

**MENTAL HEALTH IN EUROPE
NEW CHALLENGES, NEW OPPORTUNITIES**
Report from a European Conference
9–11 October 2003, Bilbao, Spain

Edited by *Izaskun Azueta, Ulla Katila-Nurkka and Ville Lehtinen*

Themes 3/2004

The conference has received funding from the European Communities.

The Commission is not liable for any use that may be made of the information contained in this publication.

The Conference has been co-sponsored by the World Health Organization, Regional Office for Europe.

ISBN 951-33-1445-6

ISSN 1235-4775

National Research and Development Centre
for Welfare and Health, Helsinki 2004

CONTENT

Preface.....	7
Conference recommendations.....	9
Conclusions from the conference.....	11
Opening addresses	
. <i>Gabriel MaInclán Iribar, Health Minister of Basque Government</i>	15
. <i>Horst Kloppenburg, Principal Administrator, European Commission</i>	18
. <i>Wolfgang Rutz, Regional Adviser, WHO Regional Office for Europe</i>	20
. <i>Vappu Taipale, Director General, STAKES</i>	24
Keynote speech	
. <i>Clive Needle, EuroHealthNet</i>	25
Theme 1: Economic and social impact of mental ill-health	
. Key presentation, <i>Martin Knapp, London School of Economics, UK</i>	29
. Response 1, <i>Silvia Evers, Maastricht University, NL</i>	49
. Response 2, <i>Mojca Dernovsek, Institute of Public Health of Republic of Slovenia</i>	54
. Workshops 1A + 1B report.....	56
Theme 2: Impact of transitions on mental health	
. Key presentation, <i>Dainius Puras, Vilnius University, LT</i>	59
. Response 1, <i>Agustin Ozamiz, University of Deusto, ES</i>	68
. Response 2, <i>Richard Plette, NCPH National Institute of Occupational Health, HU</i>	71
. Workshop 2A report.....	79
. Workshop 2B report.....	81
Theme 3: Needed infrastructure for mental health promotion and prevention	
. Key presentation, <i>Heinz Katschnig, University of Vienna, AT</i>	83
. Response 1, <i>Jan Czabala, Institute of Psychiatry and Neurology, PL</i>	111
. Response 2, <i>Leo De Graaf, Mental Health Europe, NL</i>	115
. Workshop 3A report.....	122
. Workshop 3B report.....	125
Theme 4: Prevention of premature mortality and abuse problems	
. Key presentation, <i>Iveta Bluka, Health Promotion Centre, LV</i>	127
. Response 1, <i>Danuta Wasserman, Department of Public Health, Karolinska Institute, SE</i>	138
. Response 2, <i>Lubomir Okruhlica, Center for Treatment of Drug Dependecies, SK</i>	142
. Workshop 4A report.....	149
. Workshop 4B report.....	154
Concluding presentations	
. <i>Eero Lahtinen, Ministry of Social Affairs and Health, FI</i>	157
. <i>Andrej Marusic, Institute of Public Health of the Republic of Slovenia</i>	159
Annex 1: Programme of the conference.....	162
Annex 2: List of participants.....	165

PREFACE

Mental health is an indivisible part of public health. This has been the uppermost idea of the process "Putting Mental Health on the European Agenda", which was started as early as 1995. The main objectives of this process have been to gain more value and visibility for mental health issues in the context of public health policy, and to integrate the promotion of mental health and prevention of mental health problems with general health promotion on the one hand, and with practical mental health work on the other. The European Commission, the European Parliament, the European Council of health ministers, and the EU Member States have backed up these efforts in various forms, including large-scale projects and conferences. This conference 'Mental Health in Europe, New Challenges, New Opportunities', held in Bilbao on 9-11 October, 2003, has been a logical continuation of this process.

The European Union is expected to increase the membership by ten new Member States in 2004. This will bring new challenges, but also opportunities, related to mental health issues for the enlarged European Union. One major issue will be the new mental health threats encountered in the central and eastern European countries, many of them being in the accession process to the EU.

Collaboration between the European Union and the World Health Organisation in the field of mental health started in 1999 with a conference on the topic "Balancing Mental Health Promotion and Mental Health Care". After that, the WHO has been a partner in organising several EU presidency conferences in this field. The WHO Regional Office for Europe has been a cosponsor for this conference. Therefore, this conference may also be seen as a step towards the WHO ministerial conference on mental health, which will be held in January 2005.

Finally, one has to mention the crucial role of many other stakeholders in developing and implementing the European Mental Health Agenda. These include several European networks in the field of mental health, civil society organisations (NGOs), user and family organisations as well as research institutions and university departments.

The overall goal of this conference was to analyse the challenges and opportunities for promoting mental health in Europe and for strengthening collaboration in the field by especially taking into consideration the forthcoming enlargement of the European Union.

CONFERENCE RECOMMENDATIONS

- 1. Existing models of good practices in mental health promotion and prevention of mental ill-health shall be widely disseminated with a view to implementing them in all European countries and regions.**
- 2. Special attention shall be paid to programs enabling people to better cope with transitions during their life cycle; these interventions must start as early as possible and already during school age.**
- 3. In order to cope with the rapid changes in our societies it is essential to strengthen the sense of coherence concerning life-roles, participation, and common values, as well as to strengthen change management, credibility and trust in our societies.**
- 4. Efforts shall be taken to strengthen the participation of users and carers in mental health policy planning, as well as in the implementation of relevant activities covering promotion, prevention and care.**
- 5. A European resource centre is needed for the definition of, collection on a repeated basis, analysis, interpretation and dissemination of relevant and comparable data on mental health, including suicides.**
- 6. Mental health monitoring systems shall include relevant indicators on the economic and social burden of mental ill-health**
- 7. In health impact assessment, special attention shall be paid to the development of expertise and tools for mental health impact assessment.**
- 8. Special emphasis shall be devoted to assess the economic and social impact of mental health promotion and prevention activities concerning children and young people, as well as in the workplace.**
- 9. All countries shall have a comprehensive alcohol and drug policy, including a monitoring system on alcohol and drug consumption, on implementation of that policy, and on the harm produced by alcohol and drugs. Special attention shall be directed to particular groups such as adolescents, older people, prisoners, minorities, immigrants, recreational drug users, and drivers of motor vehicles.**

CONCLUSIONS FROM THE CONFERENCE

Edited by *Ville Lehtinen, STAKES, Finland*

OBJECTIVES

The specific objectives of the conference *Mental Health in Europe, New Challenges, New Opportunities* were to:

- **Build momentum:** Take maximum advantage of previous and on-going mental health activities within the European Union supported by the European Commission through the Public Health Action Programme.
- **Develop four priority areas (conference themes):** 1) The economic and social impact of mental health problems on the one hand, and of mental health promotion/prevention on the other; 2) The impact of transitions (both on a societal and individual level) on mental health; 3) Establishment of a supportive infrastructure, including relevant information systems, needed for the promotion of mental health and prevention of common mental disorders (depression and anxiety); and 4) The prevention of premature mortality, especially suicide, including the prevention of substance abuse problems.
- **Support collaboration:** Establish contacts and collaboration to share experiences between the mental health organisations and networks within the European Union and those of countries in accession to ensure maximum dissemination of information between different cultural and societal environments. Continue and strengthen the fruitful collaboration between the EU and the WHO-Euro in the field of mental health.
- **Outline recommendations for future mental health policy** within the European Union, especially in the context of the enlargement of the Union.

PARTICIPANTS

The conference was attended by 144 active registered participants from 14 EU Member States (all except Portugal), the three EEA countries, and the ten accession countries. In addition, the conference had participants from Bulgaria, Romania, Montenegro, Serbia, Switzerland and even as far away as Nigeria. The WHO Regional Office for Europe supported the participation of four people from Central and Eastern Europe. Participants represented the European Commission, the WHO Regional Office for Europe, several Health Ministries of the European countries, different European projects and networks, civil society organisations (NGOs) in the field of mental health, especially those of users and caregivers, as well as administrators, experts, researchers and professionals in the field of mental health promotion, and prevention and care of mental health problems.

CONFERENCE CONCLUSIONS

Each of the four conference themes was covered by a key presentation, two responses and two parallel workshops. In addition a key-note speech about the health implications of the enlargement of the EU was given, and a round table discussion about user and carer participation was held. In the concluding session the first outline of these conclusions and recommendations were presented and discussed, and also some viewpoints about the future perspectives and needs of the accession countries were given. The conclusions which are presented in the following are based on the presentations, the workshop reports, and general discussion during the conference. It should be noted that the full workshop reports are also included in this Conference Report. The conference recommendations, which are presented in the beginning of the report, are derived from these conclusions.

1. Concerning the economic and social burden of mental disorders:

It is essential to:

- develop national policies and strategies on mental health which should be integrated and funded across a range of sectors and agencies;
- give priority to promotion, prevention, and community services development, particularly for service reforms in the accession countries;
- stimulate evaluation of the performance of systems for promotion, prevention, care and treatment.

There is a special need to:

encourage a focus on mental health promotion and prevention within employment and workplaces by:

- emphasising support for employment for people with severe mental illness;
- emphasising strategies and programmes aimed at gaining and sustaining work for people with common mental health problems

encourage a focus on mental health in children by:

- implementing programs to support good parenting;
- providing home-based support for parents with mental health problems;
- encouraging schools to address mental health issues.

2. Concerning the impact of transitions on mental health:

It is essential to take into consideration that:

- people are often unable to follow the high-speed intensity and diversity of changes; thus, there is a great challenge for learning.
- people may react to this stress with either hopefulness or pessimism, depending on the perception and interpretation of the situation;
- life transitions can also enable the individual to find new ways of life and opportunities for personal growth by overcoming situations in which one feels one is stuck without being able to make changes;

- erosion of traditional support systems makes it necessary to build up compensating institutional provisions of help that are accessible, acceptable and problem-sensitive; effective means to cope with these challenges are available.
- transitions effect social institutions either positively by managing the removal of structural barriers to mental health through effective initiatives, or negatively by conserving barriers for implementation of modern principles i.e. through strong traditions of a culture of dependency at all levels.

3. Concerning mental health promotion and prevention of mental health problems:

For the implementation of the policy recommendations it is essential to:

- agree on common definitions for mental health and mental health promotion;
- identify responsible organisations working in promotion and prevention to be engaged in the implementation process of the mental health policy recommendations;
- set priorities for the implementation process taking into account local and regional needs and circumstances.

For mental health monitoring it is important to consider that:

- one of the major challenges is the fact that necessary data on mental health indicators is often missing or at least noncomparable between countries and even within a country;
- it is important to collect data on a repeated basis to be able to follow the trends;
- two types of data are needed for monitoring purposes: routine statistics and data which need population health surveys;
- there is need to build up a European-wide system of data collection and analysis.

4. Concerning the prevention of premature mortality and abuse problems:

For the prevention of suicides and other premature mortality it is essential that:

- each country includes in its national health plans the requirement to address the need for suicide preventive measures;
- each country establishes its national suicide prevention strategy;
- a European database will be established and maintained about good practices and methods in suicide prevention across all sectors of society and national borders.

For prevention of abuse problems it is essential to recognise that:

- drug addiction represents a priority per se both in EU and accession countries given the amount of health, economic and social problems connected to it;

- there is a need to promote cooperation and integration between different public, private and NGO actions, and to search for common goals for different stakeholders;
- there is need to make available specific treatments to everyone who needs them by providing a comprehensive range of programs and interventions.

5. Concerning user and carer participation:

- the main barriers are a lack of resources (like funding, information, collaboration, experience and organisational skills);
- clear strengths can be identified as:
 - an understanding of what works
 - energy and commitment;
- governments can support user/carers participation by funding, providing information, education, and affirmative actions;
- professionals can support user/carers participation by giving them more time, interaction, participation on an equal basis, trust, and listening.

OPENING ADDRESSES

Gabriel M^a Inclán Iribar, Health Minister of Basque Government

Opening of the Conference

Good morning. First of all, I should like to welcome to the Basque Country all the professionals who have come to this Conference on Mental Health from a large number of European countries, some of which are current members of the European Union and others who are to join the EU next year.

It was precisely the extension of the European Union that led us to organise this event among professionals involved in this field, in order to discuss the subject of how we are to face the challenge of improving mental health care in our respective systems, and particularly in those countries that are having to face the challenges involved in achieving better standards of mental health care after many years of isolation from the mainstream developments that have taken place in so-called Western Europe. Although we recognise that we can still learn a lot from all of you, we intend to offer an overview of how we in the Basque Country have developed over the last 20 years, when we started from a similar situation to that in which the countries I have just referred to find themselves today.

Clearly, a Conference such as this one is not the product of improvisation, but the result of the cooperation we have developed over recent years with the European Commission's Directorate General for Public Health, STAKES (the Finnish National Research and Development Centre for Welfare and Health); and the Finnish government itself who, without doubt, have made exceptional contributions in introducing the subject of mental health onto the agenda of the European Union.

I was saying that our intention with this Conference is to promote the protection of mental health with even greater determination, sharing our experience on how we have dealt with the impact of the transition with those countries that are to join the European Union in the near future.

For example, in the Basque Country, we have experienced a similar transition to the one which some of these countries are undergoing at the present time, changing from a totalitarian system to a democracy, from imposed ideologies to freedom of expression. In our case, the change coincided with a serious economic crisis, with unemployment figures that reached 33% of the population in some areas, and so on. In short, a scenario in which mental health policies together with several social service and economic planning strategies played a decisive role in maintaining cohesion and bearing the costs of change.

Therefore, in this short introduction I should like to give you a brief account of the developments we have seen in psychiatric care over the last 20 years, in keeping with the series of economic, social and political changes that have taken place in our society.

Work on the planning of Psychiatric Care in the Autonomous Community of the Basque Country began in 1979 when the preliminary analyses were made of the status of

psychiatric care at that time. Some years after this, in July 1982, the Advisory Committee was created, which was responsible for drafting the first Psychiatric Care and Mental Health Plan of our community, which finally saw the light of day in 1983.

Since then, we have seen major changes in the care applied in the field of psychiatry. Thanks to new therapeutic procedures, we have developed from the traditional model based on mental hospitals to multidisciplinary psychiatric practices, integrated in the community and with deep roots in medical practice.

This has led to the development of psychiatric organisations away from hospitals, the integration of short-term psychiatric services such as general hospital units, and the progressive modifications of medium and long-term hospitals towards ambulatory support structures in the form of day hospitals and/or centres, and even assisted residential facilities.

On the other hand, and in a parallel manner, the changes experienced by western societies over the recent years have led to the gradual incorporation of citizens in decision-making processes in different areas, including health. In this way, citizens have the right to give their appraisal of the treatment they receive, participate in therapeutic decisions, question our actions, and take part in other forums. Thus, in general, medical practice has seen changes in its operating procedures, from paternalistic models with unequal levels of information, to models of doctor-patient relationships with sufficient levels of autonomy and information, in which patients cease to be considered as mere receivers and submissive followers of the orders and recommendations of the "experts".

All these changes have involved a parallel development of health service structures. Thus, today the human resources dedicated to psychiatric care in the Basque Autonomous Community represent a total of 2000 professionals, with ratios of 15.4 doctors for every 100 000 inhabitants, or, in other words, a total of 6 500 inhabitants for each professional (psychiatrist or psychologist). Overall, approximately one person in every 1000 inhabitants in our community works in public organisations associated with psychiatric care, excluding the civil society organisations involved in this area.

In spite of all the developments we have described here, there are still some aspects that need to be worked on, such as, for example, clarifying the role of long-term hospitals; improving rehabilitation resources; covering the residential and professional needs of patients more adequately; improving the integration between levels inside and outside hospitals, etc.

It is for this reason that, having overcome the initial transition phase from the mental hospital model, the **community model** continues to be the programmatic basis of the mental health and psychiatric care model in the Basque Health Service/Osakidetza.

We understand that during this stage such a model must maintain and promote:

- Its definition as a specialised care structure, understood as a structure dedicated to the appraisal, diagnosis and treatment of the most complex cases, with the highest level of disability. To do this, it is necessary to identify priority groups of patients in order to provide them with direct services with a high technical level based on evidence; and offering, at the same time, inter-doctor consulting with primary care and other services that deal with the most frequent and mild disorders.

- The maintenance of care centres as part of the community, with adequately-equipped multidisciplinary teams, forming an interdependent care structure which is accessible and includes the different psychiatric resources existing in a specific geographical area (network concept) defined in the Mental Health Care Map, and any others that might be developed.
- The early diagnosis and treatment of psychiatric disorders preferably in primary care services (health centres).
- Collaboration with other health and social services in the community, within the framework of the social-health space, in order to achieve in the mid-term an adequate integration of mentally-ill individuals in all aspects of daily life (education, employment, housing).
- Actions designed to foster mental health in general and a reduction in the exposure to risk factors for mental disorders, encouraging educational activities to fight against the stigma associated with mental illness.
- The integration of self-help associations, strengthening the responsibility of the patient, the family and the community in caring for their own health by means of appropriate educational programs.
- The development of training and research as the means necessary to acquire new care techniques that allow the "advanced" nature of our network to be maintained.

This conception of mental health gives you an idea of the importance we attach to psychiatric care in our community, and this is also shown by the fact that it is considered a priority area in the health plans drawn up by the Health Department of the Basque Government for the periods 1995-2001 and 2002-2010. During the latter period, actions in the field of mental health have established priorities in the area of care for infants and young persons; in the most prevalent mental disorders or those of major importance in the care of the adult population; in the care of drug addiction in general, and in the prevention of suicides; all this is done in accordance with the guidelines set out in the WHO document "Health for all in the 21st century".

Moreover, in all these areas of activity, the importance of early diagnosis, prevention and health promotion work are mentioned expressly as a formula that needs to be approached with determination in our community. It is true that, although in some areas of mental health, such as drug addiction, a great deal of work has been done, and is being done, on prevention, in other areas work has focused especially on the development of rehabilitation and on providing patients with rapid access to medical care. This probably has a lot to do with the development from an institution model in which rehabilitation work was clearly seen to be an area for development.

Now that these bases have been established, it seems logical to provide clear support for the central theme of this Conference, based on the promotion and prevention of mental disease.

For all these reasons, our Department supported the idea of holding this Conference in Bilbao with great enthusiasm, as it will, without doubt, help us to exchange know-how and experiences in mental health plans and policies. Without more ado, I declare this conference to be officially inaugurated.

Horst Kloppenburg, Principal Administrator, European Commission

The European Commission Perspective on Mental Health in Europe

Ladies and gentlemen, I am very pleased on behalf of the European Commission to present some perspectives on mental health at this conference on new challenges and new opportunities in Bilbao. As you all know, the European Union has a relatively targeted mandate in public health. Pursuant to Article 152 of the Treaty, the European Union has to ensure a high level of human health protection by complementing national policies, with the aim of improving public health by preventing human illness and diseases. Thus, in the arena of mental health, the European Union has primarily concentrated on positive health promotion and on the prevention of mental health problems. It also has focused its activities to fighting the negative consequences of mental health problems such as social exclusion and stigma.

We have, in particular, developed prevention and promotion strategies in relation to mental health within projects funded under the Community Action Programme on Health Promotion and the Health Monitoring Programme. Under the Health Monitoring Programme, European indicators for mental health have been set up with a view to mirroring the mental health status of all citizens and to determining specific responses to needs within the Member States. We, in cooperation with the Member States, candidate countries, and EEA countries, will seek to make these mental health indicators operational, and to initiate or to invite these countries to carry out concrete intervention measures in promoting mental health and well-being. At the same time, these indicators will provide a basis for fighting stigma and discrimination in relation to mental health problems. The Work Plan 2003 of the new Community Action Programme in Public Health, which has been implemented since the beginning of this year, foresees the creation of a working party on mental health for collecting the relevant data for the mental health indicators. These indicators will allow cross-border comparisons and might later initiate the establishment of European standards in the area of mental health in relation to health care and prevention of mental health problems.

The most important message in mental health was incorporated within projects funded under the Health Promotion Programme, e.g. 'there is no health without mental health'. This message was used within the Council Resolution on Promotion of Mental Health in 1999.

