Report edited by
Juha Lavikainen
STAKES, Mental Health
September 2001

FUTURE MENTAL HEALTH CHALLENGES IN EUROPE

The Impact of Other Policies on Mental Health

Report of the consultative meeting, Brussels, 3–4 September 2001

PREFACE

The European Commission's proposal for a new programme of Community action in the field of public health (2001–2006) aims at setting set out an integrated and comprehensive action plan for public health activities of the European Union. The programme has three general objectives:

(1) To improve information and knowledge for the development of public health;
(2) To enhance the capability of responding rapidly to threats to health; and
(3) To address health determinants.

Reflecting the obligations of Article 152 of the Amsterdam Treaty, the programme will give special emphasis on the issue of the impact of other policies on health. Public health expertise will be linked with other policy areas in order to develop and ensure joint actions beneficial for health. According to the principle of subsidiarity, the programme also fully respects the responsibilities of the Member States for the organisation and delivery of health services and medical care.

In the context of mental health overall, the issues of information and health determinants particularly merit further consideration, as in mental health these matters are in many ways underdeveloped in comparison with those in physical health. In addition, there is an urgent need to contemplate on how to maintain and strengthen the practical activities in the field of promotion of mental health, and, more generally, also on how to best keep the momentum for mental health that was achieved through several activities in the Community action programme on health promotion, information, education and training under the 1993 Public Health Framework.

The proposed Community action programme should provide a timely opportunity to introduce and implement a suitably wide ranging and yet integrated mental health approach to the stated three priorities.

This consultative meeting aimed at promoting discussion and at determining the more urgent mental health priorities for inclusion within this programme, giving sufficient emphasis on relevant aspects of mental health promotion. Thus, one principal objective of the meeting was to provide concrete support to the Commission's preparations with regard to the implementation of the new programme. The goal is to strengthen mental health as an integral part of public health and to find effective and feasible ways to promote mental health at the Community level.

In the longer run, the outcomes of the meeting will be measured through successful implementation of the adopted strategies and actions developed and carried out within the new Community programme. These strategies and actions will be expected to have a strong impact on improving the mental health status of the citizens of the European Union in order to contribute to ensuring a high level of human health protection. It is also foreseen that, for example, mental health impact assessment may become a standard procedure in future policy planning in various sectors, such as those that were discussed in this meeting.

The meeting was organised on the initiative and financial support of the DG Health and Consumer Protection of the European Commission. The Federal Ministry of Social Affairs, Public Health and the Environment (Belgium) and the National Research and Development Centre for Welfare and Health, STAKES (Finland) were responsible for the programme and practical arrangements.

OPENING SESSION

Mr. **Horst KLOPPENBURG**, representing the convenor of the meeting, the Directorate General Health and Consumer Protection of the European Commission, welcomed the participants and announced that this event is best seen as another joint effort of the Commission and the WHO in the field of mental health.

Mr. Kloppenburg set the scene by emphasising the economic burden of mental health problems to the European Union. This manifests itself as exceedingly high costs to the Member States.

In view of the above, there is a certain lack of information which could be used in backing up political decision making on mental health issues on in e.g. the European institutions. Needless to say, such information would be highly welcomed.

Mr. Kloppenburg went on to quote the words of Commissioner David Byrne, who on the occasion of the World Health Day in Geneva has maintained that "we must endeavour to bring mental health issues into the mainstream of a health-conscious society".

The next speaker, Dr. **Wolfgang RUTZ** from the WHO Regional Office for Europe, stressed the need for co-operation between WHO and EU. According to him, current expectations as to the nature and quality of such co-operation are high indeed. Dr. Rutz acknowledged the existence of somewhat differing foci with regard to the dimensions of promotion and prevention in the activities of the two organisations.

According to Dr. Rutz, issues such as social inclusion, sense of coherence as well as alcohol and risk-taking behaviour are of great importance in this context.

He went on to strongly support the notion that all political decision making should be checked for their possible impact on mental health.

INTRODUCTORY SESSION

The first speaker in the introductory session, Dr. **Eero LAHTINEN** (Ministry of Social Affairs and Health, Finland) reviewed the development of the European Mental Health Agenda process originating from a discussion initiative made at the Health Council in 1997 by the Finnish Minister of Health. This initiative, first greeted with some controversy has provided, however, in recent years to be a success.

Dr. Lahtinen introduced the three strands of the new public health programme, which will enter into force in 2002. He stressed the fact that the strand on health information most likely provides to be a long-time process and also drew the attention of the participants to the fact, that the strand of reacting rapidly to health threats is indeed an issue that closely touches the topic of mental health.

