workshops, suggesting priorities for concrete action to promote mental health and prevent mental ill-health. Several measures that could be taken in the near future have been mentioned.

Without the participation and co-operation of those of you who helped us to organise the conference, whether individually or as representatives of Member States or organisations, this would not have been possible.

I extend my gratitude to Dr Gro Harlem Brundtland, Director General of the World Health Organization, for having demonstrated her commitment to mental health and for having emphasised the importance of mental health at the global level. We need to remember the countries beyond the borders of the European Union, the applicant countries and other Central and Eastern European countries, and also the developing countries in other parts of the world.

In my view, our European activities in the development of mental health policies and the promotion of mental health, will in the end benefit everyone - not merely our citizens of the European Union Member States - through the increased visibility and through the concrete results we will and shall achieve in the European context.

Dear colleagues, Minister Dominque Gillot from France, Minister Lars Engqvist from Sweden, Minister Els Borst-Eilers from the Netherlands, Minister Gisela Stuart from the United Kingdom, Secretary of State, Mr Francesco Ramos from Portugal. Your participation has given this meeting the status it deserves, and I thank you most warmly for your support and encouragement.

With reference to the discussions held here, we can feel justified in claiming that there is no health without mental health, and that mental health is indivisible from public health. Mental health deserves attention, not as a separate matter, but as an integral part of overall health and as a precondition for social inclusion. We must continue working on the themes of the conference and, if necessary, introduce other relevant dimensions of mental health into the discussion.

The conference has encouraged and given support to the Presidency to seek consensus in the Council for conclusions on mental health. The conclusions will be based on the results of this conference.

Ladies and gentlemen,

The results of this conference will serve as a message to the Community Institutions and to the Member States on the importance of focusing on mental health in the public health action at Community level.

The following presidencies of the EU - Portugal, France, and Sweden - have all voiced their support for the message and for keeping it on the agenda during the process leading up to the adoption of a new EU strategy for public health.

Finally, we hope that the Member States will appreciate and support the efforts to increase the prominence of mental health on the WHO agenda on a global scale. In order to do this, financial support is necessary and we hope this additional challenge can be met by the Member States. Action in Europe could become a good example for others.

I would like to finish with an idea to arrange a follow-up meeting to this conference in - let's say - three years time. There will be need to look carefully at the process that has been started.

Ladies and gentlemen, speakers, chairpersons, rapporteurs, delegates of the Member States and the Applicant Countries, participants, organisers, staff members,

Thank you all very much.

I wish you all a mentally and physically safe journey back home.

Appendix 1: workshop reports

Workshop 1:
Enhancement of the value and visibility of mental health

RECOMMENDATIONS: SUMMARY

1) Mental health and social inclusion are decisive preconditions for individual's meaningful participation in life and ability to live and work. Moreover, the mental health of citizens contributes to the useful participation of individuals in a country's economy and thus makes a marked contribution to national productivity.

Mental health problems mean individual losses and suffering and often marked extended problems in families and subsequent generations. On society level, these problems contribute to marked expenses as care, pensions, sick leaves etc.

However, mental wellbeing and mental problems are developmental results of protecting factors vs. risk factors during lifetime. Mental health can be promoted and mental disorders prevented by tackling these factors through mental health policies. Policies should be based on existing research and best available knowledge.

Relevant factors belong to realms of many sectors of life and, consequently, to many policies. This is why comprehensive collaboration of sectors and of professionals and users of services and citizens is needed in securing mental health.

2) Mental health promotion should be recognized as a basic human right. It should therefore be included in the plan of the declaration of civil rights of the EU citizens.

Mental health should be, in addition to the national policies, clearly defined and expressed as an explicit strategy in the field of EU policy.

This should ensure that a certain provision should be made for mental health in public health discourse and funding

A mechanism should be found to ensure that necessary prerequisites can be provided to build a feasible strategy.

Due to the nature of mental health concept, activities on many levels and many sectors are demanded. The most relevant policies to be considered are

- social policy
- employment
- education
- research
- employment
- migration
- justice and
- alcohol policy.

As part of the health monitoring activities a comprehensive information system on mental health and promotion of mental health is needed.

Options for co-ordination of activities with WHO, other international organizations and NGOs should be taken into account and facilitated.

Workshop 2: Development of mental health indicators

The workshop commenced with an introductory session that included two presentations.

Rob Bijl, from the Netherlands, lectured on *"Use of population surveys in monitoring systems"*. According to Bijl the central question is what to monitor? There are several options: risk factors for disorders, the prevalence and incidence of disorders, consequences of disorders, and several alternative measures.

Creation of a monitoring system requires the following points to be considered: 1) the focus of the monitoring system has to be clarified; 2) a choice of information is needed (which indicators are eligible?) and 3) sources of data available have to scrutinised. Survey data as information source for monitoring has some setbacks and some advantages. Firstly, a survey is not easy to perform, it is costly and laborious. However, with a good study design, a survey gives valid and reliable assessments through interviews of subjects, which are the primary data sources. Surveys provide good sources of data pertaining to mental health policy. A proper balance can be assigned between supply and need. These are, however, complex issues.