By accepting mental health problems in the same way as we accept physical health problems, we shall be able to avoid the stigma and social exclusion of sufferers from mental health problems and their carers. We have to overcome the fear that mental health problems automatically give rise to anti-social behaviour and attitudes or violence from which the general public has to be protected. In the past, the consequences of these unwarranted fears were often to detain or institutionalise those people suffering from mental health problems instead of treating them appropriately.

We have to be aware that mental health problems very often lead to the socio-economic deprivation of sufferers from mental ill-health and also of those who are indirectly affected by these problems such as carers, families and friends. Deprivation in many cases is closely linked to inequalities in health, be it access to health services or to treatment of costly mental diseases. A pan-European project on tackling inequalities in

health, which was funded under the Health Promotion Programme, showed evidence that among the disabled population people suffering from mental health problems have the lowest participation rate in the labour market. Moreover, their unemployment rate is considerably higher than that of the rest of the population. Furthermore, evidence from recent studies shows that although life expectancy in general has increased from 75 to about 79 years, there are gaps in life expectancy between people at the top and at the bottom of the social hierarchy of typically between 5 to 10 years. As sufferers from mental health problems normally do not belong to the top of the social hierarchy, they face a reduced life expectancy in addition to their disease.

These aspects have been discussed during the Greek presidential conference on mental health and stigma in March this year. The Council Conclusions, which are based on this conference, have given rise to new initiatives to fight stigma and social exclusion across the whole of Europe. To implement this aim, a closer cooperation of the Commission Services, in particular between DG SANCO and DG EMPLOYMENT is foreseen.

In order to obtain more information on compulsory admission and involuntary treatment of mentally ill patients, we have funded a project to collect the relevant data on legislation and practices in all Member States. The focus of this project was to emphasise commonalities and differences between the Member States of the EU. Currently a follow-up project on forensic psychiatry is being carried out.

Due to the fact that depression has the highest prevalence among mental health problems, Belgium had devoted its Presidency in 2001 to mental health promotion and prevention strategies for coping with depression and stress related problems in Europe. The Council Conclusions based on the mental health conference gave rise to a project on coping and prevention strategies in relation to anxiety, depression and stress-related problems during the life cycle. Specific attention was paid to critical periods of transition during the life cycle such as transition from education to working life, from working life to unemployment, and from working life to retirement. This project was funded under the Health Promotion Programme. The results shall be presented at this conference.

The Commission intends to build up the public awareness of mental health problems by widely publishing the results of the mental health status of the European population, based on the Eurobarometer health survey. It clearly emerged from this health survey that physical diseases and mental health problems are frequent and can affect anyone among us. For instance, one in four people suffer from depression at some stage of their life cycle. This is a figure we should have in mind when a family member suffers from a mental health problem such as a depression.

With the ever-increasing prevalence of mental health problems in the different Member States, it has become obvious that more quantitative data on the burden of mental health problems are needed. Thus we have funded another project under the Health Promotion Programme on the financial burden of mental health problems. For the first time, data on costs for treatment of some mental disorders will be collected and analysed, including the costs attributed to prevention and promotion measures. We shall share the results with the Member States and will promote an evidence-based approach in prioritising between measures of mental health care and mental health promotion and the prevention of mental health problems.

We are also working closely with the WHO to develop a ministerial conference in January 2005 in Finland on mental health. This conference will help to raise the profile

of and encourage debate on mental health in our society. We also intend to support reparatory discussions focusing on specific aspects of the conference and linking with work done in the EU Public Health Programmes and their relevant networks and working groups. Thank you.

Wolfgang Rutz, Regional Adviser, WHO Regional Office for Europe

A Focus on Societies in Transition

Ladies and gentlemen, social, environmental, and public mental health strategies, especially those focusing on the promotion of mental health, have frequently been questioned in recent years, demonstrating the conflicts seen between qualitative evidence and quantitative criticism, and even indicating a new biological, often genetic, reductionism which today can be found in the areas of psychiatry and mental health.

I think, ladies and gentlemen, in this situation, it is important to remember again the real *raison d'être* of mental health promotion as well as disorder prevention, therapy and rehabilitation, as they are related to the realities which we have to cope with - mentally vulnerable as we all are - in Europe today.

In the European region of the World Health Organisation, reaching from Ireland to Vladivostok, from Greenland to Malta, we see today consequences of heavy and dramatic societal transitions:

- In the eastern European states belonging to the former Soviet Union that have recently become independent,
- In central Europe where dramatic changes occurred during the last decade
- But also in Western Europe, where people are exposed to dramatic changes, namely young women in Scandinavia; young men in Finland and England; farmers in Wales and Ireland; adolescents in France; elderly people in Portugal, Lithuania and Eastern Germany; indigenous people in Greenland; and immigrants in Denmark; but also people exposed to fear and terrorism in Israel, Spain, Russia and Northern Ireland.

As a consequence of this societal stress, we find in these countries and populations a “Societal Syndrome” consisting of morbidity and mortality related to stress and mental ill-health, a cluster of depression and aggression, alcoholism and addiction, violence and suicidality, risk-taking behaviour and destructive lifestyles, cardio- and cerebrovascular diseases, as well as accidents, both traffic accidents and those in the workplace.

In many countries, people are forced to reorganise their own lives, to develop new values and to swear off from those beliefs that earlier have guided them. The background for this we find in the consequences of the dramatic changes in society, the loss of dignity and identity, the loss of males, the unemployment and loss of dignity of not being the family provider, important for self respect and family respect in more traditional societies. Many people have, moreover, to live and cope with unpredictability and meaninglessness they have never had to experience before.

Thus, in some of these countries of heavy transition, the rate of homicides and manslaughter, even those directed against children, have risen to figures nine times

higher than in the European Union, having before already been at a level somewhat over the EU average.

Thus, from the macro-perspective of the WHO, we can see what has been reproduced in animal trials, namely how individuals in times of prolonged and all too heavy stress, hopelessness and helplessness, will not only break down, unable to cope or adapt, but also turn against each other and their own offspring.

What has been said here, also seems to ring true for risk groups of the mentally ill and vulnerable, where recently increasing violence has recently been reported, in part certainly due to the deterioration of services, but also - as Scandinavian examples show - having a background in increased tension, split and stress in society.

But there is also positive news. In some of the countries I have been describing, after a maximum deterioration in the middle of the nineties, positive changes can be noted due to economic and societal development leading again to optimism, hope and an increased feeling of control, participation and predictability.

Ladies and gentlemen, dear colleagues. The World Health Report (WHR) 2001, the WHO year of Mental Health in 2001, and the activities and publications emanating from it have clearly underlined some important messages: that the burden of mental ill-health and related conditions is immense, from 15%, related merely to strict psychiatric diagnoses, to 30 - 50% or still more, for conditions more or less directly related to stress and mental ill-health. The WHR also points out new possibilities for promotion, prevention, treatment and support, not so much related to singular new advancements in the field of neuropsychiatry or new techniques of psychotherapy, but by combining different approaches to holistic, therapeutic programmes, really reflecting the "Conditio Humana" of both being brain and mind.

Thus, the WHR underlines the importance of avoiding a split between socio- and psychotherapeutic humanistic approaches on the one hand, and biological positivistic therapies on the other; between quality and quantity; and between nurture and nature. Through this, it stresses new scientific knowledge about the neuroplasticity of the brain, the mutual interaction and reinforcement between positive environments and cerebral strength as well as between adverse environments and cerebral dysfunction and structural pathology.

How does this all fit into the need for rethinking social and public mental health approaches that are so strongly felt today? Looking at the community syndrome, consisting of depression and aggression, addiction and violence, self-destruction and suicide, cardiovascular and cerebrovascular diseases, accidents, risk-taking lifestyles and – let me call it – moral insanity, we see how this is related to the factors we today know as the most important determinants of mental health, namely existential cohesion and ethical values, social interaction and capacity, helplessness and control, identity and dignity.

Following this, we identify a strong need for non-professional and professional support, in society as well as in the areas of mental health, primary health and public health. We also identify a strong need for the promotion of mental health with an engagement of all sectors of society, both on national and regional levels as well as in the communities.

In the few institutions we absolutely need in a balanced system of mental health care and support, and in the many community-based supportive and advisory services which

have to be created, importance should be given to coping ability, integrity, autonomy and empowerment, to increasing social capacity, facilitating social cohesion, and the ability to maintain it, with a realistic self-image and adequate help seeking behaviour.

Furthermore, in societies in the aftermath of war and internal conflicts, a focus should fall on the regressive phenomena of scapegoating, intolerance, fundamentalist ideation and social exclusion mechanisms which characterise people in stress. Here, I think of a social and societal responsibility of mental and primary health professionals and all sectors of society as well as a need for innovative social psychiatric and public mental health efforts, for raising awareness about the dynamic and regressive mechanisms behind psychopathologies both in individuals, in groups and in societies, and for analysing the consequences of societal changes, political decisions and policy implementations on public and mental health.

What is needed are strategies of increasing coping ability, of empowering people, of increasing autonomy, self-control and participation, of catalysing social cohesion and competency, of facilitating realistic self-images, of counteracting anomy and of reinforcing a pluralism of value systems which enables individual choice – and finally, to make political decision-makers aware of the importance their decisions have on the mental health of a population.

Knowledge should be created on how to facilitate a society which is kind to human beings' serotonin-system, takes into account the biological presuppositions of human functioning, and is respectful to basic human needs related to the human condition of being body and mind in an indivisible unity. Psychosocial, psychiatric and general medical professionalism has a most important role to play here. Mental health and general health professionals in services and society should not and cannot any longer abdicate from their social responsibility.

Thus, looking at the societies which I have described, we can see what speculatively and simplistically could be called a “societal serotonin syndrome”. We know today that serotonin-related systems in our brain function enable us to cope with stress and adverse environments, to fight or flee, to socialise, to control impulses and aggression, to enjoy nutrition, to feel emotions, to meet challenges, to develop coping strategies, to take pleasure in behaviours essential for reproduction, but also to keep attached to spiritual, ethical and metaphysical dimensions. Serotonin also influences cholesterol levels and cardiac diseases, premature mortality, risk taking as well as sensation seeking behaviours and lifestyles. Thus, all the conditions belonging to the community syndrome described before clearly reflect failures in these functions. Consequently this fatal “serotonin syndrome” described, leading to suffering, mortality and sometimes depopulation, needs to be counteracted.

Thus, ladies and gentlemen, we need to recreate reward mechanisms that also motivate professionals to take up their social responsibility and to engage in a new type of public mental health knowledge in order to build better integrated and individualised support for individuals as well as more humanised, mentally more physiological societies.

Let me think about a farmer, living in an accession country, entering the European Union. This man has his basic beliefs, his ethics, his identity and professional pride, his self-awareness, his dignity and self-respect. He has been able to cope with life in his family and in a rural community with its value systems. He has tackled life events and years of bad harvest, with a difficult workload and economical shortcomings. He has also acquired and maintained respect and identity, both in his own eyes and in the eyes

of his family and community. He probably will face helplessness in the years to come, maybe depression and suicidality, alcoholism or isolation, hypertension or diabetes II – or all of these together.

What he needs are services, not only accessible but also acceptable for him, respectful to his needs and respecting his integrity and traditional masculinity. Maybe his primary health care centre would be much more suitable than any psychiatric service - given they have the knowledge and capacity. He also needs politicians who are aware that in his society economical support and materialistic solutions can not be the sole answer to the problems he has to face, and that proactive and comprehensive strategies have to be developed to assist people like him. This means that he needs innovative multi-disciplinary and multisectoral social, health care and public health expertise that utilises modern knowledge about the interrelation of spiritual, psycho-social and biological determinants of mental health and human function. He needs professionals who take their responsibility in establishing services of support, treatment, promotion and advise, and are able to educate and to increase awareness, within their own professions, but especially amongst politicians, decision-makers, working environments, educational structures and the public in general.

Finally, let me conclude: Mental health is the most valuable capital in society. It should be considered when we are discussing environmental and health concepts, when we talk about how to invest in health, and when we talk about the necessity of political decision-makers knowing about the impact of their decisions on the mental health of the population. With regard to the costs and suffering, this impact is certainly comparable to the impact of political decisions on the physical environment - an area where awareness and analysing today seem relatively well-established.

No country, even the poorest one, can afford to not protect, promote, reconstitute and invest in mental health. The costs of inaction - and there is a lot of evidence for this – are immense. To do this, our professions are of imperative importance. We work in the area of public and mental health and are knowledgeable about the interaction between the environment and mental health, about innovative efforts in seeing mental health in the light of recent lay and scientific experience as probably the most important public health issue.

Ladies and gentlemen, the WHO, the European Commission, the accessing countries and Finland as the main contractor for this conference have cooperated successfully to prepare this conference. This cooperation not only expresses a common area of interest in mental health and public health and the responsibility between us regarding the need for action and pro-activity, focusing on changes and transition to be expected in countries and populations in transition, it underlines also the character of this conference as an important step towards the WHO Ministerial Conference on Mental health to be held in Helsinki in 2005, with the Finnish government as host, several European governments as important contributors and the European Commission as well as the Council of Europe as important partners.

Ladies and gentleman, I wish all of us all success for this important event. And thank you for your attention.

Vappu Taipale, Director General, STAKES, Finland

Cooperation is Key to Increased Knowledge and More Concrete Action in Mental Health Promotion

We Finns have a long history in bringing up the issue of mental health. Thirty years ago in Finland, the number of beds in mental hospitals in proportion to the population was very near the world record. Mental hospitals were filled with chronic patients, and serious mental disorders were met with fear and silence. High suicide rates were a typical problem. Fortunately, a strong expert organisation with great visibility was active in the field of mental health. On the other hand, attitudes towards the organisation among mental patients were prejudiced. Long-term, persistent and consistent efforts in the political and administrative domains were required to formulate strategies for tackling the problem. Although there have been ups and downs in this work, progress has been made.

From this perspective, it was not purely by chance that Finland raised the issue of mental health within the European Union. I believe that similar problems exist or have existed elsewhere, and therefore the initiative could have been launched by many other countries as well. However, we are all well aware of the fact that one country alone cannot do much in the international context. It is precisely for this reason that it is delightful to see so many countries have committed themselves to backing these joint efforts that are underway within the EU and that are also closely linked with the work done by the WHO headquarters and WHO Euro.

Today dozens of countries have accomplished extensive reforms to improve mental health services and promote preventive mental health work. Great amounts of money have been invested in mental health services in many countries. Being a matter of common concern, the issue of mental health has been given continuity as successive EU presidencies have fulfilled their commitment to the common agenda and addressed the issue from different perspectives.

Here in Bilbao we will all see how the joint consideration of mental health issues has benefited all of us. Mental health has become a theme that is politically acceptable and a matter of general interest. Recognised experts will address the present conference, there is plenty of expertise available. The countries involved have notably increased their understanding of their own development and the impacts of mental health and related problems on the national economy and its competitiveness. We are also very pleased to have so many of the EU applicant countries and their expertise with us here.

I want to thank all the participating countries for their commitment to mental health issues. The countries that participated in launching the first stage of the operation of the mental health policy network, including Holland, France, the UK, Sweden and Greece, have seen many new participants and strong supporters join the network, for instance, Belgium. As for this present conference, however, I want to offer special thanks to the DG Sanco of the European Commission, the Government of the Basque Country and Deusto University and all others who have given their support to this conference, including WHO-Euro and Mental Health Europe. Certainly we are all convinced that this cooperation needs to be expanded and strengthened.

KEYNOTE SPEECH

Clive Needle, Director, EuroHealthNet

Enlargement of the EU from the Point of View of Health-Related Issues

Thank you for the invitation to join you today and to contribute some observations to help begin this interesting and important conference. Before such a distinguished expert audience I will of course not presume to try to advise you. I was recently invited to another international conference, and received a form from the organisers on which I had to indicate if I am an expert in public health or the media. As you know, politicians always have to tell the truth, so this gave me some considerable problems. Eventually, I decided to tick both boxes on the basis of an old English expression that probably applies to me: “Jack (apprentice) of all trades, Master of none”.

In fact, this is very much another learning experience for me, to which I look forward. I have already been taught much by experts that I have come to consider friends within the organisations comprising Mental Health Europe and the European Mental Health Policy Network. The phrase “There is no health without mental health” is ingrained on my soul. Perhaps you should be a little proud of me: I used it in my speech at the Italian Presidency Conference on Healthy Lifestyles in Milan in September. Sadly – I used it to complain that there was no other mention at the Conference about mental health.

That conference was supposedly about ways to improve communication, information and education about lifestyle determinants of health. People often say to European politicians that the jargon and technical language is impenetrable and contributes to poor communications, fears and misunderstandings about the EU. Conversely, I have to say to health professionals that, as someone who came into a parliament with no health background but who has become an advocate for this sector, it is not always easy to grasp exactly what is meant. I understand for example, that health education could mean something rather unpleasant and threatening in some of the countries of central and eastern Europe who are about to be welcomed into the EU. I went through my first 40 years of life without hearing the word “paradigm” as much as I heard it in 40 minutes at a single WHO health promotion conference. Therefore simplicity and memorability can be virtues, and your expression (TINHWMH) achieves both.

The other lesson about communication that I have learnt from political experience, is that you often have to repeat complex messages many times before even your supporters understand and remember. I expect that some of this audience can explain the relevant mental processes! I put that into practice at a Healthy Schools Conference in the Netherlands last year, by advising the audience to repeat key messages three times at least if they were to have an impact. As Chair for all subsequent plenary sessions, I came to regret that, as my advice was not only included in the Conference Report but also became a repetitive feature of almost every presentation. So if you want this Conference to finish on time, I recommend that you don't repeat everything three times but find new ways to achieve your aims.

During the past decade I have spent most of my time trying to understand and interpret the flowing tides of European health policies, and specifically EU public and population health policies. What I shall try to do today will be to put your work in that context and to address your objectives:

- How to take forward the work carried out so far
- To focus on your identified key issues of: supportive infrastructures; impact of transitions and specifically the current enlargement of the EU; prevention of premature mortality; and socio-economic impact
- To strengthen collaboration

So, what is the current situation for health policy at the EU level? Although I am delighted to be here, I do regret that it is to replace some excellent Parliamentarians who cannot attend but who have made excellent contributions to advancing the case for health in the European Parliament during the last 4 years. For example, although he is technically my political opponent, the work of John Bowis MEP has been exemplary in this field – please do not tell my party that I said that!

When I spoke in the Hungarian Parliament some years ago, a progress report on accession there had generated major concerns because the changes identified as necessary to health systems had more economic impact than any other aspect of joining the EU. Those changes do not just impact upon statisticians, but affect real people, and of course they tend to most adversely affect the more vulnerable people who have little or no choice in care or treatment. I note that your papers include the reports on the Social Situation in the EU, which consistently provide important reading for the health sector.

My own network, EuroHealthNet, works primarily in the field of health promotion on issues such as improving health equity. To do so at the EU level, we increasingly work across the range of EU policies as I know the mental health networks do also, and it will be important that we continue to improve our collaboration. We invited social and health NGOs to participate in a seminar in Brussels earlier this year, and I am delighted to be able to anticipate that we will be awarded a multi-annual follow-up project contract with the European Commission to develop our work on the links between health and social exclusion. Clearly our work is interdependent and I will be happy to learn how we can link our work in this field as this second phase will very much seek to focus more on the situation in the new member states.

The Bowis report makes the crucial point that not all the new member states are the same – there are very different cultures, traditions and circumstances, although of course eight health ministers in central and eastern Europe have recently signed the Prague Declaration as a commitment to partnership in the field of health, particularly concerning disease prevention and cross border mobility.

But the report does note the particular problems concerning abuse of psychiatric practices in some states and the need for structural and social reforms over time, with strong support from the EC. I have learnt that it is a mistake to think of the new countries simply in terms of need – there is a common misconception that they are joining to benefit from the wealthy west and the flows will be west-east in terms of resources and east –west in terms of people. In fact, they have much to contribute: substantial cultures of learning and research, talent and experience. Of course it is true that health spending in the new states is about half the average percentage of GDP in current EU states, but it is not just an issue of resources.