Other issues addressed in this context were equality in health in view of stigma, discrimination and visibility, the impact of other policies on mental health and the challenges that lie ahead of us. In addition, the diversity of the health determinants was acknowledged, too.

The new social policy agenda of the EU was also addressed specifically with a view on its effects on working places and employment in general.

In her presentation 'From impact assessment to implementation of actions', Dr. **Anna RITSATAKIS** (WHO European Centre for Health Policy) started by stressing the fact that the WHO has already been involved with the topic of health impact assessment for about 20 years.

Health impact assessments are being - and have been - conducted on various fields and a wide variety of different checklists and models are readily available. However, it seems evident that such models and checklists need to be adjusted and opened for further options, bearing in mind the principle of minimising negative effects and maximising positive effects.

Dr. Ritsatakis defined health impact assessment as a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health or a population, and a distribution of those effects within the population. There is currently also growing pressure at international, national and local levels, to evaluate the impact of policies and programmes on public health

Moreover, learning by doing was an essential concept that reflects a strong wish to share knowledge between the multiple actors and stakeholders. Dr. Ritsatakis continued by suggesting that selected pilot projects should be conducted but explained also that mapping of potential linkages between policies, programmes, or projects and health, is not a standard procedure yet. She also pinpointed that balancing quantitative and qualitative evidence needs to be performed and that this balancing calls for strong consultative processes.

Dr. Ritsatakis also addressed the issues of increased working hours, the ageing of the population, and the prioritisation in the sense of contemplating where to focus time, skills and money. She underscored the necessity of thinking about which policies do actually have the strongest impact on mental health, which mental health aspects need to be taken into account, which indicators should be used, where to find the information and whom to involve in these processes. Finally, Dr. Ritsatakis highlighted the importance of building partnerships and increasing dialogue in order to be ready and willing to listen to the objectives and goals of other sectors involved.

Speaking under the title of 'The use of health impact assessment in planned and unplanned developments' Dr. **Ruth HALL** (Health Promotion Wales) first reminded the audience of the fact that mental health and wellbeing matter to everyone. She explained that increasing recognition of the need for action on mental health is welcome, as is greater emphasis on the social and economic factors that determine people's health. Dr. Hall gave examples of health impact assessment for planned developments (where outcomes can be anticipated and hopefully influence decision-making) as well as unexpected situations (when the outcome may not be altered but when it still is possible to inform the response and make the most of the learning opportunity). Connected to the above, she specifically described the area of economic development on one hand, and agriculture (the current foot and mouth epidemic) on the other.

According to Dr. Hall, health impact assessment offers a framework for use by health advocates, by planners and policy makers - it promotes dialogue. Making the connections between policy areas offers potential benefits of greater synergy, increased efficiency and effectiveness, and a sharper focus on outcomes. The use of health impact assessments requires alertness to the opportunities, understanding of the process together with an appreciation of its limitations as well s its flexibility.

In Wales, the impacts of policies and programmes are considered against the National Assembly's major themes and priorities including equal opportunities, sustainable development and tackling social disadvantage. This challenging aim most likely gains from the health perspective.

Dr. Hall also emphasised the two-way nature of health impact assessment - the impact of other policies on people's health and the impact health has on other policies. Partnership and collaboration, particularly at the European level is important to avoid duplication of effort. Sharing experiences and learning from others is vital while there is also a need to strengthen the evidence base on health determinants and health outcomes.

THE IMPACT OF ENVIRONMENTAL POLICIES ON MENTAL HEALTH

Professor **Vappu TAIPALE** (STAKES) opened the session on the impact of environmental policies on mental health. The concept of sustainable development was first introduced. This concept includes the following aspects: sustainable development needs to be socially just, environmentally imperative, and economically affordable.

The need for putting people at the centre of sustainable development was also strongly stressed. Hence, sustainable development is not only a *policy* but also a *movement*. Regarding sustainable development, the European Commission will be proposing a small number of performance indicators in Barcelona in Spring 2002. Prof. Taipale raised the crucial question of the possibility to include mental health indicators among these.

The concept of social capital, according to prof. Taipale means that trust, official ways of operating in society, citizen's interest groups, social norms, networks of people and other social structures facilitate economic development. Thus, social policies are a part of sustainability. Moreover, social capital can be approached as a concept which is full of mental health dimensions.

Prof. Taipale introduced the term social impact assessment as a process of analysing, monitoring and managing the intended and unintended consequences on the human environment of planned interventions so as to create a more sustainable biophysical and human environment (according to Vanclay, 2001). In the same domain, impact was seen as something that is experienced of felt in a perceptual or corporeal sense at the level of an individual social unit (family, household, community or society).