Basically surveys can employ two different strategies regarding needs for population monitoring: 1) a follow-up of the natural history of disorders and 2) analyses of the pathway to care.

1) Natural history approach can investigate the course of a disorder and related factors at different points of time. Valid instruments to measure these aspects have been developed and used in many studies with large samples (NEMESIS, NCS, ECA studies etc.).
Onset: prodromal symptoms, precursors, risk factors, age of onset, speed of onset
Incidence: annual new cases & by age and sex
Course of illness: remission, recurrence, relapse, risk factors, protective factors
Outcome: comorbidity, functioning, Quality of Life, mortality, socio-economic consequences

2) Pathway to care approach investigates people with disorders at different levels of the public health care system. Commonly, the detection, referral and admission of persons with disorders are studied:
Mental disorders in the community: illness behaviour & help-seeking
Mental disorders among primary care attenders: detection of disorders
Mental disorders recognised by primary care: referral behaviour
Mental disorders treated by specialised mental health care: admission behaviour
Admission to mental hospital

To have an adequate monitoring system utilising survey techniques the following quality criteria should be met: The measures used should be scientifically approved; They should provide a

possibility for international comparisons; Surveys should rely only on representative samples; For monitoring purposes the surveys would have to be repeated in time; Surveys should be longitudinal and prospective. In real life, however, there are often many limitations in surveys studies. For instance, different diagnostic criteria (ICD vs. DSM) may lead to differing prevalence figures.

Gyles Glover from the UK lectured on *"The Minimum Data Set for Mental Health"*. Regional differences and reasons for differences in the use of mental health care can be analysed from utilisation data. This provides a useful way to find differences in service provision. Illnesses cluster within certain areas in the communities. Routinely collected information can help policy decisions significantly. The data that is collected tells mostly about what is going on within services. The information is not patient centred. There are different types of data allowing to investigate more or less thoroughly: raw data (possibility to "drill down") and aggregate data (presented in tables). Information systems have usually been set up at different points of time for different purposes which may impede efforts to link them.

Need for a comprehensive mental health monitoring system in Europe

The discussion section of the workshop concentrated as its ultimate goal on the development of policy level recommendations concerning mental health monitoring in Europe. In the following the main points of this discussion are presented.

Aims of the workshop

The following questions were chosen as basic starting points for the discussion: What should be done?, by whom should the recommendations be carried out (including possible co-operation) and in which EU-policy the recommendations should be carried out?

EU-policies were grouped in the following way:

1) Programme for public health: information on health and its determinants
2) Research strategies
3) Information society (telematics)
4) Enlargement policy
5) Impact of other policies on mental health

The following proposals for a policy level statement were discussed:

1) Clear need for a common system for mental health monitoring with unambiguous definitions for the indicators, which should additionally be useful, reliable and comparable.
2) An integrated part of a health monitoring system in general.
3) Sources of data: routine data when available, population based health surveys (e.g. a set of mental health items)
4) Acceptability and cultural aspects of the indicators should be considered
5) Need for further research: validity of data as well as measures and instruments

At political level it is necessary to stick to the most important points. The process of establishing the indicators should progress rapidly from the level of generality to practice. Permanent expert capacity for interpreting and analysing results of monitoring will be necessary. What is needed is a practical set of core indicators, the telematic system is already there.

Indicators and mental health needs

It is of utmost importance to consider, which questions require an answer and what information is to be collected at Member State level: 1) what are the needs in the general population, 2) how to address these needs, 3) are the needs being met in a satisfactory manner, and 4) what further actions are needed? Answers to these questions shed light on the scale of mental health problems, on which sub-populations have special mental health problems, on whether there are significant regional differences and on the reasons for the possible differences.

There is increasing data showing that diagnoses and use of mental health care are not overlapping. Some users of care do not satisfy the diagnostic criteria and some, who satisfy the criteria, do not receive the care they need. The chronic nature of mental disorders increases their prevalence figures as incidence figures for mental disorders are quite low. It is therefore important to have information on factors predicting and affecting the course of mental ill-health for promotion and prevention purposes. It should be emphasised that all cases, who satisfy the diagnostic criteria, but who are without treatment are not automatically a problem for mental health care as unmet needs are difficult to conceptualise and measure. Functional disabilities seem to be more important than diagnoses as such and therefore the interest should not just limit to diagnostic groups. Furthermore, the relationship of severe mental disorders and general population is problematic, as rare conditions are difficult to detect among the general population. Whether it is important to measure e.g. schizophrenia in a monitoring system, depends on the ultimate aims of the monitoring system.

The added value of the monitoring system

Ultimately the system is to help decision making. It can be used in estimating how the targets set for policies are met, whether there is a measurable decrease in disability, suffering and disease. The indicators offer possibilities to adequately allocate the resources for interventions, policies and programmes. This information could also be used in evaluating the mental health impact of other policies.

Quality requirements for the indicators

The indicators should monitor, what happens in populations or in sub-populations, what are the changes of mental health on population level and what are the determinants for the change. The monitoring system should use only validated and reliable measures. However, there has to be a balance between feasibility on the one hand and validity and reliability, on the other hand. In selection of the feasible indicators cultural context and the opinion of users or clients should be considered.