It is and will be a difficult transition in many ways. We know that NGOs are developed differently and do not have the same access to resources as their western counterparts, and we know that the differentials in professional and financial status of health professionals is proving problematic in recognition of qualifications and mobility issues.

But the EU has some powers to address that; Health Commissioner Byrne made a significant speech at the annual Health Forum in Gastein last week. He focussed mainly on health economics, and I know you have a fascinating session taking forward your work on mental health economics later in the programme. That is so important, because when we see Finance Ministers interested in the case for health we will really be making progress, and I urge you to engage with policy makers (not just politicians, but the people who prepare their briefs!) across the policy spectrum.

Commissioner Byrne mentioned the need for health to feature in the reform of EU structural funds. At last! Apart from agriculture spending, this is the main financial instrument available to the EC, and it makes the EU Health Action Programme funding look like peanuts. Because of member state determination to control national health systems which still persists rightly or wrongly, spending on health has largely been excluded from these instruments, yet they affect exactly the poorest, most vulnerable parts of the European population that your work informs me is in greatest need. In some areas – Portugal, southern Italy or rural Wales for example, enterprising regional officials have managed to be creative with the rules to identify programs for community health and other initiatives. I even heard at a seminar in Brussels how health impact assessments were being carried out on farmers suffering from agricultural decline and crisis, or industrial workers suffering structural unemployment. What better use of community funds could there be than to complement national and local initiatives promoting good mental health and addressing the specific burdens of mental ill-health – the stress, the stigmas, the anxieties and depressions – in local communities. And how that would at last help to bring home some of the European ideal that is infusing those new member states, particularly as a good proportion of the EU funds in years to come should apply to those new states.

The national governments currently meeting to confirm or change the draft European Convention have before them some wording that could underpin such progress. In the proposed new Treaty article on public health, article 179 part 5 states that European laws may establish incentive measures designed to protect and improve human health and combat the major cross border scourges.

While health campaigners are right to be disappointed that the new EU objectives do not specify health, they do include sustainable development, which clearly does include community health. Moreover, for the first time in a European Treaty, healthcare is mentioned. The Charter of Fundamental Rights, adopted in December 2000, has been incorporated within the treaty and includes “Everyone has the right of access to health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all EU policies and activities”.

Words on paper. Just that. There is a big gap between words and actions – we know that from previous treaties. But you are an important part of what Commissioner Byrne called the campaign for health that is now needed – and he was backed by MEPs such as John Bowis who urged the health community to organise as effectively as the green lobby has on environmental policy.

And that is what concerns me as it did at Milan. For understandable reasons, the health gap is large and competitive. Research institutions and networks need money and often have to be competitive rather than collaborative to get some. I think that does not benefit research or good policy making, and this accounts for some of the mistrust between the sectors. I understand there is good evidence that ill health, or risk of ill health, is rarely confined to a single condition. You make important links in your programme with substance, tobacco or alcohol abuse and it will be vital to link with the specialists in those fields who are working on subjects of interest to you. Similarly there are many others working on healthy ageing, workplace health, social exclusion and inequalities, and I know you will already have some good links and can extend others, particularly in new countries.

So why was mental health not part of the Milan agenda? There is still the divide between mental and physical, and we need to work together to end it. I campaign for integrated health policies – some of you may recall that I resisted including specific conditions in my 1999 report on future EU public health strategies in favour of an integrated approach. We need your special expertise as a key part of that, not a separate strand.

I was reminded recently about the previous enlargements of the EU. Where were these? East Germany – not without its traumas and stresses, but a major social and economic undertaking offering great hope and vision. Before that, the enlargement in 1995 brought Finland, Sweden and Austria into the EU, and their expertise and commitment has helped to put mental health at the top of successive ministerial agendas in the Council. Now, suddenly after Tampere and Evora and Nantes and Brussels and Athens we move on to obesity and tobacco and CVD. Fine – all are important, but does that mean mental health is forgotten at just the moment when the health status reports of new states suggest that it must not be?

Those new states can make a real contribution in keeping mental health as part of the health agenda: not replacing the emphasis on other conditions, but by stressing the need for a holistic, evidence based approach focussed around the health economics case that Commissioner Byrne set out last week.

It is crucial because it defines a clear role for the EU in partnership with the WHO. The EU is primarily a set of socio-economic institutions with clear purposes around stable markets. But to achieve its aspirations, to make the fine words in a treaty count for anything, it needs to relate to the real needs of its citizens. Time after time the Eurobarometer surveys and the Eurostat studies show that health needs are at the top of citizens agendas – and time after time they show that faith in the governments of virtually every country to meet those needs is declining alarmingly. Common problems amid cultural diversities. That is why your work is so valuable and crucial. Transferable learning and practical cooperation offer the way forward and I urge you to share your knowledge from all your varying perspectives as thoroughly as you possibly can.

People are frightened of change. There is great change coming to Europe just as there are major global threats increasing insecurity and instability. Those are the challenges we all face and can only overcome by working together. But the change for Europe is not just about farm subsidies or new coins in pockets. The opportunity is freedom – to move across once blocked borders, but also to open minds and explore new ideas. That freedom must not be limited to the few who are lucky enough to have choice.

THEME 1: ECONOMIC AND SOCIAL IMPACT OF MENTAL ILL-HEALTH

Martin Knapp¹, David McDaid² and Claire Curran³, London School of Economics and Social Science, United Kingdom

Key Presentation: Identifying and Tackling the Economic Impacts of Mental Health Problems

INTRODUCTION

Mental health services in Europe, in common with such services across the world, have as their primary and central objective the alleviation of symptoms. Increasingly, however, it is being recognised that other aims should also be pursued. In particular, most health systems are recognising the need to improve the broader quality of life of people affected by mental illness (patients, their families and other members of society more generally). Associated aims have therefore been to address the processes of care – for example, how are people with mental health problems involved in decision-making about their care – and the locus of care, as shown by, for example, the decisions taken in many European countries to shift the balance of provision from hospitals to the community, and by developing more effective ways of supporting people who live in ‘ordinary’ community settings.

Of course, there is also widespread recognition that resources are not limitless, although surprisingly this has somewhat belatedly led to recognition of the need to pay attention to the costs of mental illness (broadly defined) and the pursuit of cost-effectiveness in the ways that resources are used in treatment and support.

This paper introduces some of the key economic questions being asked in relation to mental health in Europe today. It is based on a presentation given at the landmark European conference, *Mental Health in Europe: New Challenges, New Opportunities*. The presentation raised five questions that address the economic aspects of mental health in modern Europe:

- Why should we be interested in the economic consequences of mental health problems and their treatment?
- What are the economic impacts of mental health problems?
- Economic evaluations: what are they and how do we do them?
- What do we know about cost-effectiveness?
- What are the challenges facing Europe?

¹ Professor of Social Policy, Personal Social Services Research Unit (PSSRU), LSE Health and Social Care, London School of Economics; and Professor of Health Economics and Director, Centre for the Economics of Mental Health, Institute of Psychiatry, King’s College, London, UK.

² Research Fellow, PSSRU and European Observatory on Health Systems, LSE Health and Social Care, London School of Economics, UK.

³ Research Officer, PSSRU, LSE Health and Social Care, London School of Economics, UK

WHY IS ECONOMICS RELEVANT?

Why should we be interested in economics in a mental health context? One reason – as we illustrate below – is the widespread recognition that the costs of mental health problems can be substantial, falling on those who are ill, their families, the health and social care system and the wider national economy. A second reason for the growing interest in the economics of mental illness is the apparently growing cost of treatment. Some of the newer modes of treatment for mental health problems – for example, the newer medications for depression, the atypical antipsychotics for schizophrenia and the cholinesterase inhibitors for Alzheimer’s disease – are marketed at higher prices than the older treatments they could potentially replace. Not surprisingly, many people feel that there is a pressing need to determine whether the newer treatments are cost-effective.

However, the fundamental reason for being interested in economics is because of resource scarcity: the level of resources that can be made available - professional, pharmaceutical, technological and others - for the treatment and support for of all types of health care problems, will never be enough to meet all needs. Scarcity is a permanent and pervasive feature of all societies. In the face of such scarcity, choices have to be made between alternative uses of the same resource or service. Economics can therefore be described as the ‘science of scarcity’ – it aims to provide decision-makers with data that can inform and assist their decisions as to how to allocate available resources. This obviously raises questions about the comparative costs and outcomes of the alternative ways to use resources, and we shall therefore describe later the methods that economists use to evaluate cost-effectiveness.

There is also the question of who should be interested in the economics of mental health? A variety of stakeholders are affected by, or can affect, the economics of mental health. These include funding bodies such as governments or health insurance funds that should be looking to get the best value from their expenditure; treatment professionals can work out the most efficient use of their resources; while service providers can plan how best to organise and use their scarce resources. Economic studies can also examine the cost-effectiveness of interventions, providing information of relevance to health system decision-makers, providers of services and pharmaceutical companies looking to market their products. Finally, taxpayers and contributors to insurance funds should clearly be interested in the economics of mental health to ensure, for example, that their contributions are used in efficient ways and that money is not wasted.

So, are economists obsessed with money? Yes, and no. Yes, because money is a convenient way to measure resources and it is the scarcity of those resources that gives them value, but also no, because money on its own is not very helpful. Economists also want to know about quality of life outcomes, social justice, behaviour patterns, incentives and barriers to change. These incentives or barriers might affect access to mental health treatment, employment or other publicly or privately provided services that can affect an individual’s quality of life.

WHAT ARE THE ECONOMIC IMPACTS OF MENTAL HEALTH PROBLEMS?

The impacts of mental health problems are wide-ranging. Many impacts are also long lasting, given the chronicity of most mental health problems. As we have noted, these impacts will be felt not only by those people who are ill, but usually also by their families, neighbours and the wider society. Some impacts can be seen as ‘economic’ (in the narrow sense), having effects associated with the ability to work (for example, less than 20% of people with psychoses are in paid employment in the UK; Foster et al., 1996), other productive contributions to the national economy, personal income, or the utilisation of health care and other support services. Together, these economic impacts are often considerable, as we illustrate below.

However, we need to keep these ‘narrow’ economic impacts in perspective. They stand alongside the often huge ‘personal costs’ of mental illness – distressing symptoms, sometimes awful medication side-effects, co-morbid physical disorders, limitations on social functioning, stigmatisation by the rest of society, social isolation and so on. There might also be ‘intangible costs’ for the wider society associated with some mental health problems, stemming from the fear (sadly often exaggerated) for personal safety, given that there are proven links between, for example, severe psychosis and violent crime (Taylor and Gunn, 1999).

Costs of mental health problems – international evidence

It is helpful to provide specific examples of the direct health and social care costs as well as some of the wider (often called indirect) costs of mental health problems. Studies of people with schizophrenia in a number of countries have charted the broad cost impact on health and social care systems, the need for specialist housing, and the sometimes high contact rates with criminal justice and social security (income support) systems. The indirect costs of schizophrenia include premature mortality, lost productivity from employment because of morbidity, out-of-pocket payments and lost employment for families (Knapp et al., 2002a). Although research methods vary and the breadth of cost measurement is not consistent, a recently completed survey of studies from many countries found that these indirect costs usually outweigh the direct costs (Knapp et al, 2004).

International, especially European evidence points to a number of common features with regard to the costs of schizophrenia – the sizeable indirect costs, the high proportional cost contribution of in-patient services, the low proportional contribution of drugs, the broad range of both health and other services used by patients. There are no strong reasons for believing that equivalent features would not also apply to the costs of other mental health problems: for example, see Rosenbaum and Hylan (2002) and Berto et al (2000) on depressive disorders; Jönsson et al (2002) and McDaid (2001) on dementia; Goldberg and Ernst (2002) on bipolar disorder; Crow and Peterson (2002) on eating disorders; Knapp et al (2002c) on obsessive-compulsive disorder. We shall, however, focus here on schizophrenia to illustrate some of these features.

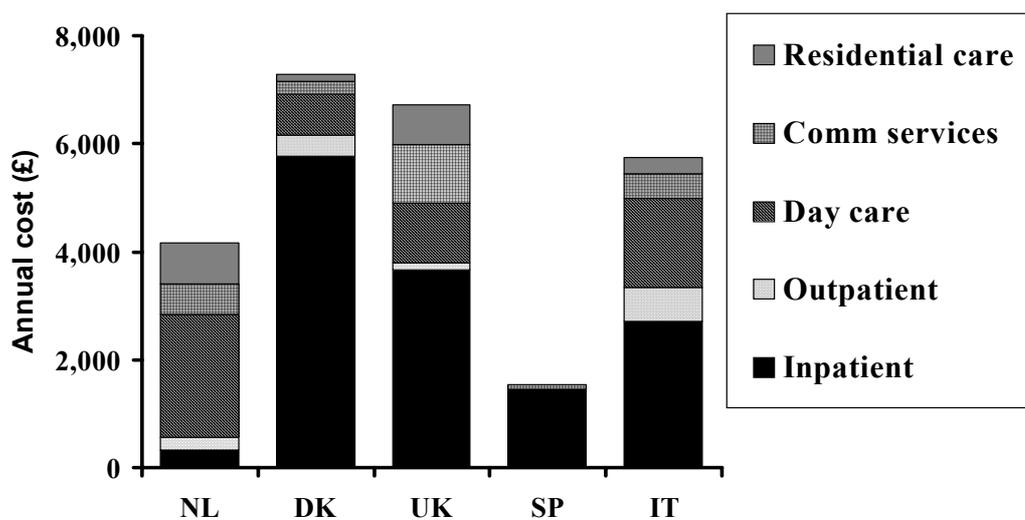
Direct costs

Health and social care service utilisation costs

In well-developed health and social care systems people with schizophrenia use a range of services. This is illustrated by the EU-supported EPSILON study, which collected cross-sectional data on 404 patients with non-affective psychotic disorder across five European sites. The main purpose of EPSILON was instrument development, but the study also allowed cross-country comparisons (Becker et al., 1999). Care systems in the centres all subscribed to a broad model of community-based mental health care, but Figure 1 shows marked differences between them in actual service use patterns. Over a three-month period, 12% of patients utilised inpatient care, and the mean number of community contacts was 8.0. Mean days spent in residential care varied across sites from 25 to 7 days. Mean one-year cost per patient, in the total sample, was £5038, but Figure 1 shows that there was substantial cost variation between sites (and within sites, too, although not shown on the diagram). Closer analysis revealed that some of this cost variation was due to patient characteristics (especially levels of functioning and needs), but quite a degree of variation remained unexplained, almost certainly related in part to health system-specific factors (Knapp et al., 2002b). Indeed, a close association was found between mean in-patient costs in each site sample and the per capita provision of mental health beds in the catchment area (Chisholm and Knapp, 2002).

The second broad conclusion to draw, therefore, is that there are marked differences between countries in the underlying costs of schizophrenia due in part – perhaps in large part - to differences in health and social care system structures and incentives. Consequently, research findings on costs or cost-effectiveness might not generalise well from one country to another without carefully placing those results in context and perhaps making appropriate adjustments. Indeed, there can be wide regional variations *within* countries for precisely this same reason (Haro et al., 1998).

Figure 1: Annual service costs in five European sites (EPSILON study)



Source: Knapp et al (2002b)

A third strong feature to emerge from the review of the costs of schizophrenia across countries is the sizeable proportion of total health care costs accounted for by in-patient

services. Even in Italy and the UK, where it has been national policy to close large numbers of in-patient psychiatric beds, hospitalisation remains a major cost factor. For example, in the 1990s, in-patient care contributed 41% of the total health care costs of schizophrenia in Verona, Italy (Amaddeo et al, 1997), as much as 69% in England and Wales (Knapp, 1997) and also 38% in a model community-based service in Germany (Salize and Rössler, 1996). Countries in Eastern Europe continue to rely much more heavily than those in Western Europe on in-patient care. Concern about hospitalisation costs has energised the search for community care arrangements, although much more influential in the drive towards community-based care has been the belief that it will improve quality of care and patient quality of life, and promote patient rights (Thorncroft and Tansella, 2002). This concern has therefore also encouraged the search for drug and other treatments that can reduce the incidence and severity of relapse because of the (commonly) associated need for inpatient admission.

Drug costs represent a *low* percentage of the total health costs of schizophrenia, typically 4-6% in the early/mid 1990s (Rouillon et al., 1997; Knapp, 1997; Salize and Rössler, 1996), and probably around 6-9% today in Western Europe, and higher in Eastern Europe. More recently the wider use of the higher priced atypicals will have pushed up this percentage. Methodological differences account for some of the observed inter-country variation, but bigger influences are likely to be the availability and relative costs of medications and in-patient services. Generally, countries that still rely heavily on (low-cost) hospital services will find their drugs bill makes a bigger proportional contribution to the total. This coupled with differences in relative prices across markets may even mean that treatments found to be cost-effective in (say) the US are not cost-effective in countries with less well developed health care systems (Hosak and Bahbouh, 2002).

Other agency costs

Turning to another mental health area provides us with a graphic illustration that health and social care service utilisation costs are not the only economic impacts. In England, the National Treatment Outcome Research Study (NTORS), a research investigation into the social costs of illegal drug use (Healey et al 1998a), followed 1075 drug users and estimated the costs of criminal behaviour, health care and addiction services for a 12-month period. The total costs for the group amounted to over £12 million over the year, the majority of which was attributable to (self-reported) criminal behaviour. The biggest element was the victim costs of crime, followed by criminal justice system costs, drug dependency service costs and finally other health service costs.

Indirect costs

Carer costs

The international evidence points to the quite substantial size of the non-service costs, such as lost productivity associated with morbidity and mortality, and with caregiver impacts (Tarricone et al, 2000; Carr et al, 2003; Knapp et al, 2003). A study of families of people with schizophrenia in five European sites found that the principal family caregiver spent 6-9 hours per day (depending on country) with their relative with schizophrenia. The 'impacts' most commonly reported by family members were restrictions on social activities, disruption to family life and feelings of loss (Magliano et al., 1998). As noted earlier, the indirect costs – where they are measured in monetary units – will often outweigh the service costs (Rice and Miller, 1996). However, these

non-service cost estimates are rather sensitive to the method of calculation (Goeree et al., 1999).

A study looking at the indirect costs of conduct disorder in childhood also found considerable costs falling on the informal carers (usually family members). Per child costs over the year (in 1996 prices) were £15,270 per child. These costs include health and social care costs, accounting for 16% and 6% of total costs respectively, but also include the costs of special education (32% of total costs), lost employment (26%), benefits (15%) household repairs (5%) (Knapp et al, 1999).

Costs to the individual

The economic impact of mental health problems on the individual with the problem should also be noted. These economic impacts include direct health care costs, indirect lost productivity costs and other indirect costs associated with premature mortality and the increased risk of somatic morbidity (Harris & Barraclough, 1998). A study of the social and personal costs of alcohol misuse in Finland (Heino and Salomaa, 1999) reported the impact of lost life-years to be more than double either the lost productivity costs or the direct health care costs.

Cost impact over time

Finally, mental health problems can of course have economic impacts over long time periods. A study that looked at the relationship between childhood mental health problems and various agency costs in adulthood found that children with a diagnosis of ‘conduct problems’ at age 10 were likely to incur over an additional £16,000 in costs between the ages of 10 and 27 years, while children with a diagnosis of ‘conduct disorder’ (more severe than conduct problems) incurred over £60,000 additional costs between these ages. For both the conduct problem and conduct disorder groups, the largest proportion of additional costs were for criminal justice services, followed by extra educational provision, foster and residential care and state benefits; health care costs were smaller (Scott et al 2001).

So we see that the economic impacts of mental health problems are broad, often leading to health and social care service utilisation as well as other agency costs, for example welfare benefit payments. Informal carer support costs may be substantial, often falling on family members, and the indirect economic costs both to the individual and society may be considerable. Further, as we have just shown, some of these cost impacts might be felt over very long periods of time. Finally, it should not be forgotten that there are also *intangible costs* borne right across society. Although difficult to value, these are undoubtedly profound, resulting from the widespread stigma and discrimination within most societies, compounded by an unjustified fear over the danger posed to society by those with mental health problems.