Finally, she emphasised the need for close co-operation with environmental policies. This needs, however, to be bilateral in nature: the mental health field needs to contribute to the concepts of environmental policies while it is, at the same time, open and willing to learn from these policies.

Professor **Clemens HOSMAN** (University of Nijmegen) draw attention to the fact that many links exist between social and economic conditions and mental health: this provides many options for mental health promotion. He also stressed that influence goes both ways: environment influences mental health and vice versa.

Prof. Hosman pointed out that some of the key issues are to share knowledge on barriers and facilitators to success, to prioritise, and to create sustainable partnerships.

Moreover, it is important to identify, learn from and make use of already existing public (health) measures that promote and protect mental health, as well as from earlier experiences.

Prof. Hosman maintained that a more comprehensive public policy is needed, which combines mental health promoting forces across sectors, addresses individual, social and economic conditions to mental health, has a wide reach within the society and guarantees sustainable implementation.

Professor **Franz BARO** (WHO Collaborating Centre on Health and Psychosocial Factors) introduced very practical examples as to the impact of environment on mental health.

Prof. Baro accentuated the costs of hip fractures which are quite common within the ageing population. Such accidents may prove to have devastating effects on mental health of the sufferers.

He continued by underlining the availability of very practical solutions achievable by e.g. improving lighting conditions as an effective preventive measure against such injuries.

Professor Baro concluded his presentation by highlighting the need for increasing dialogue between all relevant actors in such topics as a desirable, suitable and effective method for obtaining positive outcomes.

THE IMPACT OF SOCIAL WELFARE POLICIES ON MENTAL HEALTH

Mr. **Robert ANDERSON** (European Foundation for the Improvement of Living and Working Conditions) first explained that social welfare as a concept refers to a (comprehensive and integrated) system of social services, facilities and programmes and social security to promote social development, social justice and the social functioning of people. He maintained that the goals of social welfare are to achieve a just and caring society, to meet human needs and aspirations, and to enable fullest participation in social, economic and community life.

Mr. Anderson continued by presenting the challenges for social protection systems. These are to promote social inclusion, to make work pay and provide secure income, to make pensions safe and pension systems sustainable, and to ensure high quality and sustainable health care. He also said that gender aspects are an important cross-cutting theme for all four objectives.

The four key strategies for social welfare policies were partnership, integration, activation and coordination. For policy makers he outlined several messages: bridging the gulf and assisting the marginalised requires an integrated approach to social, economic and environmental policy. There is a need to make provisions flexible and to offer choice, so that they can be sensitive and tailored to people's needs. The participation of people in the design, development and operation of provisions should be encouraged and enabled. Coordination is of prime importance as is the mobilisation and involvement of all relevant agencies. Mr. Anderson also underlined the need to form partnerships for action.

Finally, Mr. Anderson presented the following recommendations: quality of services to users, partnership and participation, coordination and integration, quality of working life, equal opportunities and social inclusion, evaluation, transferability and the future research agenda.

Dr. **John HENDERSON** (Mental Health Europe) first reviewed some of the recent developments geared to the EU public health in general.

He then went on to present the Social Policy Agenda, which demands the means to ensure that the positive and dynamic interaction of economic, employment and social policy and the agreement to mobilise all key actors to work jointly towards the new strategic goal of social policy as a productive factor.

Dr. Henderson explained that within this framework a key challenge is to tackle social exclusion and to move to one which fosters social inclusion and to mainstream this into the heart of all policy making.

He also maintained that it is a great failure of our society that in spite of socio-economic advances in knowledge, improved employment prospects, increased social mobility, income enhancement and material improvements to life styles we are still faced with deprived and vulnerable groups like those with unmitigated mental health problems.

Mr. Clemens HUITINK (ENUSP) strongly stressed client participation in the planning and development of social welfare policies.

By taking the client perspective into account it is possible to draw appropriate attention to fundamental human rights and to the issue of equality. In fact this viewpoint is very well aligned with the current trend which heavily pinpoints client-centred approaches in the delivery of social and health services.

Mr. Huitink emphasised the importance of combating stigma and continuing the anti-discriminatory initiatives and measures.

THE IMPACT OF EDUCATION POLICIES ON MENTAL HEALTH

Dr. **Katherine WEARE** (University of Southampton) first reminded the audience of the fact that some negative developments at schools have recently taken place. For example, the increase in outside scrutiny, quality control, assessment, and formal testing may cause teachers increased stress and give them less time for social and affective education.