Organisations like the OECD or WHO do not have the same resources to complete the development of an indicator set. Even in the Eurostat there is awareness of the fact that only some of the data collected are comparable. Therefore the quality aspect is very important. A list of areas of indicators will inform, what kind of information is needed. A set of instructions providing guidelines on how the indicators should be interpreted, has to be developed.

In surveys a limited number of questions can be used. Reliability of short instruments may be questionable. Important question are, which survey instruments are better than others, and to what extent can data be collected with present instruments or is the development of new measures needed. Special surveys may be required to complete the picture.

It should be remembered that what is needed is a representation of mental health for pragmatic

purposes. Any set of indicators will always upset someone due to the complexity of the issue. Favourite ideas and indicators can be lost, but the wider perspective is more important. Pertaining to the selection of the indicators, their psychometric aspects should be paid close attention to. Are e.g. positive mental health measures validated in the general population?

It is known from previous experience that there are serious difficulties to change the indicators already in use by the Member States. It should not be forgotten that patients are the basis for mental health indicators. Indicators referring to the structure of the care system are to be included in the indicator set not, but indicators concerned with the quality of care.

The information (e.g. aggregated data including tables) should be made available for the public in the internet. A transparent system of comparable reliable core information should be created.

Types and sources of data
There are at least two types of indicators: "absolute indicators" that are more reliable (e.g. "mortality") and relative indicators" that are less reliable (questions like e.g. "are you depressed?"). The indicators should include a variety of instruments from the simple ones to the more sophisticated measures: basic indicators (social stress and demographic indicators from routine data); standardised measures of distress (use of survey scales); and intervening variables (survey scales measuring social support and positive mental health). Additionally, it is important to consider, what does an indicator indicate, as one indicator is affected by various things.

Experience of service users is an increasingly important aspect. Data for such analysis could be collected in annual surveys. Positive mental health should also be taken into account, not just ill-health, which is measured in utilisation data and epidemilogical surveys of disorders. Additionally, what is available in routine data needs to be included also. Survey data that refers to risk and protective factors should be likewise included in a monitoring system for promotion and prevention purposes.

If a national survey measure is already being used for a long time, it will be difficult to add questions or change it due to resistance. Finally a consensus should be reached concerning the indicators. Possibly a European survey is needed. An alternative is to add a kit of questions pertinent to mental health into other surveys. This should be done with respect for interests of Member States.

A survey on routine data, along the lines of Hupkens in Eurostat, was suggested. This could provide a picture of the infrastructure work required for the monitoring system. Also, surveys may fail to find marginalised populations (homeless and institutionalised persons e.g.).

The final policy recommendations of the workshop

CORE ISSUES CONCERNING RECOMMENDATIONS

1) What do we want to know?: The indicators are to provide information for the targets that have been chosen as relevant for mental health: what are the mental health needs at population level?, how to address these needs in the Member States? and are the needs met in a satisfactory manner in the Member States?
2) How and where do we get the necessary information?: The mental health indicators should make maximal use of data already routinely collected in the Member States. However, addition

of items into e.g. national surveys or the European Community and Household Panel will, likewise, be necessary.
3) How do we ensure the necessary quality (comparability, reliability, validity)?: Only validated and reliable up-to-date instruments should be used when surveys are concerned. When routine data is concerned, only data that allows comparisons, should be used. This potentially implies co-ordination of the definitions of individual indicators.
4) How do we ensure quality reporting and interpretation of data?: Instructions should be provided for the interpretation of the indicators. These instructions should be clear and unambiguous.

RECOMMENDATIONS

Italics = related policy

1. There is a **clear need for a common system for mental health monitoring** (positive mental health, mental ill-health and its determinants). A set of clearly defined, useful, unambiguous, reliable and comparable indicators should be used for mental health monitoring. The European Commission should take responsibility in implementing the monitoring system. Collaboration with WHO should be explored. *Relevance for public health policy*

2. The mental health indicators should be **an integrated part of a comprehensive EU health monitoring**. *Relevance for public health policies*

3. Relevant points regarding data collection:
3.1. **Co-ordination** is needed at international level to enhance the comparability and validity. An expert panel on European level should guide the implementation of the process. *Relevance for public health policies*
3.2. **Acceptability** for Member States, users and carers**;** cultural aspects of the indicators should be considered, particularly for prospective Member States. *Relevance for public health and enlargement policies*
3.3. As **data sources** the mental health indicators should rely as much as possible on **1) routine data** (a survey is needed on the scope and quality of routinely collected data) and **2)** mental health items in existing population based **health and mental health surveys** collected at national and European level. Existing national data could be collated quickly. Long term issues are (marginal) population groups likely to be missed by national health surveys. Mental health surveys or addition of set of questions concerning mental health into general health surveys will most likely be necessary. *Relevance for public health and enlargement policies*

4. Need for further development: testing of use and comparability of data and dissemination: The data should be made **easily accessible to European citizens** by telematics means including a website *Relevance for information society and public health policies*

Workshop 3: Promotion of mental health of children and young people

RATIONALE

1. Evidence clearly demonstrates that there are multiple determinants of the mental health of children and young people. These include that those are related to biological factors,

gender, the family environment, school and other social and learning environments, physical health and well-being, peer relationships, community and neighbourhood influences and economic factors.