TOWARDS EVALUATIVE EVIDENCE

The cost description studies described above – often called cost-of-illness studies – are of limited value on their own, even when conducted very carefully. While they can provide baseline information on the economic impact of a disorder, they do not measure what outcomes result from these expenditures, and so cannot tell decision-makers anything about how to prioritise resources in order to improve cost-effectiveness. In other words, they cannot provide advice on how to improve the balance between

resources expended (costs) and outcomes achieved (effectiveness). This is the topic to which we now turn.

What are the economic evaluations and how do we do them?

Decision-makers face two key questions when considering whether to use or recommend a particular form of treatment for a specified mental health problem. The first is the clinical question, which asks whether a treatment is effective in improving patient health, or – when considering two or more treatment options – which of them has the better or best outcomes. Once the decision-maker knows that the treatment is effective, they want an answer to the second question: is it cost-effective? That is, does the treatment achieve the improved patient outcomes or quality of life at a cost that is worth paying?

These two questions (Is the treatment effective? Is it worth it?) sit at the heart of cost-effectiveness analysis. While it is always going to be necessary to reformulate these questions in ways that make them answerable with empirical research, their simplicity should never be forgotten. Of course, providing answers to these questions is not always so simple!

It must also be emphasised that cost-effectiveness analysis does what its name suggests: it looks at *both* costs and effectiveness (outcomes). So, comparing the costs of one treatment with another, without any evidence on outcomes, does not constitute an economic evaluation. Such an exercise might be an interesting description of service utilisation patterns and associated costs, conducted with considerable devotion and skill, but it does not provide enough information to assist service professionals, managers or others facing the choice between two or more alternatives. Similarly, calculating the costs and outcomes of a single service could be interesting but cannot be classed as an economic evaluation unless those costs and outcomes are compared with equivalent data for another service, or even compared with the option of ‘doing nothing’, and so again the study cannot tell us whether the service is worth providing. Uncontrolled mirror design studies often run into this problem. It should also certainly be pointed out that a study that looks only at outcomes but neglects to look at costs is also inadequate: it can tell us whether a treatment is effective, but not whether it is worth delivering.

Treatment-outcome-cost links

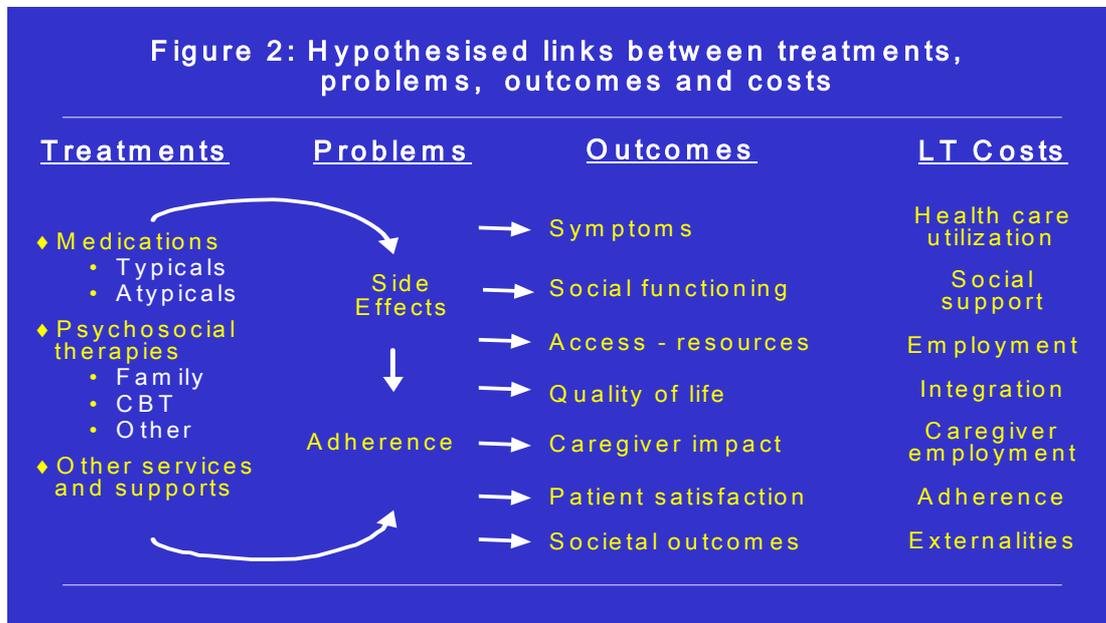
Figure 2 offers a framework within which to locate health, quality of life and cost-effectiveness and the links between them. On the left are treatments, including pharmacological and psychosocial therapies. Different treatments have different side-effects, in turn leading to different rates of adherence with treatment plans (illustrated in the second column). Side-effects and adherence are what we might call ‘intermediate effects’, but the focus of attention should really be on the ‘final’ effects or outcomes, one categorisation of which is summarised in the third column.

Successful achievement of outcomes could reduce the longer-term costs associated with the items in the final column of Figure 2. For example, successfully alleviating symptoms should reduce health care utilisation, and improved social functioning should, in time, reduce the need for social support. Figure 2 is a hypothesis map. Many of the suggested interconnections have been examined empirically, whilst others are assumptions awaiting robust testing.

Therefore, interest in economic evaluation stems from three needs:

- ❑ costs – to find out the costs of a service, intervention or policy.
- ❑ cost-offset – to see how the cost savings from the services (for example) might compare with the amounts expended
- ❑ cost-effectiveness – to understand the links between costs and outcomes.

The third of these needs is the most important.



HOW DO ECONOMISTS EVALUATE COST-EFFECTIVENESS?

There are a number of different evaluative methods available to the economist. Full details cannot be provided here, but excellent accounts of health economic evaluation methods (although with very few mental health examples) are given by Drummond et al (1997) and Drummond and McGuire (2001). See also Byford et al (2003a) for methods and examples in the social welfare and related areas, and Knapp (1995) on economic evaluation and mental health.

As described below, there are five types of economic evaluation each of which has a different scope and suitability. The type of evaluation used should depend on the question that is being addressed. The underlying aim of each mode of economic evaluation is to examine the efficiency with which resources are being utilised.

Efficiency comparisons

If the evaluation is comparing two treatments, the question to be addressed is whether one treatment achieves better outcomes for patients and families than the other treatment, relative to their respective costs. These are efficiency questions and could obviously be employed to compare different drugs, psychosocial interventions, accommodation settings, family support arrangements or national policies. The various modes of economic evaluation frame these efficiency comparisons in slightly different contexts.

Cost-offset studies

The simplest of economic studies are concerned only with costs, not (usually) because they see outcomes as irrelevant but because, in relation to the treatments or services under study, the health and quality of life outcomes have already been established from other research, or are (currently) not measurable because of conceptual difficulties or research funding limitations. One of these cost-only methods is the *cost-offset study*, which compares costs incurred with (other) costs saved. For instance, a new drug may have a higher acquisition cost (higher price) compared to an older drug, but may reduce the need for in-patient admissions and thus lead to cost savings downstream. (An example is provided by Hamilton et al, 1999, in the context of a fuller evaluation.)

Cost-minimisation analysis

Another ‘cost-only’ approach is *cost-minimisation analysis*, which seeks to find which of a number of treatment options has the lowest cost. A cost-minimisation analysis can proceed in one of two ways. It often proceeds in the knowledge that previous research has shown outcomes to be identical in the treatment or policy alternatives being evaluated. One illustration would be the randomised controlled trial of case management for homeless mentally ill people by Gray et al (1997) which found lower costs for the case-managed group (although the difference was not statistically significant, raising some important methodological issues which we cannot go into here). This cost analysis followed some months after the clinical evaluation (Marshall et al, 1995). In this sense the approach is really an “interrupted” cost-effectiveness analysis (see below). The other way a cost-minimisation analysis can proceed is to compare costs without any regard for outcomes. Such a dangerously narrow approach should not be encouraged.

Well-conducted cost-minimisation analysis can be thought of as being a special type of cost-effectiveness analysis, where evidence on effectiveness demonstrates no difference between two or more interventions. In most instances, however, clinical outcomes will not be equivalent, and more complex evaluations are required, which can make them far more informative, but correspondingly more complex to conduct. Nowadays, these other forms of economic evaluation are commonly carried out alongside clinical trials.

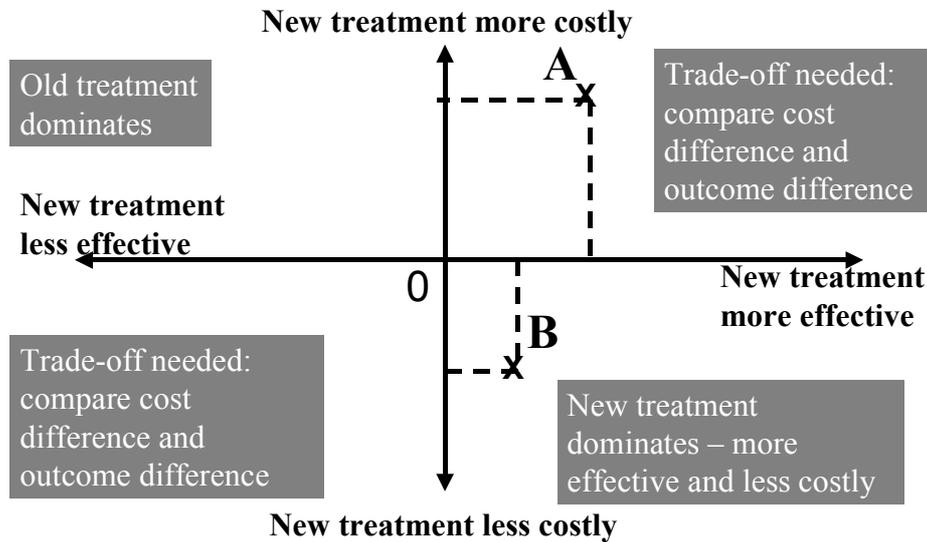
Cost-effectiveness analysis

Probably the most intuitive and straightforward modes of economic evaluation are *cost-effectiveness* and *cost-consequences analyses*. Both measure outcomes using instruments and scales familiar from clinical studies. Both are employed to help decision-makers choose between alternative interventions available to or aimed at specific patient groups. A cost-effectiveness analysis (CEA) looks at a *single* outcome dimension - such as the number of life-years saved, the number of symptom-free days or the duration of time to relapse - and then computes and compares the ratio of the difference in costs between the two treatments being evaluated to the difference in (primary) outcome. For example, Essock et al. (1996) computed costs and scores on the Brief Psychiatric Rating Scale for patients given clozapine and those given other medication in three US state hospitals.

A common problem is that the majority of evaluations of new treatments or interventions find them to be both more effective (the outcome profiles are better than for old treatments or interventions) but simultaneously more expensive. Decision-makers therefore face the challenge of weighing up the outcomes against the higher

expenditure necessary to secure them. The decision is far from straightforward in these cases. The widely used cost-effectiveness ‘plane’ illustrates the range of possible CEA results and the difficult decision-making task.

Figure 3: The cost-effectiveness plane



The cost-effectiveness plane is illustrated in Figure 3, and shows the possible combinations of outcomes and costs when comparing two interventions or treatments. The point marked as B in Figure 3 indicates that the new treatment (say a new drug) is both more effective (it has better outcomes) and less costly than the old treatment. In these circumstances the task for the decision-maker looks quite straightforward: recommend wider use of the new treatment. However, many of the new interventions being introduced or considered for introduction in health systems are more like point A: they produce better outcomes than older interventions but at a higher cost. The decision now is more complex, because a trade-off is needed: are the better outcomes worth the higher costs?

To aid such decision-making, economists have developed cost-utility analysis (see below) and more recently the net benefit approach, linked to the construction of cost-effectiveness acceptability curves. These show the probability that a new intervention will be cost-effective for each pre-specified or implicit valuation of an outcome improvement by the decision-maker. Comparisons are then possible across quite disparate clinical areas. This kind of decision context is, of course, exactly the one faced by decision-makers one or two steps removed from the patient interface. An example of the use of the net benefit approach and acceptability curves is provided by Byford et al (2003b), linked to the clinical evaluation reported by Tyrer et al (2003).

An obvious weakness with the strict cost-effectiveness methodology is the enforced focus on a single outcome dimension (in order to compute ratios) when most people with mental health problems have multiple needs for support and when most clinicians would expect to achieve improvements in more than one area. Carrying multiple outcomes forward in an analysis is less tractable analytically, but three options are

available, associated with three other modes of economic evaluation. One option - which is cost-consequences analysis - is to retain all or most outcome dimensions (using standard clinical scales). The other two options weight the outcomes, either in terms of money (cost-benefit) or in terms of utility (cost-utility).

Another weakness in the whole approach is that most interventions have never been evaluated properly, so that comparators in trials may not always be appropriate and the opportunity costs within health care systems of narrow economic evaluation outcomes may be unfavourable (see Oliver et al, 2002, for a discussion of this).

Cost-consequences analysis

A *cost-consequences analysis* has the ability to evaluate policies and practices in a way that arguably comes close to everyday reality. For each treatment alternative the evaluation would compute total (and component) costs and would measure change along every one of the relevant outcome dimensions. The cost and outcome results would need to be reviewed by decision-makers, the different outcomes weighed up (informally and subjectively), and compared with costs. The decision calculus is therefore certainly much less tidy and more complicated than when using cost-effectiveness ratios or monetary or utility measures of impact (see below), but it could be argued that decision-makers in health care systems - from strategic policy-makers at macro level to individual professionals at micro level - face these kinds of decisions daily.

On the other hand, the weighting of the various outcomes is implicit, subjective and 'technocratic', whereas the choice of the single outcome dimension in a CEA and the weighting algorithms in other evaluative modes are explicit, less susceptible to influence from the value positions of one or two individuals and (potentially) reflective of societal values. One example of 'cost-consequences analysis' is a study of motivational interviewing to improve adherence with medication which looked at costs, insight, attitudes to medication, global functioning, symptoms and of course adherence (Healey et al, 1998b).

Cost-utility analysis

Another and increasingly popular evaluative mode which seeks to reduce outcomes to a single dimension is *cost-utility analysis (CUA)*, which measures and then values the impact of an intervention in terms of improvements in preference-weighted, health-related quality of life. The value of the quality of life improvement is measured in units of 'utility', usually expressed by a combined index of the mortality and quality of life effects of an intervention. The best known and most robust index is the Quality Adjusted Life Year (QALY). CUAs have a number of distinct advantages, including using a uni-dimensional measure of impact, a generic measure which allows comparisons to be made across diagnostic or clinical groups (for example, comparing psychiatry with oncology or cardiology), and a fully explicit methodology for weighting preferences and valuing health states. These same features are also sometimes seen as disadvantages: the utility measure may be too reductionistic, the weights for health states may derive from unrepresentative populations, the generic quality of life indicator may be insufficiently sensitive to the kinds of change expected in mental health treatment, and a transparent approach to scale construction paradoxically opens the approach to criticism from those who question the values thereby obtained (Chisholm et al, 1997; McCulloch 2003).

On the other hand, CUAs avoid the potential ambiguities with multi-dimensional outcomes in cost-consequences studies and are obviously more general than the single-outcome CEA. The transparency of approach is also to be welcomed. The result is a series of incremental cost-utility ratios (potentially from across the widest diagnostic range i.e. not just from mental health) that can then inform health care resource allocation decisions or priority setting.

A broadly similar approach, although one that does not use utility measures, examines costs alongside changes in ‘disability adjusted life-years’ (DALYs). This again allows comparisons across diagnostic groups although the outcome measure (DALY) is not as sensitive as QALY measures when carrying out ‘micro evaluations’ such as clinical trials. DALYs are of more value for macro-level discussions (for example, at national or regional level).

Cost-benefit analysis

Cost-benefit analysis (CBA) addresses the extent to which a treatment or policy is socially worthwhile in the broadest sense: Do the benefits exceed the costs? This potentially would allow decision-makers to consider the merits not only of allocating resources within health care but also to consider whether it would be more appropriate to invest in other sectors such as housing, education or defence (Tudor-Edwards and Thalanay, 2001). All costs and benefits are valued in the same (monetary) units. If benefits exceed costs, the evaluation would recommend providing the treatment, and vice versa. With two or more alternatives, the treatment with the greatest net benefit would be deemed the most efficient. CBAs are thus intrinsically attractive, but conducting them is especially problematic because of the difficulties associated with valuing outcomes in monetary terms.

Some CBAs have chosen to focus on a subset of the outcomes. A good example is the classic evaluation of assertive community treatment (ACT) by Weisbrod et al (1980) which compared a quite wide measure of costs with a relatively narrow monetary outcome: patient earnings from employment. A CBA of this kind can describe only a part of the overall impact of an intervention, in this case the employment effect of ACT, but fortunately Weisbrod and colleagues also used what we would now call a cost-consequences approach, covering a larger set of outcome domains.

Recent methodological advances in health economics offer a way to obtain *direct* valuations of health outcomes by patients, relatives or the general public. These techniques ask individuals to state the amount they would be prepared to pay (hypothetically) to achieve a given health state or health gain, or observe actual behaviour and impute the implicit values (e.g. see Diener et al, 1998). However, they are likely to be quite difficult to apply in mental health contexts. Another approach that has been developed and is increasingly used to value health interventions is ‘conjoint analysis’. Individuals are asked to rank different real world scenarios, which may consist of several dimensions (including, for instance, health outcomes, time inputs, discomfort, possible externalities and stigma) and by including cost as one of these dimensions a monetary value can be elicited. Although complex, this approach has the advantage of not specifically asking individuals to put a monetary value on health states or health gain, which can make the technique easier to administer than traditional willingness to pay studies (e.g. see Ryan, 2000; Ratcliffe, 2000).

WHAT DO WE KNOW ABOUT COST-EFFECTIVENESS?

The accumulating evaluative evidence in some fields is now sufficient to warrant overarching reviews. Examples include substantive commentaries and systematic reviews of economic evidence on interventions for depression (Rosenbaum and Hylan, 2002), dementia (Jönsson et al, 2002), schizophrenia (Knapp et al, 2002a), child and adolescent mental health problems (Romeo et al, 2003). The Cochrane collaboration also includes economic evidence in some of its reviews.

A very recent systematic review of economic evaluations (looking at both costs and outcomes) of mental health in adults and older people has reported on evaluations published between May 2002 and April 2003 (Byford et al 2003c). This review found 28 studies that fitted the criteria of an economic evaluation of mental health problems in adults or older people. The authors suggest that the quality of evaluations is improving over time. US studies dominated (over 50% of the studies), with 25% conducted in the UK. Twelve of the studies found were cost-effectiveness analyses, two were cost-utility analyses, two were cost-benefit analyses and the others were not complete evaluations. Costs and outcomes were found to be measured narrowly in quite a number of these studies. Many economic evaluations are linked to randomised controlled trials (39%). An earlier review by Evers et al (1997) reported 30% of evaluations were linked to RCTs.

While this increased demand for economic evidence is encouraging, there continue to be significant challenges to facilitating the *use* of economic evidence (Milbank Memorial Fund, 2000). One issue that we touched on earlier is the challenge of determining whether the results and conclusions of a study produced in one context or setting can be generalised or adapted to fit other contexts or settings. An important step is to produce economic evidence using common standards such as those in widely accepted international guidelines. Using such standards should mean that information can be presented in a transparent fashion, allowing, for instance, different costs to be applied to resources to adapt to local settings.

Until recently, dissemination and implementation of evidence have been overshadowed by the need to *produce* evidence, but it is clearly essential to facilitate improved use of economic evidence in the decision-making process. Economic information needs to be both relevant to decision-makers' needs, and presented in accessible forms. To help strengthen the 'receptor capacity' for evidence, some people have argued for an investment in training a new cadre of professionals, who would have expertise both in the policy-making arena and also in scientific disciplines such as epidemiology and health economics (Lomas, 2000). These so called 'knowledge brokers' could act as conduits between the policy-making process and economic research, helping to facilitate use of the latter as part of the decision-making process.