However, in contrast to the negative impact, there is much positive in recent educational developments on which to build promotion of mental health. Among these policies are the whole school approaches, anti-bullying, anti-racism, relations with parents, drugs in schools, pupil behaviour and social and educational inclusion. In fact, evidence shows that emotional and social intelligence seems to be more important than cognitive intelligence for success.

Dr. Weare continued by introducing four features that have been shown to lead to a wide range of positive mental health and academic outcomes (e.g. higher self-esteem, higher morale, higher motivation, more enjoyment of school, more effective academic achievement and less absenteeism among both pupils and teachers). The four features are: warm and supportive relationships, participation, clarity and transparency and autonomy. These features can be fostered by relatively simple measures such as 'draw and write' and 'bubble dialogue' of which Dr. Weare showed concrete examples.

Dr. Weare brought up several other measures that can be applied at schools in order to develop positive mental health. Among these were helping troubled and troublesome students, developing mental health competences, supporting anti-bullying policies.

As to the question of which curricula are appropriate to teach health promotion in general and mental health in particular, Dr. Weare stressed that the curriculum needs to be e.g. holistic and integrated, explicit and planned. Finally, she emphasised the importance of the physical environment as well as the links to the outside (e.g. to parents).

Professor **Rachel JENKINS** (Institute of Psychiatry, King's College) first underscored the long period (of about 15000 hours) that all pupils spend at schools during their lifetime. Therefore, it is of vital importance that this time allows the development of positive mental health.

Next, she brought up some critical challenges that we are faced with in connection to specific conditions. One of these was the problems posed by pupils suffering from dyslexia. Difficulties in reading and writing are prone to lead to difficulties during later life as well as to undermine normal development. One example of the above is the fact that dyslexics are over-represented in prisons.

As to other challenges within the field of education those posed by lifestyles, the curricula, and the fees of the universities were introduced by Prof. Jenkins.

One crucial issue in this whole context - as seen by Prof. Jenkins - was the promotion of social trust which is too often undermined by competitive mentality in educational settings.

Dr. **Gunilla OLSSON** (University of Uppsala) presented her views on mental health work in schools. She stressed the importance of early interventions and the role of nurses, psychologists and social workers for prevention of future mental health problems. Linked to the above, education of school staff on mental health issues is crucial.

Dr. Olsson continued by presenting in more detail several of the problems that are evident in today's schools. Among these are the attention deficit hyperactivity syndrome (ADHD), aggressiveness, learning difficulties, conduct disorder, depressive disorder, somatic complaints, bipolar disorder as well as alcohol and drug abuse.

As to improving mental health in schools Dr. Olsson suggested that each child should be regarded as an individual and that difficulties should be looked at with an attitude to help. Class sizes should be reduced and education of staff should be increased. She also stressed co-operation with child psychiatry.

WORKSHOPS

The workshops discussed the themes of environment, social welfare and education, which are perhaps most probable to have an impact on mental health. The main challenges and needed actions concerning mental health were elaborated in more detail and the conclusions drawn in each of the workshops will be presented in the next section.

ENVIRONMENT

Ville Lehtinen (Chair)
Juha Lavikainen (Rapporteur)

DEFINITIONS AND SCOPE

First and foremost there arose the need in the group to define what is meant by environment in this context in particular. It became evident that the concept needs to be dealt with in the broadest possible sense. Hence, the participants suggested that environment should be approached as an umbrella concept, under which to place the following areas:

1. natural environment
2. built environment
3. social environment.

Later on, in addition to the above, the need to include disasters as a fourth specific 'strand' was agreed in the group.

Next, the contents of each of the strands were briefly specified[1].

- The *natural environment* includes air, water, together with anything else that belongs to nature in general.
- The *built environment* entails housing, neighbourhoods, recreational places, traffic, regional planning and urban development. (Infrastructure in general can capture the essence of the contents under this heading; it needs to be borne in mind that it mainly is influenced by political decisions.)
- The *social environment* contains social capital, partnerships, social relationships, neighbourhoods, communities, workplace management, communication.
- *Disasters*, either natural, man-made or others (an example of which was an accident in a nuclear power plant).

[1] N.B. The description neither is nor is meant to be exhaustive.

OBJECTIVES

Three specific objectives are applicable to each of the four strands. The objectives are to

1. raise awareness
2. increase wellbeing
3. prevent negative impacts.

NEEDED ACTIONS

The next issue was to discuss the links between the strands and the objectives - in other words what are the needed actions or main challenges in this field. Important aspects were

- to collect evidence-based information on the consequences and impacts that environment has on mental health and psychological wellbeing
- to gather evidence of specific actions
- to choose new indicators need to follow-up the impact and influences the environment has on the individuals and the population
- to develop suitable tools and interventions as a subsequent step to the three others.