2. Evidence also clearly demonstrates that there has been an increase in the mental health problems of children and young people across Europe, particularly those that are related to psychosocial adversities.

3. The mental health of children and young people has relevance not only early in childhood and adolescence but throughout the lifespan. Approaches which seek to provide support both early in life and also early in the development of problems will reduce the burden of mental health difficulties later in life.

4. Our future aspirations are that children's rights and welfare, including consideration of their other mental health, will be incorporated within all policy developments and in all initiatives that focus on mental health.

RECOMMENDATIONS

Public Health Framework

1. The awareness and importance of mental health for children and young people needs to be raised in all sectors as well as in the whole population.
2. Consideration should be given to the incorporation of a developmental approach within the framework that includes a focus on the mental health and well-being of children and young people.
3. Public Health initiatives should support preparation for parenthood and provide support for parents and families. This should include support to parents of teenagers besides supporting the early interaction with young children.
4. The Public Health Framework should establish a close relationship with other policy areas that have relevance to children and young people including those to do with education, social policy and juvenile justice.
5. There needs to be an increased focus on children and young people who are vulnerable and at risk of social exclusion. [These include those who are absent from school, who are involved in crime, who have mentally ill parents etc.]. New ways to support these groups need to be developed and evaluated in order to both prevent mental health problem developing and also to help those who are already experiencing difficulties.

Research

Priority should be given to establishing and supporting an EU and member states research programme on child and adolescent mental health.

1. A programme to collate and assess current research activity across the EC and rest of Europe needs to be established.
2. Consideration needs to be given to the EU supporting efforts by member states and the international community to the wider dissemination and use of the evidence base and good practice and the establishment of research training fellowships.

3. Further research is required into developing new methodologies for the study of mental health promotion processes, methods and effectiveness.
4. Specific research should be commissioned into the effectiveness of interventions in developmental disorders, childhood depression and conduct disorder.
5. Positive indicators for the mental health of children and young people need to be developed and tested across all European countries.

Enlargement

The recommendations on mental health promotion from this conference should be considered as a support to the accession countries. Strategies for implementation should be developed in collaboration with these countries and WHO.

Telematics/Information society

1. Telematics should be used as supportive tools in the promotion of awareness of the mental health of children and the young people and in the dissemination of relevant information about good practice and research across all agencies and countries.
2. The use of telematics should be considered in our efforts to involve children and young people in developing their own awareness about mental health.. and in the development of strategies to improve their mental health and well-being.
3. New initiatives within the field of telematics that have relevance to children and young people mental health should be evaluated in order to assess both the potential for positive benefit and for harm.

Policies in areas other than health

Efforts need to continue to support and further develop mental health promotion in school by ensuring that schools

- are supportive to pupils and teachers
- facilitate true pupil participation and partnership
- incorporate relevant materials within the curriculum that will further the acquisition of life skills required for positive mental health
- help teachers develop the skills both to understand and better address the needs of children and young people with mental health problems.

This can be supported in conjunction with the health promoting school programme.

1. The awareness of mental health and well-being of children and young people needs to be raised in all sectors and in all policies as well as in the whole population, using a developmental child centred approach.
2. Public Health initiatives should support preparation for parenthood and provide support for parents and families.
3. There needs to be an increased focus on children and young people who are vulnerable and at risk of social exclusion.
4. EU should support specific programmes to assess, disseminate and use sound research evidence and good practice in mental health promotion of children and young people using a broad base.
5. EU research programmes should provide for adequate funding of research on child mental health and the treatment of specific childhood disorders.
6. Indicators of positive mental health and mental health problems in children and young people need to be developed and tested across all European countries.

7. EU needs to continue to support and further develop environments, both inside and outside the school setting, which enable children, young people, and their teachers and carers to learn effectively and develop their capacities for positive mental health.

Workshop 4: Promotion of mental health in old age

PREPARATION OF THE WORKSHOP MEETINGS: DESCRIBING THE STATE OF THE ART

Preparation for the workshop on mental health promotion in old age was started by a meeting of ten experts in this field. As a product of the meeting a background document for the conference was produced[2] . This document was the basis for the workshop working during the conference and most of the experts participating in preparation of the background document also participated in the conference. According to the document, the most serious threats to mental health in old age are posed by depression, cognitive impairment and pain. Other threats are poverty or socio-economic insecurity, loss of independence and ageism. In addition, abuse, malnutrition, and excessive use of medication are clear risks for mental health. Mental health promotion in old age should have two prongs: minimisation of disease and disabilities, and promotion of opportunities for positive ageing.

The document also mentioned that a gradual loss of independence frequently accompanies the ageing process. Associated with this loss of independence are the frailty and declining resources experienced by many individuals at advanced age. Western cultures and societies have moreover been accused of ageism, and thus of making ageing socially and culturally even more difficult.

Loss of independence does not automatically lead to a loss of autonomy. Ideally, people can retain the right to make decisions about their own lives even if they are in continuous need of help. Autonomy is another key issue in discussions on the promotion of mental health in old age.

