Executive Summary

This report aims to describe and compare the state of mental health in the European Union and Norway, in the context of longstanding efforts of EU public health programmes to promote good mental health and to prevent mental ill health.

A documented knowledge of the population's mental health status, and its determinants, is essential to establish the basis for such programmes and to monitor and improve them.

In preparing this report, it has been assumed that collecting and comparing information on mental health between countries will enable Member States to improve their understanding of mental health issues and to plan appropriate policy responses. Mental health has to be considered as a public health priority due to the heavy burden it places on the EU and its Member States.

The report's starting point is the acknowledgement that Member States are different in terms of population density, aging, poverty levels, cultural background and habits. Furthermore, all of these factors have been shown to have some links with mental health status and some of them have been identified as risk factors.

This project has involved representatives from all EU countries plus Norway, WHO Europe, a representative of a non-governmental organisation (Mental Health Europe) and a representative of OECD Europe.

Each country representative was asked to summarise all the surveys on mental health which had been carried out in their country. In addition, the experts each prepared a report on their country, its health system and particular issues relating to the mental health domain.

Routinely collected statistics, such as cause of death or the reasons for hospital discharge, do not fully reflect the reality of the majority of mental health problems, which do not lead to death or hospitalisation. This means that surveys among the general population are very important for assessing the state of mental health.

Consequently this report has been prepared combining two main kinds of data:

- routinely collected statistics on deaths from suicide, the use of drugs and alcohol and psychotropic drug consumption
- results from general population surveys.

The report is based on previous expert recommendations on mental health indicators, which propose that mental health should be described in three dimensions. Positive mental health relates to well-being and the ability to cope with adversity. Negative mental health comprises both psychological distress, which refers to the presence of symptoms (mainly depression or anxiety), and diagnosis of psychiatric disorders. These are the three dimensions which have to be measured through surveys.

However, although many surveys which include mental health measures were identified, the differences in survey techniques and research methods make real comparisons almost impossible. This highlights the importance of collecting data in a comparable manner across the EU.

Two EU designed surveys – Eurobarometer and ESEMeD – provide important information for comparisons for most of the countries. But even EU designed surveys face methodological challenges when interpreting differences.

This report compiles the diverse indicators and describes the major differences across countries in different dimensions, with an attempt to set up individual country profiles where sufficient information was available.

Measures of positive mental health do differ significantly between European countries. Similarly, measurement of psychological distress in the two European surveys shows significant differences between Member States. After controlling for major socio-demographic variables, differences also appear for most of the psychiatric disorders across the countries involved in the surveys. However, there are quite different patterns when considering these three dimensions and this underlines the necessity of collecting information on diverse dimensions (Section 3).

Suicide varies across Europe, ranging from 3 deaths per 100,000 in Greece to 24 deaths per 100,000 in Finland. Although males have higher suicide rates, the ratio of male:female suicides differs across countries as well as the relative proportion of younger and older people who committed suicide.

Since methods for collecting suicide data are not totally identical, data on deaths whose suicidal intention is doubtful (deaths from events of undetermined intent) have been compared as well.

In general, suicide rates have dropped across Europe in the last 20 years. In all countries a decreased trend is observed for suicide in males with the exception of Ireland and, to a lesser degree, of Spain and Luxembourg. This decreasing trend is stronger for suicides among women.

Alcohol, tobacco and drug use all vary between Member States. Alcohol-related problems are responsible for around nine per cent of Europe's total burden of disease. Cigarette smoking is also relevant to mental health because nicotine dependence has been defined as an addictive disorder. Use of illicit drugs varies from country to country and different usage patterns are also reflected in national differences in acute drug-related deaths.

Since mental health surveys results have to be interpreted with caution, a promising way to make comparisons is to compare risk groups across countries. The main relevant factors are gender, age, marital status, employment, socio-economic status, rural-urban place of living and immigration status (See Section 4).

Important differences are reported concerning the relative risk of women for psychological distress and depressive and anxiety disorders across countries. Similarly, there are differences for young people in some countries. Data on the older population were more difficult to compare for depressive disorders, as well as for cognitive disorders, although they will represent a major challenge for each country. To be divorced or to live alone is also a risk factor all around the EU, as are unemployment and poverty but the magnitude of these risks varies. Data on urban/rural comparisons are more difficult to compare, partially because socio-demographic compositions of the two populations are different and also because uniform definitions of what constitutes rural and what is urban have to be found. Very few data exist to allow comparisons on immigrant mental health status across countries.

The extent to which people seek help for any mental health problems, who they seek help from and what help is on offer also differ throughout the EU. Human and material resources are different, quantitatively and qualitatively, across the EU. The reported use of care and health seeking behaviour, however, does not fit the availability of resources and differs remarkably across countries as does the type of help sought. Similarly, the relationships between the primary care system, which is the most frequent provider in all countries, and the specialised mental health system are very different. Consequently, the type of care provided varies too (Section 5).

Thanks to the ESEMeD and Eurobarometer surveys, it is possible to present a complex picture of mental health in six countries, by putting together all available indicators.

This report demonstrates that comparisons of mental health, and its socio-economic determinants, are essential and feasible. Yet such comparisons should be interpreted with caution, at least until data is collected in a more comparable manner across Europe.

Widespread, although not universal, improvements in some indicators, such as suicide or alcohol consumption, point to effective public health policies. The effectiveness of these interventions should encourage the remaining countries, including the new Member States, to introduce similar policies.

Comparisons of the different mental health provision patterns may also be fruitful for EU countries.

The report recommends that, at the EU level:

- information be collected about mental health across the EU in an appropriate way to enable valid comparisons. EU level surveys have to be set up including longitudinal surveys and surveys on children, adolescents, immigrants and older populations. Data collected in various surveys such as labour force surveys should include a mental health component developed in collaboration with mental health surveys experts
- a report on mental health which collects and compares data from all sources, and which includes the enlarged Europe, should be produced on a regular basis in order to stimulate common efforts across the Member States

Many of the above recommendations apply at the national level as well as at the EU level. In addition, some further recommendations are made at Member State level. These stress the importance of:

- implementing EU data collection guidelines and instruments in each health-related survey and of conducting mental health surveys accordingly at regular periods.