In sum, it is of great importance to make the already existing appropriate data available to the public and to the decision makers.

There was also the need to put more emphasis on economic aspects. Some examples of the areas where this is highly relevant are depression and stress-related problems e.g. in the working environments, the rising proportion of costs caused by mental health problems of the GNP etc.

In the same context, it was also noted that costs are primarily an indicator of ill-health. Therefore, determinants of mental health could to be thought of from a different angle, e.g. that of proactive influencing. Consequently, the mental health terminology could encompass expressions such as satisfaction, relaxation, recreation, safety, happiness etc.

FURTHER REFLECTIONS

Other topics that were discussed by the participants were the fact that due to the cultural differences, variable concepts in the Member States for expressing the issues at hand do exist. The group touched the issues of noise and pollution as major environmental

factors and shared the view that agriculture could be included in discussions on environment. In general, it was seen that a number of overlaps do exist that easily pass the theoretical borderlines.

Finally, it was also noted that there are a wide variety of environmental programmes and strategies already available in the EU - e.g. in the Framework programme of research and development, in sustainable development. Therefore, there exists a 'bridging problem' between health and other sectors that needs to be addressed. This bridging is - at present - insufficient also with the view of the global vision of mental health and other sectors.

SOCIAL WELFARE

Odd Steffen Dalgard (Chair)
John Henderson (Rapporteur)

FROM SOCIAL EXCLUSION TOWARDS SOCIAL INCLUSION

The participants discussed the question of whether or not the Social Policy Agenda of the EU was subservient to primacy of the Economic Policy of the EU?

Nevertheless the rhetoric of the EU Policies demand a visibility of the move from combating social exclusion towards a more reintegrative policy for people with mental health problems[2].

Two paradoxes were recognised: first of these is that social exclusion can be a determinant of mental disability and mental disability can itself be a determinant of social exclusion.

Another paradox is that economic downturn may lead to increased mental disability but a high level of economic progress may give rise to work stress and work pressure which in turn may lead to mental disability.

In the area of employment prospects for people with mental health problems there are in Europe big gaps in terms of gender, age and disability when accompanied with evidence of diagnosed mental disorder.

Opportunities for upgrading work skills, for life long learning and increased knowledge may all enhance opportunities for people with mental health problems.

In the pursuit of fundamental human rights for people with mental health problems it was asked if there was a role for *positive discriminatory action* to achieve the means of equality.

CHALLENGES

Housing availability for people with mental health problems demands a cohesive society in which positive public attitudes of tolerance and respect have to be adopted and ensured, it demands strategies for combating public stigmatisation, discrimination and ignorance regarding mental health problems.

For people with mental health problems, planners have to guard against ghettoisation, prefer dispersal to concentration and take positive steps required to prevent segregation and promotion of exclusion.

Benefits and welfare payments have to be provided in an equitable manner without discrimination by reason of mental health problems. Participation and empowerment of clients becomes a necessity to ensure this principle of equity of access and benefit.

Challenges include the measure and appreciation of EU added value in member states working together. How to make social policy "sexy" and an attractive element of EU policy making.

REQUIRED ACTIONS

Among the actions of a social inclusion policy are the following with reference to people with mental health problems:

- social protection,
- gender equality,
- disability equality,
- fundamental human rights,
- international co-operation in the member states and
- enhancement of social dialogue.

The challenge to the decision makers is how to become convinced of the fact that investment in social inclusion for people with mental health problems has a cost benefit.

Action is required to gather information, facts and data concerning direct and indirect costs of mental health problems in both social and health policies (e.g. in the field of unemployment by reason of mental disorder

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[2] People with mental health problems have much in common with socially weak and marginalised groups in general

and in the field of welfare benefits and eligibility by reason of mental illness).

Moreover, there is an urgent need to
- consider the benefits of legislation as a means of achieving social inclusion for all
- improve the conditions for social dialogue by including stakeholders in the mental health field
- seek to make use of the European Social Fund in the domain of mental health problems
- ensure that the new Public Health Action underpins the Social Policy Agenda for health and mental health matters.

EDUCATION

Robert Jezzard (Chair)
Rachel Jenkins (Rapporteur)

RATIONALE FOR ACTION

Depression and stress are increasing across EU in all age groups including children. Therefore preventive action and mental health promotion in schools is vital.