Loss of independence is closely associated with disability, whether somatic or mental, or both. Studies have shown that a vast number of disabilities can be avoided. They are associated with incompetence to act in a modern society, with a built environment that is not accessible, with inappropriate treatment of somatic or mental symptoms and disease, with social isolation, and finally with a lack of access to services and financial resources.

The expert group also emphasised that in terms of mental health promotion, independence and autonomy are crucial: they constitute the basis on which an individual acts as a full citizen, contributes to society and receives support when needed. The importance of these issues in old age is at least as important as in any other phase of a person's life span, if not even more so.

It was also stated that to be able to promote mental health in old age, we must understand how older people live; we must know what their social networks are, understand their wishes and see what effect their advanced age has on the way society treats them. Investigating these issues can help us to understand the social and cultural factors that either promote or threaten mental health. The rapid ageing of the European population means that the subject of avoidable disabilities in old age must be incorporated in a European Agenda.

Although the circumstances of the elderly vary much more than do those of younger age groups, they have a great deal in common: they are not part of the active labour force, poverty is common in this age group, they have experienced many losses, and they tend to live alone or in institutions more often than do people in other age groups; there are, however, considerable variations between different countries in Europe. Feelings of loneliness and insecurity are widespread among elderly people. Moreover the risk of chronic diseases increases with age. These issues have been shown to have a bearing on mental health and on mental health disorders, such as depression, in old age.

According to the background document, the main issues to be resolved in the promotion of mental health in old age are:

- how to decrease negative attitudes towards the aged;
- how to increase society's awareness of ageing process as such and, when symptoms of mental health problems emerge, to see what has caused them;
- how to inform and educate people working in social and health care and in other fields. Professionals working with elderly people have to recognise the importance of mental health promotion in old age;
- how to organise further education for health care professionals, and improve their ability to prevent, diagnose, treat and cure mental health problems, and disabling, painful and other somatic conditions with an impact on mental health;
- how to develop preventative community strategies and create systems for screening high-risk groups at the primary care level;
- how to encourage intergenerational co-operation and social cohesion;
- how to support elderly people who have suffered acute losses or who are living in chronic stress situations, for example, the carers of chronically ill family members, relatives or friends;
- how to give the aged a chance to show their need to love and be loved, and to be sexually confident;
- how to organise opportunities for life-long learning, social contacts and other meaningful activities, especially for elderly people at risk of isolation due to disabilities, exhausting care responsibilities, a lack of financial or cultural resources and other recent stressful life events.

Briefly, then, the main challenges are how to promote autonomy in old age and how to minimise disease and avoidable disabilities. Mental health promotion in old age has to start from this point and continue from there to improve the preventive, diagnostic and therapeutic skills of health care professionals.

The expert group which prepared the background document concluded that promotion of mental health in old age is such a broad issue that it encompasses older people themselves, family members, mass media, service providers, city planners, police, teachers, health and social care professionals, and researchers - everyone. The rapid ageing of the European population means that especially the subject of avoidable disabilities in old age must be incorporated in a European Agenda.

The group pointed out opportunities for action at EU level. The European Parliament, for instance, could focus on fostering tolerance and understanding between generations and it could pay greater attention to the need to reduce poverty among the elderly and negative attitudes towards the aged. If mental health promotion and awareness of avoidable disabilities could be incorporated in all planning, we would have taken a massive step towards creating a

society for all ages. Examples of areas in which more could be done are in barrier-free planning, architecture, design and gerontechnological solutions. Likewise, greater attention should be paid to the voluntary work done by or among elderly citizens. These efforts should be supported by the community and given the basic facilities they require. Because mental health promotion is closely linked to social participation, the role of voluntary work might be one of the best ways in which to act.

At Community level, the expert group recommended that networking, to produce high-quality training programmes dealing with mental health problems in old age, should be set up for health and social care professionals. Material should be produced to help train other professions in the field of ageing. European-level co-operation within training and education is also needed to ensure that reliable material about cultural differences is available, and that good quality services for older refugees and other immigrants are developed.

Workshop results

During the conference there were two workshop meetings. In the first one professor Sirkka-Liisa Kivelä introduced the aims of the workshop and Dr Päivi Topo the background document. In addition, Dr. Riitta-Liisa Heikkinen described the main results of a population-based study focusing on mental health and especially on depressive symptoms of older people[3]. She emphasised the importance of social networks and contacts on promotion mental health in old age: loneliness showed a clear correlation with depressive symptoms, as did poor self-rated health, too. The rest of the meeting was used for discussing about the main challenges in promotion of mental health and in pointing out how the prevention could be done on the level of the European Union. On the basis of the first workshop meeting the rapporteurs, Dr. Gabriela Stoppe and Dr Riittakerttu Kaltiala-Heino wrote a proposal on recommendations of the working group. The proposal was discussed in the second workshop meeting and a final version was written by the end of the meeting. The recommendations were included into the executive summary of the conference. They were the following:

The key factor in health promotion in late life is personal, active participation by the elderly themselves at all levels. Other factors are the necessity to combat ageism, promote autonomy and empowerment, facilitate social support, social integration and social participation, and reduce social isolation. There is also a need for evidence-based information and for increasing research initiatives in the field of ageing and mental health.