Well-conducted economic evaluations can make significant contributions to our understanding in almost every aspect of policy and practice development in the mental health field. They can support decisions relating to the funding and provision of services and can help to improve the efficiency with which scarce mental health resources are allocated.

BALANCING EFFICIENCY AND EQUITY

Overlaid onto these cost-effectiveness or efficiency analyses are questions of equity in the availability and utilisation of resources and in the attainment of health and welfare

improvements. Are efficiency improvements achieved at the cost of greater inequity? Do the costs of a new policy fall disproportionately on an already disadvantaged group? Are the beneficial effects of a new treatment made available only to patients who are perhaps not seen as the greatest priorities for support?

Of course the meaning of equity is not itself straightforward and there are numerous definitions, which include

- equal access to health care for equal need,
- equal use of services for equal need, and
- equity in final health outcomes.

This last concept goes beyond everyday consideration by decision-makers, as many other factors may influence health outcomes, including for instance income and its distribution, nutrition, housing, and lifestyle. Equal access to health and social care for equal need – the first option above - is perhaps more appropriate if the focus is confined to health and social care services alone, where individuals (with equal need) face a reasonably equal opportunity to access necessary interventions. Thus the aim should be that their use of services is not influenced by ‘extraneous’ factors, such as their ability to pay for the service, the location in which they live, or their race or gender.

There is much evidence indicating that many of the needs of people with mental health problems remain unmet even when ability to pay for services is not a barrier (e.g. Andrews et al, 2001; McAlpine and Mechanic, 2000; Zuvekas, 1999). In part this may be due to the impact of stigma, social exclusion and a fear of being labelled, or in some cases, even because the ability to make judgements on service use are impaired. Thus simply having equity in the opportunity to access services may not be enough. Decision-makers may also have to consider how policies and interventions can help secure a level of use of services that is consistent with the level of population need. However, adopting this perspective on equity raises delicate issues, as some mental health services may be used involuntarily, and personal liberties might be constrained.

Bearing these equity caveats in mind, we can however, use economic analysis to provide decision-makers with information about the efficient use of resources.

CHALLENGES FOR EUROPE

Growing awareness of the need to improve not only the effectiveness but also the cost-effectiveness of health care interventions has produced various streams of demand for economic evidence. First, there are requests for measures of the overall resource or cost impact of a particular health problem, leading to cost-of-illness and ‘global burden’ studies. In particular, a lot of attention has recently focused on some of the non-health care costs – which can be very large in mental health contexts. Second, there are demands for economic evaluations of particular treatments or policies, generating cost-effectiveness and similar analyses, either carried out alongside clinical trials or independently. Third, there are searches for new service and health system reconfigurations that can improve the efficiency of use of available resources. Examples of such changes with potential efficiency consequences are the managed care changes in the US and the less dramatic developments in ‘sectorisation’, privatisation of provision and care programming in some European countries.

Decision-makers in Europe are facing both challenges and opportunities in the mental health arena. Economic studies can help. Economic analysis belongs within the broader policy context, and policy-makers need to consider the broad and long-term implications of their decisions. This is especially pertinent when one recalls that neglecting to make decisions can often cost more than taking the appropriate and timely action. There is also much benefit to be derived from greater cooperation and collaboration across Europe and beyond. Such collaborative endeavour has the ability to improve our understanding of the ways in which different mental health care systems are organised and function, and can help to build common approaches to data collection. Such action could therefore help to improve the generalisability of research, and also contribute by pooling and augmenting access to health economics expertise, which remains very limited in some parts of Europe. As we have shown, mental health has impacts on many different sectors and a continuing challenge will be to produce economic evidence that ranges beyond the health care sector to encompass inputs from and impacts on the social care, housing, education employment and criminal justice systems.

The recently established Mental Health Economics European Network, supported by the European Commission, represents one approach to improving cooperation across the 15 Member States, Iceland and Norway (see Box 1). The Network is currently collecting data and exploring issues across a number of dimensions. Such initiatives might be expanded to include the new Member States. What is needed is a body of expertise ready to help Europe tackle the many challenges facing mental health systems. These include the need to collect more and better information on the economic aspects of mental health and mental ill-health in Europe, and to develop policies for the funding, prioritisation and evaluation of services. One particular emphasis might be to research further the complex relationships between mental health and employment. Member States should also be encouraged to introduce promotion and prevention policies for mental health in the workplace as well as evaluating services that promote employment for individuals with more severe mental health problems, emphasising strategies aimed at gaining and retaining work. Finally, the economic evidence clearly points to the need for the mental health of children and young people to be given more attention in European health systems.

Box 1 – The Mental Health Economics European Network (MHEEN)

This Network has been established as an 18-month EC funded programme. It started in November 2002. The Network spans the 15 EU Member States, Norway and Iceland. It is co-ordinated by Mental Health Europe and the Personal Social Services Research Unit at the London School of Economics.

The Network has three main aims:

- ❑ to prepare a framework for data collection on relevant economic dimensions;
- ❑ to collect *some* data to allow cross-country comparisons to be made; and
- ❑ to learn about mental health economic issues and how they are being addressed in each country.

Through this partnership programme, seven major themes have been identified by the Network as areas for exploration. These include:

- mental health care financing
- expenditure and unit costs
- provision: services and professionals
- employment (of people with MH problems)
- economic evaluation summary
- epidemiological data with economic potential
- resource allocation

Papers on the financing of mental health services across Europe and employment issues for people with mental health problems are being prepared at the moment. Data collection for the next major research area (expenditure, unit costs and provision of resources) is due to begin in early 2004.

REFERENCES

- Amaddeo F, Beecham JK, Bonizzato P, Fenyo A, Tansella M, Knapp MRJ (1997) The use of a case register to evaluate the cost of psychiatric care, *Acta Psychiatrica Scandinavica*, 95, 195-198.
- Andrews G, Issakidis C, Carter G (2001) Shortfall in mental health service utilisation, *British Journal of Psychiatry*, 179, 417-425
- Becker T, Knapp MRJ, Knudsen HC, Schene AH, Thornicroft G, Tansella M, Vázquez-Barquero JL and the EPSILON Study Group (1999) The EPSILON study of schizophrenia in five European countries, *British Journal of Psychiatry*, 175, 514-521.
- Berto P, D'Ilario D, Ruffo P, Di Virgilio R, Rizzo, F. (2000) Depression: cost-of-illness studies in the international literature, a review, *Journal of Mental Health Policy and Economics*, 3, 3-10.
- Byford S, McDaid D & Sefton T. (2003a) *Because It's Worth It. A practical guide to conducting economic evaluations in the social welfare field*. Joseph Rowntree Foundation, York Publications.
- Byford S, Knapp MRJ, Ukoumunne O, Greenshields J, Jones V, Tyrer P et al (2003b) Cost-effectiveness of brief cognitive behaviour therapy versus treatment as usual in recurrent deliberate self-harm: the POPMACT study, *Psychological Medicine*, 33, 977-986.
- Byford S, McCrone P, Barrett B (2003) Developments in the quantity and quality of economic evaluations in mental health, *Current Opinion in Psychiatry*, 16, 703-707.
- Carr VJ, Neil AL, Halpin SA, Holmes S, Lewin TJ (2003) Costs of schizophrenia and other psychoses in urban Australia: findings from the Low Prevalence (Psychotic) Disorders Study, *Australian and New Zealand Journal of Psychiatry*, 37, 31-40.
- Chisholm D, Healey A, Knapp MRJ (1997) QALYs and mental health care, *Social Psychiatry and Psychiatric Epidemiology*, 32:68-75.
- Chisholm D, Knapp MRJ (2002) The economics of schizophrenia care in Europe: the EPSILON study, *Epidemiologia e Psichiatria Sociale*, 11, 1, 12-17.
- Crow S, Peterson C (2002) Social burden of eating disorders: a review, in Maj M, Halmi K, López-Ibor JJ, Sartorius N (editors), *Eating Disorders*, John Wiley and Sons, Chichester.
- Diener A, O'Brien B, Gafni A (1998) Health care contingent valuation studies: a review and classification of the literature, *Health Economics*, 7:313-326.
- Dixon A. Dilemmas in financing mental health. *Eurohealth*. 2002;8(1):25-28
- Drummond MF, O'Brien B, Stoddart GL, Torrance GW (1997) *Methods for the Economic Evaluation of Health Care Programmes*, Oxford Medical Publications, Oxford.
- Drummond MF, McGuire A, editors (2001) *Economic Evaluation in Health Care: Merging Theory with Practice*, Oxford University Press, Oxford.
- Essock S, Hargreaves WA, Covell NH, Goethe J (1996) Clozapine effectiveness for patients in state hospitals: results from a randomized trial, *Psychopharmacology Bulletin*, 323:683-697.
- Evers SMA, Van Wijk AS, Ament AJHA (1997) Economic evaluation of mental health care interventions. A review, *Health Economics*, 6, 161-177.

- Foster K, Melzer H, Gill B, Hinds K (1996) Adults with a psychotic disorder living in the community, *OPCS Survey of Psychiatric Morbidity Report 8*, HMSO, London.
- Goeree R, O'Brien BJ, Goering P, Glackhouse G, Agro K, Rhodes A, Watson J (1999) The economic burden of schizophrenia in Canada, *Canadian Journal of Psychiatry*, 44, 464-72.
- Goldberg JF, Ernst CL (2002) The economic and social burden of bipolar disorder, in Maj M, Akiskal HS, López-Ibor JJ, Sartorius N (editors) *Bipolar Disorder, Volume 5*, John Wiley and Sons, Chichester.
- Gray AM, Marshall M, Lockwood A, Morris J (1997) Problems in conducting economic evaluations alongside clinical trials: lessons from a study of case management for people with mental disorders, *British Journal of Psychiatry*, 170:47-52.
- Hamilton SH, Revicki DA, Edgell ET, Genduso L, Tollefson G (1999). Clinical and economic outcomes of olanzapine compared with haloperidol for schizophrenia: Results from a randomized trial, *Pharmacoeconomics*, 15, 469-480.
- Haro JM, Salvador-Carulla L, Cabases J, Madoz V, Vazquez-Barquero JL (1998) Utilisation of mental health services and costs of patients with schizophrenia in three areas of Spain, *British Journal of Psychiatry*, 173, 334-340.
- Harris EC, Barraclough B (1998) Excess mortality of mental disorder, *British Journal of Psychiatry*, 173, 11-53
- Healey A, Knapp M, Astin J, Gossop M, Marsden J, Stewart D, Lehmann P, Godfrey C. (1998a) Economic burden of drug dependency: social costs incurred by drug users at intake to the National Treatment Outcome Research Study, *British Journal of Psychiatry*, 173,160-165.
- Healey A, Knapp MRJ, Astin J, Beecham JK, Kemp R, Kirov G, David A (1998b) Cost-effectiveness evaluation of compliance therapy for people with psychosis,
- Hosak L, Bahbouh R (2002) Costs and outcomes of risperidone treatment in schizophrenia in the Czech Republic, *European Psychiatry*, 17, 231-321.
- Jönsson B et al (2002) Costs of dementia: a review, in Maj M, Sartorius N (editors), *Dementia, 2nd Edition*, John Wiley and Sons, Chichester.
- Knapp M, editor (1995) *The Economic Evaluation of Mental Health Care*, Ashgate, Aldershot.
- Knapp M (1997) Cost of schizophrenia, *British Journal of Psychiatry*, 171, 509-518.
- Knapp M, Scott S, Davies J (1999) The cost of antisocial behaviour in younger children, *Clinical Child Psychology and Psychiatry*, 4, 4, 457-473.
- Knapp M, Simon J, Percudani M, Almond S (2002a) Economics of schizophrenia: a review, in Maj M, Sartorius N (eds) *WPA Series in Evidence-Based Psychiatry: Schizophrenia*, John Wiley and Sons, Chichester, substantially revised second edition.
- Knapp M, Chisholm D, Leese M, Amaddeo F, Schene A, Thornicroft G, Vasquez-Barquero JL, Knudson HC, Becker T and the EPSILON study group (2002b) Comparing patterns and costs of schizophrenia care in five European countries: the EPSILON study, *Acta Psychiatrica Scandinavica*, 105, 1, 42-54.
- Knapp M, Mangalore R, Simon J (2004) The global costs of schizophrenia, *Schizophrenia Bulletin*, forthcoming.

- Lomas J (2000) Using 'linkage and exchange' to move research into policy at a Canadian foundation, *Health Affairs*, 19, 236-40.
- Magliano L, Fadden G, Madianos M, Caldas de Almeida JM, Held T, Guarneri M, Marasco C, Tosini P, Maj M (1998) Burden on the families of patients with schizophrenia: results of the BIOMED I study, *Social Psychiatry and Psychiatric Epidemiology*, 33, 405-412.
- Marshall M., Lockwood A., Gath D. (1995) How effective is social services case management for people with long-term mental disorders? *Lancet*, 345:409-412.
- McAlpine D, Mechanic D (2000) Utilisation of speciality mental health care among persons with severe mental illness: the role of demographics, need, insurance and risk, *Health Services Research*, 35, 277-292.
- McCulloch D (2003) *Valuing Health in Practice: Priorities, QALYs and Choice*, Ashgate, Aldershot.
- McDaid D (2001) Estimating the costs of informal care for people with Alzheimer's disease: methodological and practical challenges, *International Journal of Geriatric Psychiatry*, 16, 400-5.
- Millbank Memorial Fund (2000) Better information, better outcomes? The use of health technology assessment and clinical effectiveness data in health care purchasing decisions in the United Kingdom and the United States. New York: Millbank Memorial Fund.
- Oliver A, Healey A, Donaldson C (2002) Choosing the method to match the perspective: economic evaluation and its implications for health services efficiency, *Lancet*, 359, 1771-4.
- Ratcliffe J (2000) The use of conjoint analysis to elicit willingness-to-pay values. Proceed with caution? *International Journal of Technology Assessment in Health Care*, 16, 270-275.
- Rice DP, Miller LS (1996) The economic burden of schizophrenia: conceptual and methodological issues, and cost estimates, in Moscarelli M, Rupp A, Sartorius N (eds) *Schizophrenia*, Wiley, London.
- Romeo R, Byford S, Knapp M (2003) Economic evaluations of child and adolescent mental health interventions: a systematic review, submitted for publication.
- Rosenbaum JF, Hylan TR (2002) Costs of depressive disorders: a review, in Maj M, Sartorius N (editors), *Depressive Disorders*, 2nd Edition, John Wiley and Sons, Chichester.
- Rouillon F, Toumi M, Dansette GY, Benyaya J, Auquier P (1997) Some aspects of the costs of schizophrenia, *Pharmacoeconomics*, 11, 578-594.
- Ryan M (1999) Using conjoint analysis to take account of patient preferences and go beyond health outcomes: an application to in vitro fertilisation, *Social Science and Medicine*, 48, 535-546.
- Salize HJ, Rössler W (1996) How expensive is the comprehensive health care of schizophrenic patients living in the community? A cost evaluation from a German catchment area, *British Journal of Psychiatry*, 169, 42-48.
- Scott S, Knapp M, Henderson J, Maughan B (2001) Financial cost of social exclusion: follow up study of antisocial children into adult, *British Medical Journal*, 323, 191-194..
- Tarricone R, Gerzeli S, Montanelli R, Frattura L, Percudani M, Racagni G (2000) Direct and indirect costs of schizophrenia in community psychiatric services in Italy: The GISIES study, *Health Policy*, 51, 1-18.

Taylor PJ, Gunn J (1999) Homicides by people with mental illness: myth and reality, *British Journal of Psychiatry*, 174, 9-14.

Thornicroft G, Tansella M (2002) Balancing community based and hospital based mental health care, *World Psychiatry*, 1, 84-90.

Tudor-Edwards R, Thalanany M (2001) Trade-offs in the conduct of economic evaluations of child mental health services, *Mental Health Services Research*, 3, 99-105.

United Nations Office of the High Commissioner for Human Rights (1991) Principles for the protection of persons with mental illness and the improvement of mental health care. General Assembly resolution 46/119 December 17, 1991.

Tyrer P, Thompson S, Schmidt U, Jones V, Knapp M, Davidson K et al (2003) Randomised controlled trial of brief cognitive behaviour therapy versus treatment as usual in recurrent deliberate self-harm: the POPMACT study, *Psychological Medicine*, 33, 969-976.

Weisbrod BA, Test MA, Stein LI (1980) An alternative to mental hospital treatment 2: Economic cost-benefit analysis, *Archives of General Psychiatry*, 37:400-405.

Zuvekas SH (1999) Health insurance, health reform and outpatient mental health treatment. Who benefits? *Inquiry*, 36, 127-146.

Silvia Evers, Maastricht University⁴, The Netherlands

Response 1: Mental Health Economics Research

WHAT IS VALUED IS COUNTED!

One of the main reasons why we should pay attention to health economics in mental health care is by the simple fact that “What is valued is also counted”. Health care professionals, policy-makers, and politicians have an urgent need for systematic information about national health care expenditures. In the Netherlands (1) a study has been performed which looks at the total costs of health care for the year 1999. In this study every euro spent on Dutch health care has been attributed to a diagnosis. For each health care sector, data have been used about the utilisation of care by diagnosis group by all the people that were ill in that year. The framework for the division into diagnoses is given by the International Classification of Diseases, Injuries and Causes of Death: ICD, 9th revision.

The study showed that in 1999 in the Netherlands about 22% of the budget is spend on mental disorders. Because of these figures research in the field of mental health is put on the research agenda in the Netherlands. This is especially true for economic evaluation studies; this is a technique developed to provide a decision-making framework to help in assessing the costs and benefits (effects) of alternative mental health care intervention. Another interesting finding of this same study was that within the group of mental disorders, mental retardation consumes the largest part of the budget, about 36% followed by dementia (22.6%). This was not visible in the Dutch health care sector, as care for the mentally retarded falls within a separate sector with its own financing.

"MENTAL HEALTH ECONOMICS IS ABOUT HEALTH ECONOMICS ONLY MORE SO..."

Frank and McGuire (2) stated that “Mental health economics is about health economics only more so ...” pointing to the fact that mental health economics can claim no special methodology, but due to its peculiarities, has always been a separate subfield within health economics. These specific problems relate to the financing and organisation of the mental health care sector (§ 3) and additional problems, which one has to confront as a researcher in the field of mental health economics (§ 5). In my response, attention is paid to the “state-of-the-art” in mental health economic research (§ 4). Furthermore attention is paid to the need for early economic evaluation studies in the field of mental health care (§ 6) and the possibility of using economic evaluation studies from other countries for results in you own country (§ 7). Finally, I will highlight some of the information which is already available and which you can use when performing economic evaluations in the field of mental health care.

⁴ Silvia Evers, Maastricht University, Faculty of Health Sciences, Department of Health Organisation Policy and Economics P.O. Box 616, 6200 MD Maastricht The Netherlands, tel: +31-43-3881602, fax: +31-43-3670960, e-mail: S.Evers@beoz.unimaas.nl, Internet: <http://www.beoz.unimaas.nl>

FINANCING AND ORGANISATION

In September 2001 the European Commission organised a conference entitled "Future Mental Health Challenges in Europe" which revealed that too little information was available in the field of mental health economics. Mental Health Europe (3) in cooperation with the London School of Economics and Political Sciences started therefore the "EU Mental Health Economics Project". The purpose of the project was to identify and gather economic information, which is relevant to the mental health care sector, and to formulate indicators which make comparisons between countries feasible. To realise this, the "Mental Health Economics European Network (MHEEN)" was built with partners from 17 European countries (4). Based on a study looking at the financing and organisation of the mental health care sector in the MHEEN countries it can be concluded that in all European countries the financing and organisation of the mental health care sector is quite different from the somatic health care sector. This study revealed that for the mental health care sector, in comparison to other health care sectors, governments pay more and private insurers less. When looking at the financing and organisation of the mental health care sector, two shifts are visible: the first is a shift from public financing to private financing; the second is a shift from the health care sector of several facilities towards the social-welfare sector. The problem with this latter movement is that access to the health care sector is a basic right in most countries, whilst access to social-welfare facilities is often not seen as a basic right. Finally, overall in the MHEEN-countries there is access to mental health care facilities.