ACTION FOR EC

1. **A Joint DG Health / DG Education Action Programme giving opportunity for**
   a. cooperation
   b. joint action
   c. horizontality
2. **Collaborative multidisciplinary literature reviews**
   - mental health and education (relationship between)
   - value of mental health promotion in schools
   - antisocial behaviour and health

   These should be conducted using reviewers, literature and outcome measures from public health, psychiatry, psychology, education, social science, social welfare, employment, criminal justice system. Moreover, terminology, concepts, interventions and outcomes need to be addressed.
3. **Elaborate possibility for Education Framework with a mental health link** to include addressing what employers are looking for to enhance employability e.g. adaptivity, social and emotional competencies, skills and literacy.
4. **Build on and continue the progress already made by the EC in relation to the Whole School Programme -** more pilots, and extend it more widely, and value the cooperative links with WHO in relation to the schools programme.
5. **Commission work on developing programmes for teachers on social and emotional literacy, stress reduction and burnout.**

ACTION FOR NATIONAL GOVERNMENTS AND LOCAL AUTHORITIES

1. **Overall education policies to include**
   - universal mental health promotion in schools
   - address common problems early e.g. dyslexia and hyperactivity, in a way that normalises while giving vigorous help. These difficulties are a continuum and help needs to be titrated to need.
   - education in prisons to address previous underachievement and skills
   - adult lifelong education
   - support and training for teachers
2. **Support teachers**
3. **Educational programmes for teachers**
4. **Listen to ministers' specific concerns and link to mental health (social, education, justice and health)**
5. **Change terminology of mental health to social and emotional literacy**
6. **Ask countries to disseminate Whole School Network and whole school approach**
7. **Increase programmes on social and emotional literacy**

CONCLUSIONS OF THE MEETING

FROM PROGRAMMES AND STRATEGIES INTO THE IMPLEMENTATION OF ACTIONS

The horizontal nature of the new public health strategy opens up new possibilities for ensuring a high-level of health protection in view of several EU policies.

It has become evident that health impact assessment - which has been developed and discussed for quite a while - can and must be tailored to serve also the specific needs of mental health impact assessment.

Coupled with the above, it also became clear that there is no such technique or measures readily available and that these need to be developed and elaborated further (bearing in mind that this process may be time-consuming).

In pursuit of these objectives multidisciplinary, open and effective collaboration between relevant actors is required.

CHALLENGES

The workshops tackled the challenges posed by environmental, social welfare and education policies and brought into the fore several important viewpoints:

- with hindsight it can be easily argued that adding 'disasters' as a fourth strand when talking about the impact of environment turned out to be quite adequate
- the screening and evaluation of environmental policies with their possible impacts on mental health needs to be strengthened with a view on maximising positive and minimising negative effects
- preventing stigmatisation and social exclusion - or rather increasing social inclusion of people with mental health problems - need to become crucial elements of the social welfare policies
- employment and fundamental rights are core issues in the social policy agenda
- in the field of education preventive action and promotion of mental health at schools is vital
- the possibility of developing innovative collaborative structures at several levels (local, national, EC) should be addressed.

Taken together, actions are still needed within all these policies to raise awareness, increase wellbeing and prevent negative outcomes.

There is a need to firmly include the mental health dimension in the new Health Forum initiative and to ensure that the Public Health Action underpins the Social Policy Agenda for health and mental health matters.

INFLUENCING THE DECISION-MAKING PROCESS

Health economists need to be engaged to take part in the debate with regard to e.g. cost-effectiveness evaluations.

Reasonable argumentation needs to be applied on all suitable occasions. For example, the 'disability adjusted life years' - DALYs - are not well known outside the health field.

The precautionary principle, when approached specifically as a risk management strategy, needs to be borne in mind.

A wealth of data is readily available on suicide which can be (and has been) used as a basis for calculations and estimates on e.g. years of lives lost and on damage to economy.

Mental health indicators are needed; the problem in comparison with e.g. specific diseases such as cancer is the intrinsic complexity of the whole mental health field. Here, the feasibility of the indicators needs to be raised and the possibilities to utilise existing data - as a basis for informed decision-making - needs to be explored further.

The importance of addressing the European Parliament - which together with the Council of the European Union has the legislative power in the EU - was

highlighted. Here, the significance of introducing the economic aspects in relation to mental health was seen to be crucial.

THE WAY FORWARD

The discussions and results of e.g. the present meeting should be linked into the general health agenda - especially in view of health impact assessment - in order not to 'reinvent the wheel' and to avoid duplication of efforts.

The need to continue the collaboration between the Commission of the European Communities and the World Health Organization was underscored - while this meeting proved to be an example of such collaboration.

The results of this meeting need to be brought to the attention of the health ministers of the Member States in view of e.g. preparing for the Mental Health Conference organised by the Belgian Presidency in October 2001.