There is a need to:

- increase the knowledge, competence and skills of social and health care professionals, members of NGOs and carers in the field of normal ageing and ageing with deviations;
- reduce risk factors for impaired mental health and well-being such as isolation, poverty, disability, malnutrition, abuse, pain and drug side effects through
  - special programmes for risk groups,
  - community based mental health promotion programmes for all elderly people, and
  - dissemination of good practices;
- focus research on the risk factors, prevention, recognition, treatment and care of mental ill-health; and
- establish a network promoting mental health in elderly people to serve the efforts of research, information, dissemination of good practices, monitoring and training.

Workshop 5: Working life, employment policy and promotion of mental health

1) KEY MESSAGES

- Paid work is a central component of mental health well being and social inclusion. However in a labour market where most people will move regularly and have periods of unemployment, we should develop a new understanding, destigmatizing unemployment and valuing other contributions to community life (e.g. through the social economy).
- Strategies to achieve mental health well being and social inclusion in and through employment must bring together the mental health promotion and equality/anti-discrimination agendas. (Amsterdam Treaty Articles 6, 37& 137)
- The psycho-social effects of a rapid social change regarding new requirements in the workplace and the increased risk of experiencing spells of unemployment during a career have to be addressed and appropriate measures taken to counteract these effects.
- Strategy and policy at all levels must take a holistic approach to the life of the individual in and out of work. (Amsterdam Treaty Article 152)
- Publicly supported employment opportunities for unemployed people with impaired health should be acknowledged as a means to reduce the risk of social exclusion of this vulnerable group.
- To achieve this complementarity, coordination, integration, cross referencing and support must be ensured at all levels between policy areas, e.g. Equality and Human Rights, Health, Employment, Education and Training, Transport etc.
- All policy and programme design work that refers to disabled people and others at risk of or experiencing social exclusion should include the experience and expertise of end users and beneficiaries.
- Many people with severe mental illness are employable given the right support and reasonable adjustments to their conditions of work.

2) INTEGRATING MENTAL HEALTH PROMOTION AND EQUALITY FOR DISABLED PEOPLE IN EU EMPLOYMENT GUIDELINES

These are concrete and urgent recommendations to the Council of Ministers on much needed changes to the Employment Guidelines, which incorporate mental health promotion and equality. Other policy statements and declarations will need similar work

EU level: We refer to the Council Resolution on the 1999 Employment Guidelines

- Modify Section 1 on Improving Employability to include transitions other than school to work that have particular mental health implications e.g., job loss (redundancy), return from maternity leave, transition from requalification to reemployment, work to retirement, etc. Priority
- Modify Section 3 on Adaptability to include provision for lifelong learning and development for employees in support of section 1. Priority
- Add to section 3 a section on the commercial benefits not only of adaptability, but also of promoting structural and functional adjustments for health in the workplace – especially mental health
- Include in section 4 on Strengthening Equal Opportunities all the groups identified

as liable to exclusion in paragraph 9. It is inappropriate to confine equality of opportunity to gender relations only. Priority

- Ensure that the experience and voices of the people identified as liable or already subject to exclusion become part of the process of policy and programme formation. They too, are social partners together with Employers, Unions and other stakeholders.

National level:

- National Employment Action Plans should be based on the modified Guidelines.
- Encouragement to the above should be given by the EU asking for examples of good practice in implementing the Guidelines and these should be shared around the Union each year. E.g. Finnish paper on the Innovation Process by STAKES
- Consultation on drafting and monitoring of National Action Plans should be required to include relevant NGOs
- National Action Plans should include a section on how mental health and general health policies will support the plan eg. the National Service Framework for Mental Health Services in UK makes explicit reference to the duty of mental health and primary care services to support user's employment aspirations.
- National Governments should be encouraged to take a lead in implementing guidelines in their capacity as employers.

EU Targets

- Ensure that the modified Guidelines are reflected in all National Employment Action Plans (NAPs)

Collaboration between EU and WHO

- Joint project to modernise and disseminate existing relevant WHO and ILO guidance: e.g. UN Standard Rules on Equalisation of Opportunities and ensure that mental health and mental health service users are explicitly included.

3) SPECIFIC INVESTMENT RECOMMENDATIONS FOR EU AND NATIONAL GOVERNMENTS

- Developing comprehensive criteria and research programmes for evaluating effective interventions promoting mental health and social inclusion in and through employment and other social determinants.
- Life-long learning and development for individuals in and out of work.
- Support systems for people in occupational transitions that are legitimate and accessible.
- Rehabilitation and training for people with SMI leading to employment options.
- Monitoring employment for workplace quality, safety and mental health indicators.
- Support systems for unemployed people and their families including promotion of the social economy and other "grassroot" initiatives.
- Early intervention to get people back into work quickly after illness.[4]
- Work with the media to destigmatize unemployed people – they are a resource.
- Training and support for professionals across disciplines and sectors with a focus on employment support and integration.

- Social companies complementary to the primary labour market for vulnerable groups should be instituted and co-financed via public support.
- Work with employers to incorporate the promotion of mental health in the workplace and the legitimate claim to receive professional help in the case of unavoidable redundancy into the concepts of corporate social responsibility (CSR) now being developed across Europe. E.g. Framework of Declaration on Businesses against Social Exclusion.
- Existing structures and concepts (e.g. European Network Workplace Health Promotion (ENWHP) should be used to integrate mental health promotion in the workplace.
- National Governments may wish to integrate, horizontally and vertically, their actions aiming at a) minimising unemployment, b) minimising over-employment, c) promoting mentally healthy work practices and d) humanising workforce restructuring.