MENTAL HEALTH ECONOMIC RESEARCH: STATE OF THE ART

A good overview of state of the art in of mental health economic research can be gained from a review which was published in 1997 (5). The reason for endeavouring with this study was that overall a rapid increase in economic analyses in health care was observed. However one could question whether this increase in volume also means a rise in the quality of these studies.

This review considered the quality of economic evaluations in mental health care. Economic evaluation, if well performed, has great potential for improving the quality of decision-making and for making mental health programmes more effective and efficient. The purpose of the review was to provide insight into the status and quality of economic evaluation in the field of mental health care. Although it is somewhat dated recent reviews show that its conclusions are still valid today. The review showed that only a few comprehensive economic evaluation studies have been undertaken in the field of mental health care. Most of the studies were restricted to analyses of the costs only, that is, they did not look at the costs of intervention in relation to its effects.

Regarding the epidemiological design, randomised controlled trials are generally regarded as the most scientifically rigorous method of hypothesis testing. However the possibilities for randomisation in mental health care are not always realistic. In the review 30% of the studies were based on randomised controlled trials. Almost all of the studies used clinical outcome measures or an assessment of the consumption of (medical) resources to value the consequences of the treatment. Few studies used health-related quality of life measures, although quality of life is regarded as the broadest concept for valuing consequences. Especially in mental health care, where intangible costs such as psychosocial consequences play an important role, quality of life assessment and utility measurement should be used to quantify these effects. Finally only a few studies explicitly measured production losses and caregiver costs.

PROBLEMS IN MENTAL HEALTH ECONOMIC RESEARCH

One of the reasons why the quality of the studies in the field of mental health care is not optimal might be that researchers in the field of mental health care will always confront some additional problems. These problems relate to informed consent and communication, the organisation of the trial, the measurement of costs and the measurement of effect.

Informed consent and communication

With regard to informed consent and communication, the researcher has to confront the problem that treatments in the field of mental health care can be involuntary. Furthermore patients are often cognitively impaired and have difficulties expressing opinions and evaluation. Because of this they might not be able to give their own consent and proxy consents have to be used. Finally the assumption that the psychiatric patient is self-interested in treatment is dubious, possibly leading to a lesser likelihood of participation in research.

Organisation of the trial

First, the organisation of the trial is difficult as uncertainty and variation in diagnosis and treatment are greater than in somatic care. Furthermore the success of treatment for any chronic disease may vary over time. For instance, how long must an alcoholic be alcohol-free in order to label the outcome of the treatment a success? Finally, it is difficult to limit follow-up due to the fact that mental illnesses are long-lasting while an external subsidiser requires a limited follow-up.

Measurement of costs

Looking at the identification of costs, this is often difficult due to comorbidity, and the social and external consequences of the disease (unemployment, crime, violence, homelessness, "burden on the family"). As an indirect cost "foregone wages" are an important item in economic evaluation, especially the measurement of lost paid working time due to an illness or treatment. The mentally ill are, however, less likely to be employable. Furthermore, psychiatric patients often lose their jobs in the prodromal phase, before they are actually diagnosed as being mentally ill. This implies that one has to look not only at paid working time gone, but also at non-paid working time, leisure time, decreased possibilities etc. These latter aspects are much more difficult to measure and value. Next to this, some valuation methods (human capital) are discriminating to the unemployed, and psychiatric patients.

Measurement of effect

Finally regarding the measurement of the effect of an intervention, the impaired cognitive function of a patient in mental health care is a limiting factor. Outcome measurement in mental health economics is often done by utility measurement. In a utility measurement, patients rank their current health status on a range from death (0) to perfect health (1). The problem with this valuation technique is that some mental health care patients might prefer death over life. As a result, traditional utilities measures are not valid. Another aspect, which is difficult to take into account in a traditional outcome measure, is that in the field of mental health care one has also to take into account the reduced possibilities which psychiatric patients may have. As the

psychiatric problems may start early in life, patients with psychiatric problems are likely to attend less schooling and are not able to build a career. This is difficult to include in traditional outcome measures.

NEED FOR EARLY ECONOMIC EVALUATION

In the clinical research organisation there is a tendency to first look at the effectiveness of a mental health care intervention and then to study the costs of an intervention in relation to its effects. It is however important that economic evaluation studies are also planned in the early phases of the clinical trial. One of main reasons is that interventions otherwise diffuse, i.e., enter and become part of the mental health care system, even if they are not proven to be cost-effective.

Another reason is that it is often 'effortless' to also include costs alongside a clinical trial which looks at the effects of an intervention. These piggy-back studies, in which the additional economic and health outcomes needed for an economic evaluation are added to a randomised controlled trial, are efficient, and provide timely information that builds on existing clinical trial data.

TRIALS IN OTHER COUNTRIES

With the rapid growth of economic evaluation studies in the field of mental health care at an international level a lot of information is becoming available. Decision-makers in some countries, for instance the new member states of the European Union, who have limited resources to perform their own economic evaluation studies, may wish to reinterpret in their own country the results of an economic evaluation study that was done elsewhere. However one should be cautious about using results from other countries, as in most cases it is not possible to transfer results from one country to another without performing additional analysis. There are a number of reasons why economic evaluation results are not easily transferable. These include differences in epidemiology, ways of coding principal diagnosis and comorbidities, use of definitions and outcome measures, availability and use of treatment option, and organisation of the health care system (policy and reimbursement).

INFORMATION AVAILABLE

What is mentioned above does not mean that one has to start from scratch to gather all the information which is necessary to perform an economic evaluation study. For a description of the health care system in the various countries one can use the European Observatory on Health Care Systems (6). Epidemiological information and information on the burden of the disease is gathered by the "Project Atlas Mental Health Resources in the World" (7). The consumption of pharmaceuticals might be revealed by the IMS (8). Information regarding the availability of services can in part be deduced by using the information which is gathered by the OECD and the European Service Mapping Schedule (9-11). Information on the burden on the family and labour participation can be collected respectively by the EUFAMI-project (12) and the "European Network on Workplace Health Promotion" (13). Finally, within the WHO-project "On common health interview surveys in Europe (EUROHIS)" initiatives have been undertaken to formulate indicators in the field of mental health within the European Health Inventories.

ACKNOWLEDGEMENT

A lot of input from this response was gathered through participation in the Mental Health Economics European Network. I would like to thank all the members of the network for the interesting and lively discussions.

REFERENCES

1. Polder JJ, Takken J, Meerding WJ, Kommer GJ, Stokx LJ. Kosten van ziekten in Nederland, De zorgeuro ontrafelt (www.kostenvanziekten.nl). Rotterdam/Bilthoven: Instituut Maatschappelijke Gezondheidszorg Instituut voor Medical Technology Assessment van de Erasmus Universiteit Rotterdam/Centrum voor Volksgezondheid Toekomst Verkenningen van het Rijksinstituut voor Volksgezondheid en Milieu; 2002.
2. Frank RG, McGuire TG. Economics and mental health. In: Cuyler AJ, Newhouse JP, editors. Handbook of Health Economics. Amsterdam: Elsevier; 2000.
3. <http://www.mhe-sme.org>.
4. <http://www.mentalhealth-econ.org>.
5. Evers SMAA, van Wijk AS, Ament AJHA. Economic evaluation of mental health care interventions: a review. Health Econ 1997;6:161-177.
6. <http://www.euro.who.int/observatory>.
7. http://www5.who.int/mental_health en <http://mh-atlas.ic.gc.ca/>.
8. <http://www.imshealth.com>.
9. Salvador Carulla L, Romero C, Martinez A, Haro JM, Bustillo G, Ferreira A, et al. Assessment instruments: standardization of the European Service Mapping Schedule (ESMS) in Spain. Acta psychiatrica Scandinavica. Supplementum 2000;405:24-32.
10. Johnson S, Kuhlmann R. The European Service Mapping Schedule (ESMS): development of an instrument for the description and classification of mental health services. Acta psychiatrica Scandinavica. Supplementum 2000;405:14-23.
11. Becker T, Hulsmann S, Knudsen HC, Martiny K, Amaddeo F, Herran A, et al. Provision of services for people with schizophrenia in five European regions. Social psychiatry and psychiatric epidemiology 2002;37(10):465-74.12. <http://www.eufami.org/>.
13. <http://www.enwhp.org/>

*Mojca Dernovsek, Institute of Public Health of Republic of Slovenia, and
Rok Tavcar, University Psychiatric Hospital Ljubljana, Slovenia*

Response 2: Burden of Mental Ill-Health in Transitional Countries

Slovenia is a country which has fortunately escaped the majority of transitional problems, but when someone analyses our situation more precisely and closely, several problems can be found.

MAIN DETERMINANTS OF HEALTH IN TRANSITION PERIOD

Since mental health is just one part of health, the overall worsening of health determinants applies also to mental health. There are a number of health determinants that are important in the phase of transition: People's lifestyles undergo quite dramatic changes; Life becomes more stressful due to increased alcohol related problems, drug related problems, criminality, and violence.

Loss of cohesion and lower security are important factors and they are part of the family and community support system. Culture has slowly oriented towards greater marginalisation and stigmatisation of disabled people. In some transitional countries we can see alienated children – especially the disabled ones, under severe stress, and often left alone. Polluted environments can be found around work and living areas.

CONSEQUENCES

We can imagine the consequences. The burden of mental and somatic disorders increases in the population. But due to other severe economical, political, ethnical, religious and other problems, mental health issues are not usually considered as major health problems.

In environments with the previously mentioned factors we can expect an increased incidence and prevalence of stress-related mental and physical disorders. The needs of the population and special groups within the population (vulnerable, disadvantaged and marginalised groups of people) have increased enormously.

Here is an example: there was an increased incidence and prevalence of stress-related disorders in Bosnia and Herzegovina after the war while the resources (infrastructure, communications, health care facilities, especially hospitals) were largely insufficient or quite often even destroyed.

HOW TO USE OUR SHARED KNOWLEDGE?

It is difficult to transfer results obtained in one country to another. There are several reasons for this:

1. Most health economic studies have been done in western countries while data on southern and eastern countries are usually lacking.
2. Some analyses require subjective estimates of studied parameters, and these may be culturally specific.

3. The transition burden is not the same in all countries. Different countries have different priorities.

It is important to have national and international studies on mental health economics in transitional countries. It is also important to get data on the burden due to specific mental disorders in each country – the use of this methodology would provide evidence for setting better priorities. For example in Slovenia there is a high suicide rate and alcohol-related morbidity, which needs a different approach to other countries which may have some other major mental health problems.

SCARCE RESOURCES AND DIVERSITY OF PROBLEMS ARE A REALITY IN TRANSITION COUNTRIES

The first set of problems consists of **incomplete data** on mental health and data on the evaluation of programmes and policies. This is a consequence of scarce resources not only in services for people with health problems but in research and governmental services as well. Many health professionals are involved in different tasks (clinical work, research, teaching, policy making etc.). Health statistics are often incomplete with regard to mental health data due to a lack of health seeking behaviour and problems with recognition.

Possible solutions:

1. projects that give evidence for decisions, plans, and evaluations of programmes
2. a greater awareness of the importance of mental health economics

It is important to encourage local professionals to use up-to-date methodologies for the economic evaluation of programmes, and to set and analyse policies.

The second set of problems arises from **the methodology of mental health economics** which is sometimes difficult to understand, use and integrate with the results of other studies.

Possible solutions: Education is needed. Sometimes international collaboration helps with the setting of standards or indices. Some kind of standardisation might be possible in the field of mental health economics using minimal data sets for comparisons.

The third set of problems comes from the **process of transition itself**. In the transition towards a market economy and the adoption of democratic forms of government, it's possible that before long-term gains are seen we will see a short-term deterioration. **Possible solution:** Specific research could be done about the impact of the following issues on health and their costs: reduction of income and widening of income disparities; stress and stress-related behaviour; a lax regulation of environment and occupational risks; a breakdown of basic health services and so on.

FINAL REMARK

Bearing in mind that it is possible to calculate the costs of war we may wonder whether is it possible to calculate/estimate the costs of transition?

WORKSHOPS 1A+1B REPORT: Identifying and Responding to the Economic and Social Burden of Mental Disorders

Co-ordinator: *John Henderson, United Kingdom*

Facilitators: (1A) *Vidar Halsteinli, Norway* and (1B) *Luis Salvador-Carulla, Spain*

Rapporteurs: (1A) *Francesco Amaddeo, Italy* and (1B) *Gregor Henderson, United Kingdom*

This is a **joint report from the two parallel theme 1 workshops**: 1A: Identifying and responding to the economic and social burden of *serious mental illness*, and 1B: Identifying and responding to the economic and social burden of *common mental disorders*.

THE IMPACTS

Existing evidence across Europe underlines the substantial social and economic impacts of mental illness on individuals, families and communities, work places, services and society. For example, recent WHO figures show that 20% of the burden of illness (DALYs) in the European Region is due to mental ill health.

THE EVIDENCE

Existing evidence also shows that there are effective and cost-effective interventions for caring and treating mental illness and supporting individuals and families. The evidence is strongest for interventions responding to serious mental illness, and there is some promising evidence for interventions at both the individual and population level responding to more common mental health problems. There is also promising evidence on the effectiveness of both prevention and promotion programmes in reducing the economic and social impact of mental ill-health.

CONCLUSIONS AND RECOMMENDATIONS

1. Need for data and economic information on mental health and mental ill-health

We recommend: the collection, presentation and dissemination of comparable national, regional, cross-national and cross-regional information on epidemiology, cost consequences, effectiveness, satisfaction, service provision and access; information to cover promotion, prevention and care, and treatment.

Therefore, we invite Member States and the other European Countries to:

- produce data and economic information on these key areas;
- support the use of existing well developed methods for collecting information;
- support national and cross-national evaluations of the performance of the mental health system(s) of promotion, prevention, care and treatment.
- work collaboratively to present transparent and understandable information and encourage cross-national and cross-regional training in these key areas which incorporate mental health economics. (WHO and EU support for data collection and dissemination)

2. Funding of services

We invite Member States and the other European Countries to: develop national policies and strategies on mental health which should be integrated and funded across a range of sectors and agencies;

- give priority to promotion, prevention and community services development, particularly for service reforms in the accession countries;
- develop regional and national evaluations of system performance.

3. Employment and Workplaces

Based on information on cost-effectiveness and other evidence, we recommend that Member States and other European Countries:

- encourage a focus on mental health promotion and prevention within employment and workplaces as part of wider efforts to improve employability and health and safety at work;
- emphasise and support employment for people with severe mental illness through national and regional policies and actions;
- emphasise strategies and programmes aimed at gaining and sustaining work for people with common mental health problems.

4. Children and young people's mental health

For children and young people's mental health, based on the promising evidence base and information on the social and economic costs of not taking action, we recommend the Member States and the other European Countries:

- encourage a focus on mental health in the early years (infant mental health) through parenting programmes, early recognition and identification of mental health problems and provision of home-based support and support for parents with mental health problems;
- encourage mental health promotion and prevention programmes (2 years and older) involving mental health promotion and prevention as part of a universal approach to preschool development;
- encourage education policy to address mental health issues including:
 - health promoting schools which include mental health promotion
 - support for children's emotional and mental health within the school
 - awareness-raising of mental health and mental ill-health and self-help development (improving mental health literacy within the school)
 - support to teachers
 - support to families
 - support by more specialist professions and agencies to work with and within schools as part of an integrated approach to child health.

Actions for the European Commission

We invite the Commission to support the following actions, which we believe will greatly assist in reducing the economic and social impact of mental ill-health across Europe:

- encourage collaboration across EC directorates;
- encourage collaboration with both national and regional governments and agencies;
- continue collaboration with WHO;
- encourage and facilitate exchange and learning on the social and economic aspects of mental health promotion, prevention and care;
- support and fund long-term research particularly in the areas of promotion and prevention.

THEME 2: THE IMPACT OF TRANSITIONS ON MENTAL HEALTH

Dainius Puras, Vilnius University, Lithuania

Key Presentation: The Impact of Transitions on Mental Health

Europe is facing an unprecedented process of rapid change. On all levels – individuals, families, communities, countries and the European Union – we are witnesses and participants of rapid transition. There is an increased demand for coping with such kinds of situation for both individuals and institutions. What are appropriate coping strategies? What is needed for successful coping in our joint task to improve the well-being of Europeans? What is the impact of transitions on the mental health of European citizens and what should be done to protect mental health as one of our greatest values in the modern world?

These are not easy questions for which to find the right answers. Transition should be viewed not only as a risk factor, but also as a unique chance for renewal and further progress. There have been many difficult moments in the dramatic history of Europe, when threatening challenges were stimulating further progress of the human mind, social welfare and quality of life; already in those times the lessons were learned that flexible adaptation, solidarity and mutual trust are the key issues for successful coping. Now, when the concentration of dramatic events and decisions in temporal dimensions has reached an extremely high level, we are in need of effective and balanced solutions about the future of our continent and its citizens. Wise solutions need good mental health, and this is why we are today here in Bilbao.

IMPACT OF TRANSITIONS ON INDIVIDUALS AND INSTITUTIONS

Transitions affect individuals and institutions in many ways (Fisher S., Cooper C.L., 1990; Friedli L., 2000; Warr P., 1987; Wintrobe R., 1998). On an individual level, the current situation throws up enormous challenges. Non-normative patterns of transition are increasing. All age groups are affected by the fragility of a rapidly changing situation. Europe is ageing, the number of lone-dweller households has strikingly increased, children and young people are facing challenges in a new equality (school exclusions, youth violence, high divorce rates). Uncertainty about the future raises the level of anxiety in individuals.

In such situations the network of social institutions (including state, church, private sector, NGO's) should mobilise all their efforts to support individuals who need protection during these critical moments in their lives. However, institutions themselves appear to be in a dramatic state of transition, and one of the effects of global change (globalisation, unemployment, migration, the demands of an emerging information society, the threat of terrorism) is that the role of traditional social institutions is diminishing, and individuals are often left alone to cope with the increased challenges of transition. Moreover, institutions appear not to be immune from a crisis of trust and values, and they themselves need now – because of their erosion, vulnerability, and lack of flexible adaptation to new environments - support in order to restore confidence and trust both internally and externally.

RESPONSE FROM EUROPEAN UNION TO THE IMPORTANCE AND UNIQUE VALUE OF MENTAL HEALTH

The European Union, along with other international partners, has been doing its best to respond to the new situation and to the new research data adequately (Murray C.J.L., Lopez A.D., 1996). Starting from the middle of the 90's, the general response included putting one more key word "mental health" on the European agenda and then – with each subsequent year increasing the emphasis on this key word. After many decades of residing in mental hospitals and the offices of psychiatrists and psychotherapists, mental health has now emerged as a cornerstone of modern concepts in the broad field of public health and social well-being. The concerted efforts of EU bodies, the WHO, the World Bank, Member countries and other partners (Harvard report, 1995; Putting mental health on European agenda, 1996-2000; Tampere conference, 1999; EU Council resolution, 1999; Brussels conference, 2001; World Health Report 2001; World Report on Violence and Health 2002; EU Presidency activities of Member countries) have contributed effectively to the implementation of new approaches and practices in the field of mental health promotion and prevention at this dramatic point of transition in Europe (Lehtinen V., 1997). Many important messages have been formulated and sent throughout the continent during this remarkable series of events since 1995. But what is most important is that we need to continue this remarkable process with increasing energy, confidence and knowledge, because we are all facing a very special challenge – the enlargement of Europe. This challenge will be one more task of extraordinary complexity, because the major task now is to convert transition as a risk factor into transition as a protective factor.