PROGRAMME

MONDAY 3 SEPTEMBER 2001

10:00–10:30 REGISTRATION AND COFFEE

10:30–11:00 OPENING OF THE MEETING
Mr. **Horst Kloppenburg**, Head of Unit, European Commission

Dr. **Wolfgang Rutz**, Regional Adviser, WHO Regional Office for Europe
WHO COLLABORATION: FOCUS ON IMPACT AWARENESS ON MENTAL HEALTH

11:00–12:30 INTRODUCTORY SESSION
Chairperson: Ms. **Leen Meulenbergs**, Federal Ministry of Social Affairs, Public Health and the Environment, Belgium

MENTAL HEALTH ON THE EUROPEAN AGENDA
Dr. **Eero Lahtinen**, Ministry of Social Affairs and Health, Finland

FROM IMPACT ASSESSMENT TO IMPLEMENTATION OF ACTIONS
Dr. **Anna Ritsatakis**, WHO European Centre for Health Policy

THE USE OF HEALTH IMPACT ASSESSMENT IN PLANNED AND UNPLANNED DEVELOPMENTS
Dr. **Ruth Hall**, Health Promotion Wales

12:30–14:00 *LUNCH*

14:00–15:15 IMPACT OF ENVIRONMENTAL POLICIES ON MENTAL HEALTH
Chairperson: Professor **Ville Lehtinen**, STAKES, Finland
Professor **Vappu Taipale**, STAKES, Finland

INVITED COMMENTS
Professor **Clemens Hosman**, University of Nijmegen, The Netherlands
Professor **Franz Baro**, WHO Collaborating Centre for Health and Psychosocial Factors, Belgium

GENERAL DISCUSSION

15.15–15.45 *BREAK*

15:45–17:00 IMPACT OF SOCIAL WELFARE POLICIES ON MENTAL HEALTH
Chairperson: Professor **Odd Steffen Dalgard**, University of Oslo, Norway
Mr. **Robert Anderson**, European Foundation for the Improvement of Living and Working Conditions, Ireland

INVITED COMMENTS
Dr. **John Henderson**, Mental Health Europe
Mr. **Clemens Huitink**, ENUSP, The Netherlands

GENERAL DISCUSSION

TUESDAY 4 SEPTEMBER 2001

09:00–10:15 IMPACT OF EDUCATION POLICIES ON MENTAL HEALTH
Chairperson: Dr. **Robert Jezzard**, Department of Health, England
Dr. **Katherine Weare**, University of Southampton, England

INVITED COMMENTS
Professor **Rachel Jenkins**, Institute of Psychiatry, England
Dr. **Gunilla Olsson**, University of Uppsala, Sweden

GENERAL DISCUSSION

10:15–10:45 *BREAK*

10:45–12:30 WORKSHOPS: PUBLIC MENTAL HEALTH AND OTHER POLICIES
The participants will be divided into three groups to discuss recommendations for each area

ENVIRONMENT
Chairperson: **Ville Lehtinen**
Rapporteur: **Juha Lavikainen**

SOCIAL WELFARE
Chairperson: **Odd Steffen Dalgard**
Rapporteur: **John Henderson**

EDUCATION
Chairperson: **Robert Jezzard**
Rapporteur: **Rachel Jenkins**

12:30–14:00 *LUNCH*

14:00–16:00 CONCLUSIONS AND CLOSING OF THE MEETING

REPORTS FROM THE WORKSHOPS
The rapporteurs

CONCLUSIONS OF THE MEETING
Introduction by **John Henderson**

CLOSING OF THE MEETING
Mr. **Donald van Hove**, Federal Ministry of Social Affairs, Public Health and the Environment, Belgium

LIST OF PARTICIPANTS

Mr. Robert Anderson
European Foundation for the Improvement of Living and Working Conditions
Wyattville Road, Loughlingstown
Dublin 18
Ireland

Ms. Irma Ballering
Ministry of Health Welfare and Sport
Parnussuplein 5
P.O. Box 2050
2500 EJ The Hague
The Netherlands

Mr. Franz Baro
WHO Collaborating Centre on Health and Psychosocial Factors
Esplanadebuilding, Room 303
1010 Brussels
Belgium

Mr. Marco Castellina
Permanent Representation of Italy to the EU
Rue du Marteau, 5-11
B-1040 Bruxelles
Belgium

Mr. Odd Steffen Dalgard
University of Oslo
P.O. Box 1130 Blindern
N-0317 Oslo
Norway

Mr. Mark Davies
Royal College of Psychiatrists
17 Belgrave Square
London SW1X 8PG
UK