Workshop 6: Telematics in mental health promotion and substance abuse prevention

Workshop on Telematics in mental health promotion and substance abuse prevention was organised by the Prevnet Euro project in cooperation with the European Inspiration Society Initiative, within the framework of the European Conference on Promotion of Mental Health and Social Inclusion, held in Tampere, Finland.

Chairperson of the workshop was Mr. Wim Buisman (Jellinek Preventie, the Netherlands) and the co-ordinator Mr. Eero Riikonen (Rehabilitation Foundation, Finland). Rapporteurs of the workshop were Mrs. Claire Shearman European Association of Community Networks, United Kingdom and Mr. Tuukka Tammi, Finnish Centre for Health Promotion.

There were altogether five presentations given in the workshop:
- Inspiration Society - A dream, a challenge, a reality? Eero Riikonen, Rehabilitation Foundation, Finland
- Young people and telematics: Telematics in alcohol prevention – Prevnet Euro, Wim van Dalen, NIGZ, Netherlands
- Professionals and telematics: Experiences from drug and alcohol field in the UK Harry Shapiro, ISDD, United Kingdom
- Schools and telematics: Experiences of Drugsmart project Sofia Modigh, Social Ministry, Sweden
- Organizations and telematics: European experiences from telematic services of the drug and alcohol field, Philippe Roux, EMCDDA, Portugal

A parallel video conference was organised by Prevnet Euro in Amsterdam on October 12th, a day on which telematics featured as a theme for the conference's plenary session.

The goal of the whole conference was to enhance the value and visibility of mental health and to agree on strategies concerning future European action and co-operation in the field. Use of telematics in mental health promotion and substance abuse prevention was one of the main themes, addressed in a plenary session and in a workshop. A common task for the conference's thematic workshops was to formulate a proposal for policy recommendations concerning the workshop's specific topic. The proposals were integrated into the final conclusions of the conference.

The following policy recommendations were formulated by the Workshop on Telematics in mental health promotion and substance abuse prevention.

POLICY RECOMMENDATIONS

KEY PRINCIPLES

Mental well-being goes beyond mental and general health policies to include important sectors like education, employment, working practices etc. An EU policy on mental health and social inclusion therefore needs to adopt an integrated and holistic approach. An EU mental health and social inclusion policy should incorporate user perspectives and participation along with that of mental health practitioners and have clear links to local community activities. Telematics offers an important potential to increase the quality of services and levels of user and professional involvement in both mental health promotion and substance abuse prevention. Links should be made with other EU programmes including FW5, the Structural Funds and collaborative initiatives of relevant international organisations.

PRIORITY AREAS FOR ACTION

A. Professional support (European and national level)

1. Actions to train mental health and associated (e.g. substance abuse prevention) professionals in appropriate ICT-skills and applications to support their professional development and practice.
2. Actions to promote intersectoral cooperation (e.g. between mental health and substance abuse prevention) and to exchange experiences at the operational level so as to support more effective learning between professionals.
3. Actions to identify best practice in using ICTs (including anonymity and identification) in the fields of mental health promotion and substance abuse prevention.

B. User and community support (European level including FW5 and Structural Funds)

1. Actions to promote easy access to and active use of ICTs by service users and other vulnerable groups (including those with addiction problems) in ways that enhance their sense of self-esteem, confidence and, where appropriate, recovery.
2. Actions to support ICT-based networking by service users and other vulnerable groups at the local, national, European and international levels.
3. Actions to support the development of socially inclusive ICT-based arts and mental health and substance abuse prevention initiatives.
4. Preventive actions using ICTs to promote awareness of mental health wellbeing via self-esteem and creativity in both the workplace and local community contexts.
5. Actions to support the reintegration of users and other vulnerable groups into employment and the labour market through the development of ICT and other relevant skills.

C. Research (international)

1. Actions to promote media awareness of key issues in mental health promotion and substance abuse prevention.

2. Actions involving relevant European networks (e.g. European mental health network, European Inspiration Society network, Prevnet Network and European Association for Community networking) to identify and disseminate best practice.
3. Actions to promote awareness of mental health wellbeing in the workplace, schools and local communities.

[2] Mental health promotion in old age in Europe. Background paper for European Conference on Promotion of Mental Health and Social Inclusion 10-13 October 1999, working group 4 Promotion of mental health in old age. The paper is based on the work of an expert group comprising Professor Lars Andersson, Dr. Francoise Bouchayer, Dr. Riitta-Liisa Heikkinen, Professor Sirkka-Liisa Kivelä, Professor Anthony Mann, Mrs. Christine Marking, Professor Mary Marshall, Mrs. Margaret McDonnell, Professor Gabriella Stoppe, Dr. Judy Triantafillou, Dr. Päivi Topo (coordinator/rapporteur) and Dr. Juha Lavikainen (rapporteur)

[3] Heikkinen R-L, Berg S., Avlund K.: Depressive symptoms in late life. Results from a study in three Nordic urban localities. Journal of Cross-Cultural Gerontology 1995:10:315-330.