Rich knowledge about the risk and protective factors influencing the mental health of individuals and societies has accumulated during the last few years in Europe and worldwide. With the help of innovative projects (including large-scale European projects such as the Key Concepts Project, Mental Health Promotion for Children up to 6 Years, Unemployment and Mental Health, Establishment of Indicators for Mental Health, Mental Health Promotion of Adolescents and Young People, Mental Health Promotion and Prevention Strategies for Coping with Anxiety and Depression in Europe) a paradigmatic shift was made from the traditional understanding of the mental health field as a field of treatment of mental disorders to integrating mental health into the public health approach and general social policy agenda.

We now have a great deal of evidence that effective strategies to support individuals should be focused on increasing emotional resilience through interventions designed to promote self-esteem, communication, negotiation and healthy relations between individuals. Cost-effective interventions should be used to increase individual and group capacity to cope with life events, transitions and stresses (e.g., parenting, adolescent crisis, loss or change of job, retirement, bereavement). Another focus has to be directed to the strengthening of communities – increasing social inclusion and participation, improving the neighbourhood environment, developing flexible community based health and social services, child care schemes, healthy and safe workplaces, supporting and facilitating social and self-help networks. If we manage to remove structural barriers to mental health through effective initiatives to reduce stigma, discrimination and inequalities, and to promote access to education, meaningful occupation, adequate housing, appropriate services and support to vulnerable groups, it will contribute positively to the good health (and good mental health) of the general population.

As we know, the Social Policy Agenda and the programme of Community Action in the Field of Public Health were launched as important parts of the EU roadmap for

implementing new strategies which aim at economic and social renewal and an effective investment in a healthy Europe. With the EU facing economic slowdown and governments having difficulties with unemployment, pension reform and health care reform, the value of Europe's social model centred on investing in people is greater than ever. The challenge now is to update it in the context of the transition from EU-15 to EU-25, and the role of mental health issues becomes of utmost importance in this context.

CHALLENGE OF EU ENLARGEMENT AND MENTAL HEALTH

The process of enlargement of the European Union puts all our accumulated knowledge and skills to a very special test. Next year, 10 countries will join the EU, and 8 of them are facing a very specific and heavy transition from a system based on a communist ideology to an open society and market economy. The challenge is even more dramatic because we are obliged to have a broader view on Europe. Behind these 8 countries who have been invited to join the European Union as leaders in the process of management of change, we have an additional 18 countries – members of the Council of Europe and WHO European region. In general – despite obvious progress made by the countries of Central and Eastern Europe - we should talk about the heavy transition, poor mental health and lack of coping skills and effective governance in 26 new democracies with a combined population of over 400 million people. This is a region with very high rates of self-destructive behaviour (in the list of 10 countries of the world with the highest suicide rates, 9 countries are from Central and Eastern Europe), violence, stigmatisation of vulnerable groups, and a heavy burden from the culture of dependence in the everyday activities of individuals and institutions.

Of course, it would be a big mistake not to see the huge diversity of the region. The countries of Eastern and Central Europe (including Southeast Europe) have very different cultures, economies, religions, and the processes of reform are also very different – both in quantity and quality. However, historically all of them have experienced the influence of a totalitarian ideology for 50 to 70 years, which now appears to have left long lasting effects on the ability of individuals, groups and societies to manage change.

Though it is a sad message, we should therefore understand and admit that the first decade in most of these countries witnessed a failure of transition in human lives and human services with tragic consequences for the health and well-being of the population. Despite widespread hopes for a rapid move to democracy and prosperity (R.Dahrendorf, 1990), the transition to the market economy has brought about an unprecedented recession and significant increases in poverty, morbidity and mortality in most of the countries of Eastern Europe. An analysis made by G.A.Cornia and R.Paniccia (2000) concludes that the huge public health crisis was mainly a result of the inability to cope with unexpected and prolonged psychosocial stress. Traditional coping skills, based on an experience of social passivity and full dependence on the state as a condition for survival in a totalitarian system, could not help any more in the new socio-economic environment; while new coping skills – based on a proactive response to challenges, individual initiative and competitiveness – appeared to be lacking among a large part of the population.

In most of the countries of Central and Eastern Europe, morbidity and premature mortality has increased dramatically due to a cluster of stress and helplessness-related conditions, including suicide, violence, risk-taking behaviour and self-destructive lifestyles, and even cardiovascular and other psychosomatic morbidity (Rutz W., 2001).

As we know, any transition affects to a larger extent the most vulnerable groups. So it also happened during this transition but what was different this time was that the male population appeared to be one of the most vulnerable groups with huge losses in mortality, morbidity and quality of life. In some countries of the region, the rate of suicide among men exceeds the rate among the female population by 5 times and more. We could hardly find a more illustrative example to demonstrate how these dramatic changes in social roles and other social determinants of health should be addressed by an adequate response of new health and social policies in these countries.

And even if in some accession countries the situation started to stabilise and slowly improve by the end of 1990s and the beginning of 21st century, this does not mean that epidemics of mental ill-health are over and that we can be satisfied with the general situation in the field of mental health of the population of Eastern and Central Europe. Data from the WHO database indicates there is still very poor mental health in most of these countries, with a tendency for basic improvement only in Central European countries. Thus, rates of suicides remain extremely high in Baltic States and Russia (Varnik A., 2000). Another important indicator of social “toxicity” could be the rate of youth homicides. As indicated in the World Report on Violence and Health, while most of EU countries have less than 1 case of youth homicide per 100 000 of youth (10-29 years) population, in Central European countries this indicator is 1.2-1.6, and in Baltic countries 5.4-7.7 and in Russia – 18 (World Report on Violence and Health, WHO, 2002).

One could make a logical conclusion from such data that striking difference of indicators of “social toxicity” should send a clear signal to the policy makers in the countries of Eastern Europe to invest in human resources and human relations so that protective and curative factors can be strengthened to support and empower individuals and communities as responsible participants in an improving public health system. But how is it in reality - what has been the governmental and societal response to these new kind of epidemics – epidemics of learned helplessness, destructive and self-destructive behaviour, and increased physical morbidity and mortality due to a lack of new coping skills to respond to psychosocial stress? Cornia G.A. (2000) and other experts conclude very clearly that the response was far from adequate. So what can we do in order to avoid a repetition of similar strategic mistakes in the following years?

Firstly, a need for open debate and evidence-based research of existing situations is urgent. This has to be done by local independent researchers with support from the EU. Some first attempts to evaluate context and policies in the field of mental health (initiated and supported by Open Society Foundation, Geneva Initiative on Psychiatry and other international organisations) were carried out in 1998-2001 and revealed very important preliminary findings. Attitudes and Needs Assessment in a Psychiatry study (ANAP) provided an analysis of prevailing attitudes and needs in the mental health scene in six different countries of larger Europe (Azerbaijan, Kyrgyzstan, Ukraine, Lithuania, Bulgaria, and Hungary), and drew attention to the major hidden obstacles for effective implementation of the basic principles of mental health care reform in the region in general and in concrete countries specifically (Tomov T., 2001).

As a part of an international mental health policy, programs and services project, a “Country profile” instrument was used (2000-2002) for assessment of the mental health policy and services in Lithuania, Bulgaria, Georgia, Ukraine and Azerbaijan. In a concrete example from one of the countries, analysis of contextual factors in Lithuania revealed high levels of social pathology (including violence, suicides and other self-destructive behaviours) and its combination with severely stigmatising approaches by

the general population to mentally disturbed people and other vulnerable groups. An analysis of existing data about financial and human resources invested in the mental health care system allows us to raise questions for policy makers about whether it is effective to continue traditional patterns of investment. The largest proportion of physical and human capital is concentrated in separate psychiatric institutions with large numbers of beds and psychiatric staff, and an increase in funding for medications. Meanwhile, attempts to develop new components of care which have been ignored by former systems and should be of vital importance to combat stigma and social exclusion – such as mental health promotion activities and new services like housing, psychosocial and vocational rehabilitation for mentally disturbed people, and community based child mental health services – face serious attitudinal obstacles from the traditional system and a lack of political will from policy makers.

A lack of balance in developing a bio-psychosocial model should be mentioned as a major strategic problem. After many decades of domination by an extremely medicalised mental health concept in communist countries, new European democracies are once more under threat of the same imbalance. On all levels (allocation of resources in the health care sector, priorities in medical education, and the culture and practice of health services) the psychosocial component still continues to be undervalued and usually loses in the battle for limited resources to the biomedical model which is backed by a much stronger lobby.

In Lithuania, for example, the cost of reimbursement by the national health insurance for each of several modern psychotropic medications exceeds the total amount of expenses (including all human resources invested in the system) allocated by the national obligatory health insurance fund to all child and adolescent mental health services throughout the country. It is no surprise then why so little has been done in Eastern Europe to involve individuals and communities in the protection of mental health. Only investment in new psychosocial and managerial technologies may prevent the systems and individuals from ineffective and unethical use of modern biotechnologies. In this situation, and especially in the Eastern European context, the words of Rudolf Virchow that “Medicine is a social science” becomes of strategic importance and should be seen as one of the basic messages from the EU to policy makers and leaders of academic medicine in the countries of Central and Eastern Europe.

Basic support is needed for the countries of Central and Eastern Europe in the field of development and implementation of evidence based mental health policies. In many countries statistical accounts keep the tradition of presenting processes delivered by services as outcomes, while a modern culture of evaluation of outcomes of services, programs and policies is often lacking. In the absence of an evidence-based evaluation practice of outcomes of existing services, the threat of reinforcing numerous “vicious circles” increases. Decisions by policy makers to continue investment in the traditional system and culture of mental health services – if even these services contribute to social exclusion, stigma, and exclude citizens and communities from involvement and participation – may be both a consequence and cause of the high burden of stigmatising approaches among the general population and lead to a further increase of “toxic” factors in the social environment and again provoke the next cycle of growth of stigma, social inequalities and social exclusion.

The findings from “Country profile”, as well as other tools for systems research, may be very useful for the development of modern mental health policies in the countries of Eastern and Central Europe which have been deprived for several decades from the

possibility of introducing and nurturing a tradition of evidence-based mental health policies and services.

WHAT IS MISSING IN NEW EUROPEAN DEMOCRACIES?

A preliminary analysis of contextual factors and obstacles for effective reforms in CEE countries in the field of mental health and related areas lead us to the question: what is missing in the new democracies? It is obvious that the countries have enough physical and human capital, and there have been a lot of innovative developments throughout the region in the last decade which indicate huge human resources. However, the major obstacles for healthier development of societies may be hidden in the lack and slow growth of positive social capital (Paldam M., 2001), while negative social capital is still in abundance as an effect of the former system and different realities coexisting in the post-communist environment. Trust in relations between individuals, groups and organisations and a sense of citizenship are missing in new democracies, as well as the presence of civil society in the governance of health issues (Kickbusch I., 2002). In many post-communist countries the field of public health and health care remains one of the most closed areas for the curative impact of an emerging civil society. It is obvious now that a participatory involvement of citizens, a regaining of mutual trust between citizens and state, the strengthening of civil society – these are the most powerful protective and curative factors for coping with a societal public health crisis.

The defensive styles prevailing in the traditional system of governance of human services leads to a lack of self-reflection and critical analysis of the contextual factors, the process of resource utilisation, the effectiveness of services and an evaluation of outcomes. A sense of coherence and social cohesion is lacking in the culture of individual and organisational relations (Rutz W., 2001). Ideas promoting social inclusion are still often met with scepticism, while policies and practices based on social exclusion remain popular among the general population and politicians who want to be popular among voters. This may lead again to a vicious circle where the difficulties of a society in transition provoke a public health crisis, the growth of social inequalities, feelings of helplessness, behaviour patterns of survival, and corrupted relationships; this in turn leads to further scapegoating and stigmatisation of vulnerable groups, poor governance, the pressure to continue social exclusion strategies, the threat of populist decisions by national authorities, and – as a result of the vicious circle - again an increase of social pathology, inequalities and exclusion. This was actually the mechanism which led to an increase in the number of institutionalised children in CEE countries (UNICEF, 1997) – a sad consequence of prevailing attitudes which stigmatise, moralise and blame families at risk instead of supporting them through development of a community based network of preventive services.

WHAT ARE THE NEEDS OF ACCESSION COUNTRIES IN THE FIELD OF MENTAL HEALTH IN AN ENLARGED EUROPE?

What are the needs of accession countries in their challenging task to cope with the adversities of transition and to fully integrate as equally healthy societies in the European family?

The main strategic concept of support for accession for CEE countries should be based on investment in the further growth of civil society, a sense of citizenship and positive social capital. A new quality of humans and organisational relations based on trust, civil participation and transparency has to be nurtured. The public mental health approach as a basic strategic concept should be facilitated, by the support of innovative mental

health promotion/prevention activities and community based mental health care programs. On the level of academic institutions it is very important to introduce new training schemes based on a broad public health approach and to support the growth of the research capacity in the field of mental health policy and services. Support for alternatives challenging the strict medical model – such as interventions which increase resilience, family and community involvement, and are based on strengthening of protective factors – would be of enormous importance.

The question “what to do?” is somewhat easier to answer in comparison to the questions “who will do it and how will it be done?” Civil society cannot be imported from abroad but what can be done with the support of the EU is to facilitate the cooperation of all actors in the mental health scene (national and local authorities, NGO’s, professional organisations, informal networks of interested citizens) so that mutual trust between institutions and organisations is rebuilt, human resources are activated and positive social capital is finally increased. The EU should be aware of the fact that major international donors – which have been committed to invest in positives changes in the field of mental health and mental disabilities - are currently in the process of leaving accession countries because those countries are now becoming a part of the EU and also because it has been estimated by classical economic theories (Dahrendorf R., 1990) that 10 years will be enough to secure sustainable changes in post-communist democracies. However, the challenge appears to be more complicated than expected, and it is not so obvious today if national and regional authorities will take over responsibility for the support (either with national resources or by applying to EU funds) of innovative projects directed at the building of an open society; to the promotion of mental health and the prevention of social exclusion, violence, suicide, the institutionalisation of children, mentally disturbed persons, or the stigmatisation of other vulnerable groups of the population.

All stakeholders in Central and Eastern Europe – both in accession and in other countries - should receive a clear message from EU bodies that Europe is concerned about the mental health crisis in Eastern European societies – a crisis which is threatening both social cohesion and economic progress. Social and economic problems in the new democracies of Europe will not be resolved through fiscal or medical solutions but need broad societal consensus and energy (Kickbusch I., 2002). The public health crisis will not be resolved through one-sided investments in sophisticated biomedical technologies but need a new public health approach in which a modern and transparent governance of systems is facilitated by an involvement of citizens and an investment in human resources and human relations.

Clear messages have to be sent to governments, organisations and citizens across the larger Europe that the practices of stigmatisation, social exclusion, and institutionalisation of vulnerable groups (especially of children and adults with mental health needs) belongs to the past and has no place in the system of values of Europe in the 21st century.

New approaches – accumulated during the last decades in the developed European countries – of mental health promotion and prevention of mental health problems should be replicated in a creative process throughout new European democracies, with the clear message that they are working effectively only for individuals and communities who are motivated and committed to participation, involvement and positive change.

The NGO sector should be supported in their attempts to grow and become independent and strong partners of governmental institutions. Citizens of new democracies have to get a sound message that there are no miraculous methods to make people happy and healthy in this world except realising that their future and the future of their children depends firstly on their sense of citizenship - on how much they themselves will participate in the life of their communities, countries and a united Europe.

Accession countries could learn from countries like Spain, Portugal or Greece how to manage the transition from totalitarian systems to a democracy and an open society. The EU should facilitate an open dialogue between all players and stakeholders in the huge field within and around mental health – and to facilitate new democracies in learning to better play the difficult game of democracy – with shared responsibility, mutual trust and genuine human values. By assisting new countries in recovering from severe crisis, the developed countries of Europe will no doubt become stronger in solving their own problems. There is no need and sense to make divisions in Europe when we talk about our major joint tasks for good mental health – they are equally important to all European nations and citizens. We have to

- rebuild peace, trust and mutuality;
- invest in healthy relationships between individuals, organisations and nations;
- perceive and manage transition as unique opportunities for positive change and growth of social, human and economic capital;
- maintain a healthy balance between traditions and innovations;
- learn from other fields how to use new technologies in management of change. This strategy – the strategy of sharing responsibility, mutual support, tolerance and trust, investing in good quality of relations between individuals, institutions and nations – will lead us to better health and to a better quality of life. There will be no need to add “mental health” to “health” every time because it will be clear without needing to say it. There will be no need to draw numerous vicious circles because we shall be able, as a united Europe, to learn from the mistakes of the past, to combine tradition and experience with flexibility and innovative approaches and to turn the vicious circle into a circle of success and empowerment for the citizens of a united Europe.

REFERENCES:

Cornia, G.A., Panizza, R (eds.) *The Mortality Crisis in Transitional Economies*. Oxford university Press, Oxford 2000.

Fisher, S., Cooper, C.L. *On the Move: the Psychology of Change and Transition*. Wiley 1990.

Friedli, L. Mental health promotion – how do you feel? *The Journal of Primary Care Mental Health*. Vol.4 No.2 (2000) 30-32.

Kickbusch, I. Mobilizing citizens and communities for better health: The civil society context in central and eastern Europe. A background paper for USAID Conference, Washington, DC, 29-31 July 2002: “Ten Years of Health Systems Transition in Central and Eastern Europe and Eurasia”. Washington, DC, 2002.

Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B., Lozano, R. (eds.) *World Report on Violence and Health*. Geneva: World Health Organization 2002.

Lehtinen, V., Riikonen E., Lahtinen E. (eds): *Promotion of Mental Health on the European Agenda*. Stakes, Helsinki 1997.

Murray, C.J.L., Lopez, A.D. (eds.) *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected to 2020*. Harvard University Press, Cambridge 1996

Dahrendorf, R. *Reflections on the revolution in Europe*. New York, Random House 1990.

Paldam, M., Svendsen, T. Missing social capital and the transition in Eastern Europe. *Journal for Institutional Innovation, Development and Transition*. 5 (2001) 21-34.

Rutz, W. Mental health in Europe: problems, advances and challenges. *Acta psychiatrica Scandinavica*. 104 (suppl. 410) (2001): 15-20.

Tomov, T. Mental health reforms in Eastern Europe. *Acta Psychiatrica Scandinavica*. 104 (suppl. 410) (2001): 21-26.

UNICEF. “Children at Risk in Central and Eastern Europe: Perils and Promises”, *Regional Monitoring Reports*, 4. Florence: UNICEF Innocenti Research Centre 1997.

Warr, P. *Unemployment and Mental Health*. Oxford: Clarendon Press 1987.

Wintrobe, R. *The Political Economy of Dictatorship*. Cambridge UP: Cambridge 1998.

Värnik, A. *Depression and mental health in Estonia*. WHO report. Geneva: WHO, 2000.

World health organization: *World Health Report 2001 – Mental Health – New Understanding, New Hope*. WHO, Geneva 2001.

José Agustín Ozamiz, University of Deusto, Spain

Response 1: Social Capital and Mental Health Promotion in Social Transitions

IMPACT OF TRANSITION ON MENTAL HEALTH

When considering the impact of the transition on mental equilibrium, it involves acquiring a somewhat diverse perspective as regards to mental health problems existing in medicine. Most doctors are essentially concerned with relieving symptoms and how to deal with syndromes. When speaking of the transition and its impact on mental health, we are considering critical situations which require re-adaptation and re-balancing. This perspective is more suitable for dealing with primary prevention and for promoting mental health.

All societies throughout the history of humanity have developed strategies for dealing with periods of transition in life, known as life cycles. All civilisations have developed rites which facilitate the transition and essentially the social recognition of the new status to the individual who may have to develop a new role. Rites of transition, also referred to as rites of passage, are thus fairly significant for the social balance and mental health of members of a community.

On the other hand, social transitions have been slow and there have even been societies which have changed little over the centuries. Industrialisation involved a profound social transition. It took the industrialised societies over 100 years to reflect on the social and psychological repercussions of that change and to face up to them with models of social organisation that provide a balance and social well-being to communities.