Mr. Eddy Engelsman
Permanent Representation of the Netherlands to the EU
Hermann Debrouxlaan 48
1160 Brussels
Belgium

Ms. Siân Evans
WHO Collaborating Centre on Health and Psychosocial Factors
Esplanadebuilding room 329
1010 Brussels
Belgium

Ms. Michele Funk
WHO
Avenue Appia 20
1211 Geneva 27
Switzerland

Ms. Phyllis Gabriel
ILO
4 Route des Morrillons
1211 Geneva
Switzerland

Ms. Ruth Hall
Health Promotion Wales
Ty Glas Avenue/Llanishen
Cardiff CF4 5DZ
Wales

Mr. John Henderson
Mental Health Europe
Boulevard Clovis 7
1000 Brussels
Belgium

Mr. Clemens Hosman
University of Nijmegen
PO Box 9104
NL-Nijmegen
The Netherlands

Mr. Clemens W. Huitink
ENUSP
Postbus 645
3500 AP Utrecht
The Netherlands

Ms. Rachel Jenkins
Institute of Psychiatry King's College
De Crespigny Park
Denmark Hill
London SE5 8AF
UK

Mr. Robert Jezzard
Department of Health
133-155 Wellington Road
London SE1 8UG
UK

Mr. Horst Kloppenburg
European Commission DG Sanco/G3
Euroforum 3182
L-2920 Luxembourg
Luxembourg

Ms. Viviane Kovess
MGEN, DRESP
3 Square Max Hymans
F-75748 PARIS Cedex 15
France

Mr. Karl Kuhn
Federal Institute for Occupational Safety and Health
Friedrich-Henkel-Weg 1-25
D44149 Dortmund
Germany

Mr. Eero Lahtinen
Ministry of Social Affairs and Health
P.O. Box 33
FIN-00023 Helsinki
Finland

Mr. Juha Lavikainen
STAKES
P.O. Box 220
FIN-00531 Helsinki
Finland

Mr. Ville Lehtinen
STAKES
P.O. Box 220
FIN-00531 Helsinki
Finland

Ms. Leen Meulenbergs
Federal Ministry of Health
Esplanadebuilding, Room 303
B-1010 Brussels
Belgium

Mr. Michael Murray
Clifford Beers Foundation
Mariazell 5 Castle Way
Stratford ST16 1BS
UK

Mr. Clive Needle
ENHPA Liaison Office
Rue Philippe le Bon, 6
B-1000 Brussels
Belgium

Ms. Gunilla Olsson
Department of Child and Adolescent Psychiatry
Uppsala University
Uppsala SE 750 17
Sweden

Mr. Agustin Ozamiz
University of Deusto
Apartado 1
48080 Bilbao
Spain

Ms. Kerttu Perttilä
WHO European Centre for Health Policy
Boulevard Pachéco 19 b5
B-1010 Brussels
Belgium

Ms. Anna Ritsatakis
WHO European Centre for Health Policy
Boulevard Pachéco 19 b5
B-1010 Brussels
Belgium

Mr. Wolfgang Rutz
WHO Regional Office for Europe
Scherfigsvej 8
2100 Copenhagen
Denmark

Mr. Hans Joachim Salize
Central Institute of Mental Health
J5
D-68159 Mannheim
Germany

Mr. Robert Samuel
The Scottish Office
Department of Health
Room 366 St Andrew's House
EH1 3 DG Edinburgh
Scotland

Mr. Marc Servaes
Flemish Ministry of Health
Markiesstraat 1
B-1000 Brussels
Belgium

Ms. Vappu Taipale
STAKES
P.O. Box 220
FIN-00531 Helsinki
Finland

Ms. Nicoline Tamsma
NIZW International Centre
Catharijnesingel 47
Postbus 19.152
3501 DD Utrecht
The Netherlands

Ms. Pascale Van den Heede
Mental Health Europe
Boulevard Clovis 7
B-1000 Brussels
Belgium

Ms. Josée van Remoortel
Mental Health Europe
Boulevard Clovis 7
B-1000 Brussels
Belgium

Ms. Katherine Weare
University of Southampton
Highfield
SO17 BJ Southampton
UK

Ms. Josepha Wonner
European Commission DG Sanco/G3
Euroforum 3182
L-2920 Luxembourg
Luxembourg

Mr. Evangelos Zacharias
Ministry of Health and Welfare
Department of Mental Health
19 Aristotelous Street
10187 Athens
Greece

Ms. Ingrid Zechmeister
Department of Social Policy
Vienna University of Economics and Business Administration
Reithlegasse 16
A-1190 Vienna
Austria