[4] E.g. In the Netherlands employers are not only responsible for the well being of their workers but also have to accept the financial consequences when people are unable to work. Employers have taken an interest in improving working conditions, and in making sure that preventive measures are in place. They also invest in the development of specific health care programmes that include getting people back to work quickly.

I

(Information)

COUNCIL

COUNCIL RESOLUTION

of 18 November 1999

on the promotion of mental health

(2000/C 86/01)

THE COUNCIL OF THE EUROPEAN UNION,

1. RECALLING the Council resolution of 2 June 1994 on the framework for Community action in the field of public health [1] where it was stated that mental diseases, which account for a very high level of morbidity and total health expenditure, must be examined forthwith with a view to identifying the kind and extent of actions that have to be undertaken at Community level in order to assist the efforts of the Member States in this area;

2. RECALLING the Commission communication of 16 April 1998 on the development of public health policy in the European Community which identified mental health as an issue to be taken into account in the future Community action in the field of public health;

3. RECALLING the Council conclusions of 26 November 1998 on the future framework for Community action in the field of public health [2] which stated that the greatest benefits for the health of EU citizens are likely to be achieved by focusing Community action, *inter alia*, on reducing mortality and morbidity related to general living conditions and lifestyles, with regard to both physical and mental aspects;

4. TAKING NOTE of the resolution of the European Parliament of 9 March 1999 on the Commission report on the state of women's health in the European Community which called on the Commission to improve the presently scarce data on mental health and disease in the Union and to create awareness of appropriate treatments for depressive syndromes;

5. TAKING NOTE of the joint World Health Organisation/ European Commission meeting on 'Balancing mental health promotion and mental health care' held in Brussels from 22 to 24 April 1999, and its conclusions entitled 'There is no health without mental health';

6. WELCOMES the European Conference on Promotion of Mental Health and Social Inclusion held in Tampere from 11 to 13 October 1999, which highlighted the importance of mental health and the need for action as a part of the Community public health strategy;

7. RECOGNISES that mental health is an indvisible part health;

8. CONSIDERS that mental health contributes significantly to quality of life, to social inclusion and to full social and economic participation;

9. UNDERLINES that mental problems and illnesses are common, cause human suffering and disability, increase mortality, and have negative implications for national economies;

10. UNDERLINES that the problems of mental health are often linked to, among other factors, unemployment, social marginalisation and exclusion, homelessness and drug and alcohol abuse;

11. RECOGNISES that there are effective methods to promote mental health and to prevent mental problems and illnesses;

12. CONSIDERS that there is a need for enhancing the value and visibility of mental health and to promote good mental health, in particular among children, young people, elderly people and at work;

[1] OJ C 165, 17.6.1994, p. 1.

[2] OJ C 390, 15.12.1998, p. 1.

13. CONSIDERS it important to cooperate with the World Health Organisation in a coordinated way on mental health issues as well as with other international organisations;

14. RECOGNISES the need for addressing the promotion of mental health in the increased cooperation with applicant countries;

15. INVITES the Member States:

— to give due attention to mental health and to strengthen its promotion in their policies,

— to collect good quality data on mental health and actively share it with other Member States and the Commission,

— to develop and implement action to promote mental health and prevent mental illness and promote exchange of good practices and joint projects with other Member States,

— to stimulate and support research on mental health and its promotion, also using the opportunities provided by the fifth framework programme of the European Community for research, technological development and demonstration activities (1998 to 2002) adopted by Decision No 182/1999/EC of the European Parliament and of the Council [1];

16. INVITES the Commission:

— to consider incorporating activities on the theme of mental health in the future action programme for public health, such as exchange of information and good practices, networking,

— to develop and implement, as a part of the Community health monitoring system, a component for mental health and to produce a report on mental health,

— to analyse the impact of Community activities on mental health, for example in the fields of education, youth policy, social affairs and employment,

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

[1] OJ L 26, 1.2.1999, p. 1.

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3 Proceedings of the European Conference on Promotion of Mental Health and Social Inclusion.
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This report is a collection of the speeches and presentations given at the *European Conference on Promotion of Mental Health and Social Inclusion* held in Tampere, Finland, on 10–13 October 1999. The conference, part of the official programme of the Finnish Presidency of the EU, was a central landmark of the *European Mental Health Agenda*, a long-term process - supported in many ways by the European Commission - striving to gain more value and visibility for mental health issues within the European context.

This report reviews the contents of the plenary sessions, the panel discussions, and the workshops of the conference. It includes speeches given by David Byrne (European Commissioner for Health and Consumer Protection) and Gro Harlem Brundtland (Director-General of WHO). It also presents the recommendations concerning the priority areas demanding urgent actions in Europe within the field of mental health.

Ministry of Social Affairs and Health
Department for Promotion of Welfare and Health
P.O.Box 33
FIN-00023 Government, Finland

Telephone: +358 9 160 4031
Fax: +358 9 160 4144
Internet: www.stm.fi

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SUOMI FINLAND 99

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MINISTRY OF SOCIAL AFFAIRS AND HEALTH