The change we are experiencing in our era may be more profound than the change experienced in the 20th and 21st centuries in Europe. Now it is clearly faster. The speed of the transition we are experiencing makes it difficult to adopt social strategies in the same time-frame as the individual who has to adapt much faster during the course of his or her transitions in life to new situations.

Uncertainty and risk are the characteristics of our society which our psyche has to face throughout life. These include: professional uncertainty, uncertainty in terms of work, uncertainty when faced with vital projects and sometimes even about the support that may be provided by the family, and uncertainty as regards environmental safety and pollution. Faced with this outlook, it is essential to adopt conceptual strategies which may enable us to deal efficiently with the negative consequences of the impact of transitions in the mental balance of the person. The positive thing about the era in which we live is that it provides us with precious instruments of communication that may help us to exchange information, and reflect jointly on matters which may facilitate the development of strategies for dealing with problems.

Dainius Puras's exposition is an example of the knowledge provided by this possibility of exchanging information. I should like to draw attention to three ideas from this brilliant exposition and add some comments about them.

NEED FOR CONCEPTUALISATION

Puras suggests new concepts and strategies for dealing with the promotion of mental health both on an individual level (skills of pro-active response when faced with new situations of challenge and competitiveness) and on a social level (the concept of social capital). In this sense, I should like to stress the need to draw up suitable concepts and strategies for this new situation of rapid change and the increasingly technical nature of communication.

The need for conceptualisation may be established on three levels:

1. The level of the individual: The *reflexiveness* mentioned by Puras is put forward by different authors as the essential characteristic that the person needs in our times in order to face new emotional situations and situations of interaction, and for which he or she has no safe models of conduct to refer to. Yet this reflexiveness must be developed in company with others; sometimes with experts in the form of counselling and psychotherapy; at other times with equals such as in self-help groups.

In this sense, strategies which incorporate this conceptualisation in terms of the type of intervention in the primary prevention of mental health should also be developed, such as crisis intervention, network therapy and interventions of different types.

2. The institutional level: Working environments, educational institutions and the family reflect the impact of social transition. In this sense, I think that the MHPP Project, to be discussed in this conference, has collected models of best practices for preventing common mental illnesses and promoting mental health. This also needs a new conceptualisation in order to be able to understand what occurs in these institutions.

3. The level of social structures: Literature which reinforces proof in terms of the effectiveness of social organisation and socio-economic structures in promoting health is becoming increasingly more widespread. The concept of social capital, as pointed out by Puras, is frequently resorted to in order to describe social cohesion, trust and confidence, the system of values of a society and security in terms of interactions, and what may be positive in reinforcing social participation and positive integration in society.

This concept and its interaction with mental health is promising, although research on it new, and there remains a long way to go before it becomes suitably developed. On the other hand, demonstrating the influence of mental health today in strengthening social capital is as important as describing the impact of positive social capital on mental health. This will prove to be very useful when convincing politicians and administrators of the need to invest in mental health for the balanced development of a society. We have been able to prove that pointers of positive mental health such as social participation, quality of life and levels of satisfaction with health institutions and social services are as important as production rates, the gross domestic product rate and inflation, and that negative pointers such as suicide rates and levels of drug dependency, etc., must be considered as they really are.

My suggestion is that this social conceptualisation and resulting research also requires the incorporation of new instruments which are already proving to be useful. We need to be aware, for instance, of studies that typify situations of social transition, in order to be able to be more effective in putting our recommendations into practice. Thus,

methods of analysis of social policies also prove to be useful in understanding the obstacles existing in implementing plans which in principle are carried out with the best will in the world, but which prove to be mere pipe dreams.

We also need, as Esping Anderssen says, a new theory in political economics in which the concept of social capital and its relation with mental health may be one of the keys. In short, the task of conceptualisation, reflection and implementation in promoting mental health must be multidisciplinary. The medical prospect must be enriched using social, cultural and anthropological outlooks in order to be able to help social planners in social engineering and in the development of effective mental health policies.

LEARNING FROM EACH OTHERS' EXPERIENCE

Puras says that eight of the countries from the authoritarian system of the Soviet Union that will be joining the EU next year, can learn from the experiences of Greece, Portugal and Spain, countries that have also undergone a similar transition from totalitarian systems. It would be of great interest to us to share the experience of these last two decades of transition, and I hope that this conference may be an occasion to establish contacts and agreements in this sense.

It would be very useful to share the methods we have used and the results obtained throughout this process of change in psychiatric care and the promotion of mental health. These range from the study of attitudes towards mental illnesses, which we carried out as a starting point, to the introduction of the accumulative psychiatric case register, to drawing up of a plan for mental health and psychiatric care, and finally to the development of training programs and epidemiological research geared towards understanding social factors that influence the outcome and development of mental illnesses. It would be very useful to share these experiences with countries that are attempting to face up to these changes.

Yet what we consider very advisable is to compare the practices of the different countries of the European Union with different situations, transitions, experiences and plans that they have developed, and the results obtained. In this sense, we must acknowledge the good decision taken by the DG-Sanco of the European Commission as regards promoting a Working Party for such a purpose. I believe that there is wide consensus regarding the need for comparable statistics and monitoring of different situations. New information and communication technologies will no doubt facilitate this task.

AVOIDING BIOLOGICAL REDUCTIONISM

Puras reminds us that medicine is a social science and criticises the costs of new psychotropic drugs; it is typical in some transitional countries for the purchase administration to take up a larger proportion of the budget than on all other health resources devoted to psychiatric care put together, including human resources.

I should like to emphasise something that has been repeatedly said in meetings of experts called by the DG-Sanco of the European Commission: A way of facing these dynamics of biological reductionism of mental illnesses is by promoting epidemiological research sponsored by institutions other than the pharmaceutical industries. In this sense, responsibility on the part of the public administration in research about psychosocial factors that influence mental illness, and in promotion of training professionals, teachers and social workers in psycho-sociology and promotion

of mental health, must be emphasised. While the monopoly concerning the research in psychiatry continues to be enjoyed by pharmaceutical companies, this work will require a special effort on the part of public administration.

In this sense, the stands of the World Health Organisation in Europe and the DG-Sanco of the European Commission, should be praised. However, the European Union Member States, as well as regional authorities, must make a special effort with regard to this and invest energy and budgets on the psycho-social research of mental disorders, on epidemiological studies and on prevention.

Richard Plette, NCPH National Institute of Occupational Health, Hungary

Response 2: The Impact of Societal Transition; the Case of Hungary

INTRODUCTION

In Central and Eastern Europe, thus in Hungary too, the changeover - after the year 1990 - indicated important challenges for society. The relative constancy was typical in the earlier years. Employment was practically full and in the workplace people could count on mostly secure, but low wages. The firms showing a deficit were subsidised by the state with credit support. It was possible to supply incomes in the so called 2nd and 3rd economy. In order to “whiten” the “black” or “grey” economy, (to legalise dodgy businesses by taxing them), since 1981 the state has made it possible to found small enterprises. Consequently self-exploitation has started; it means that workers to attain their minimal goals (such as having a holiday abroad, buying a plot or a car often on credit) have had to work 4-6 extra hours besides the 8-hour core time, often at their workplace (self-exploitation became a must because of the accumulation of debts).

So the changeover has found the population of Hungary in a tired and exhausted state of health. The worsening of the mortality rate of middle-aged males began in the early 1980s, culminated in 1992-93, and later in recent years it has decreased to a small degree (Figure 1).

Today, the mortality rate of young and middle-aged (25-44 years old) men in Hungary is higher, not only in the EU countries, but also in the other CEE countries. This is mainly caused by the above mentioned physical and psychical overloading, respectively the “shock therapy” of transition. The decreasing trend of the mortality rate shows some promise concerning the future.

The unfavourable public health rates – the worst being a stagnation in life expectancy – has two causes:

- trends in the frequency of unhealthy behaviour,
- quality of the socio-economic environment

Mortality rates of the Hungarian population

age: 25-44 years

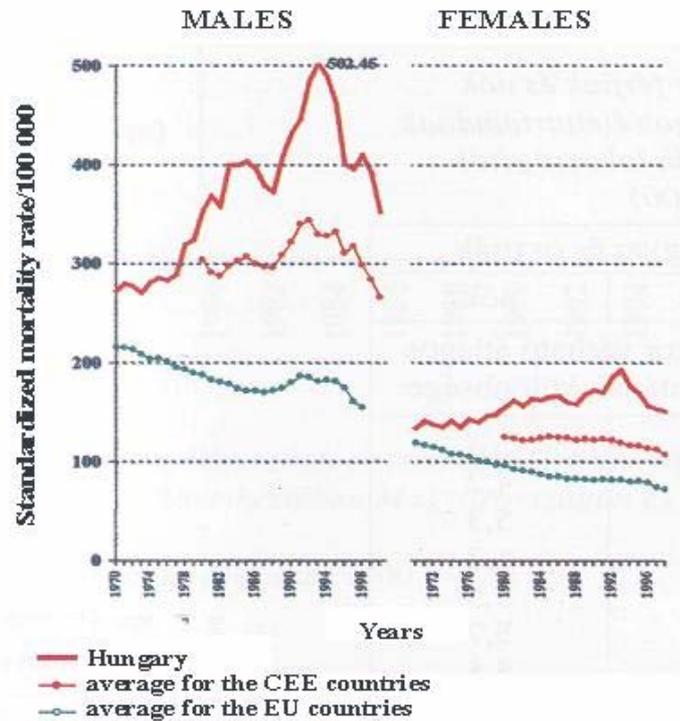


Figure 1.

According to Hungarian researchers, only 40% of deaths are caused by harmful health behaviour; in the majority of cases (60%), it is the lack of adequate responses (bad strategies for coping with stress) to the challenges that causes higher levels of morbidity and untimely deaths.

The pattern of mortality rates caused by cardiovascular diseases (Figure 2.) shows the impacts of the same socio-economic changeover. The double peak of the curve shown in Figure 2 reflects the impact of the self-exploitation in the 1980s as well as the mental shock of the transition.

Mortality caused of by cardiovascular diseases

age: 1-64 years

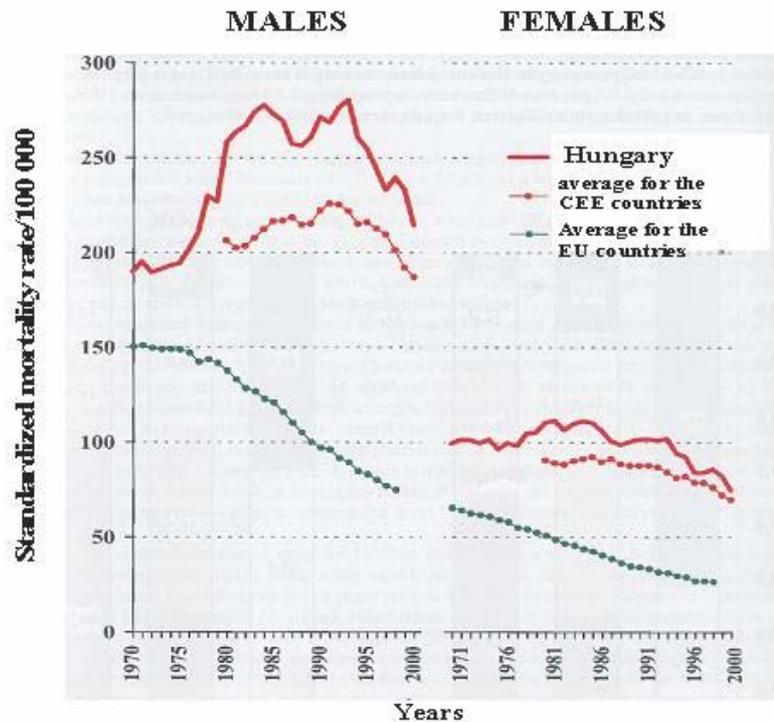


Figure 2.

According to researcher's opinion, this reflects an unrealistic demand and a wish to not fall behind in a dynamically polarised society. Striving for this creates a feeling of constant stress and exclusion from society. This is characteristic especially of the unemployed, for those with low qualifications and for the relatively poor groups that are fighting with daily problems and are living at the bottom of the settlement society. These are people who do not have the chance to change their situation or the ability to modify it even though they might have the possibility. Repeated stress and the risk of bad health are caused by the inability to cope with these difficulties; there is a constant need to secure further subsistence as well as avoiding a more serious crisis.

In those socialist countries, where change to the system was carried out dynamically and with a significant political divide, the loser and the winner positions are well identifiable. In Hungary, the feeling of alienation is increasing among the people who have an unfavourable position in the labour market after seeing other groups rapidly increasing their gain. These poorly positioned groups have difficulties in changing their situation for the better. In the current circumstances their future is not promising, as there is no sign of change. This situation leads to harmful behaviour and psychosomatic illnesses.

THE TRANSITION IN HUNGARY

Large factories went bankrupt in large numbers. In addition, complete branches of industries went broke, e.g. the heavy industry and the mining industry. At this time, so called "green field" investments started by means of which new workplaces were created. Foreign firms introduced new technology, and often also a new organisational culture. It also demanded a high commitment to work and a new and different work ethic.

The economic change resulted in mass unemployment. In particular, the unskilled and elderly people suffered losses during this process. The blue-collar workers who had been doing hard physical work for decades could not seize the opportunities arising within the technologically more advanced workplaces. The end of the secure way of life and relative equality that they were previously accustomed to found the population unprepared; the whole philosophy of the former political system was based on these values of worker equality and security. The majority of the population became poor, while at the same time certain people, who were close to the source of wealth, made huge fortunes.

Figure 3 shows the rate of unemployment in Hungary in the years of transition. This tendency was falling from its peak in 1993 to 2001.

Following the changeover – and with the opening of the frontiers – the crime rate increased sharply. In Hungary, from 1970-1995, the number of publicly reported crimes quadrupled (from 125 000 to 502 000). In 1989 there was a rise in explored criminal cases to 225 000, a level never seen before (see Figure 4). In 1990 criminal statistics registered 341 000 publicly known criminal cases. The next peak was in 1995 when 502 000 cases were registered.

The high crime rate has been stagnant since 1996. Public opinion suffered a shock because of the increasing crime rate. The Hungarian people had only three years between 1989 and 1992 to come to terms with the booming crime rate, compared to the Western Europeans' two decades in which they were able to adapt to similar circumstances. A similar situation was forming in the neighbouring countries. All of the countries going through changes in the political system experienced a doubling, if not tripling, of crime rates.

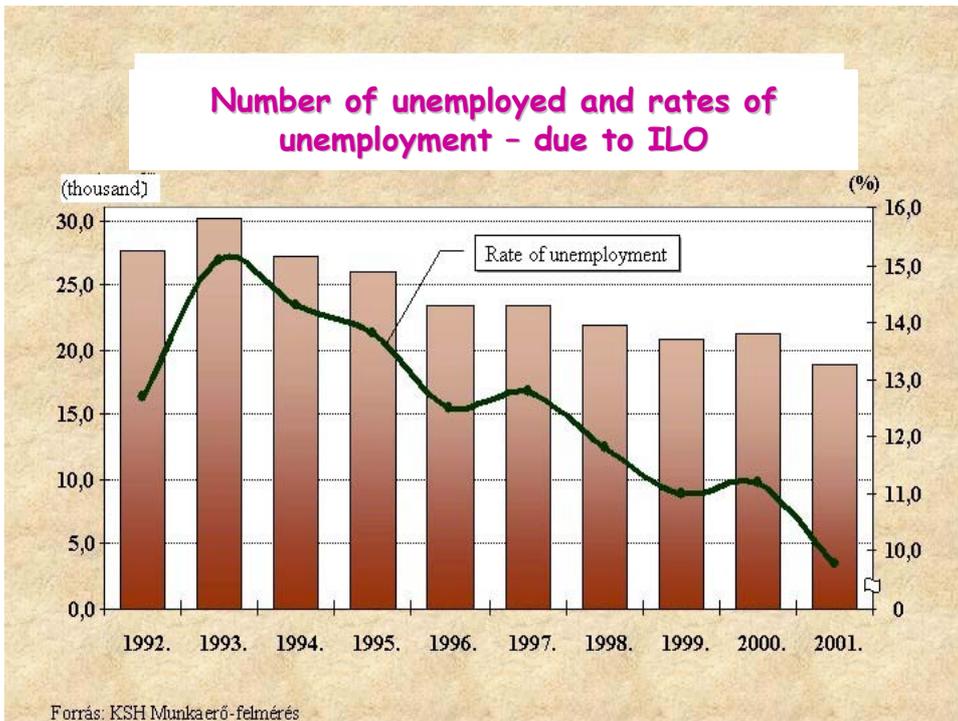


Figure 3.

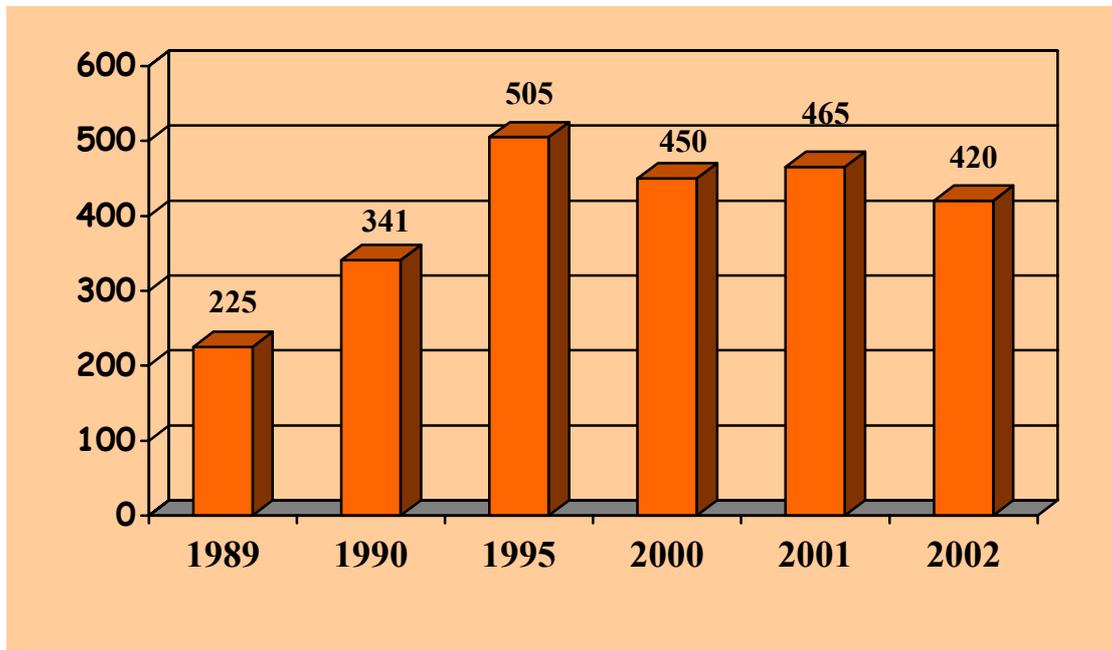


Figure 4.

*Statistical yearbook of Hungary, 2001.

THE IMPACTS

Psychological impacts

Conflict between the individual and social environment causes frustration:

- Frustrations of needs (basic needs like a lack of material resources; need for security: lack of security at workplace; social needs: feeling of falling behind)
- Pressure of adaptation
- Overwork, stress

Earlier, people weren't used to saving money. Most people lived from hand to mouth, because their daily bread still seemed to be guaranteed. The change in this situation also shocked society. A large profusion of goods – going together with a shortage of money – urged some people to satisfy their demands by means of credit, which resulted in their running up debts. Losing property due to redundancies led to real tragedies in private lives.

Some people became wealthy very quickly causing great dissatisfaction in the others. The society could hardly adapt to this situation in a short period of time. All this fight for survival caused physical and psychical overload, stress and a state of decay in health.

Stress appears when one cannot cope with all the pressure of work or cannot adapt to demands – when all of these exceed our strength. Concomitant psychological stress reactions are anxiety, anger, aggression, insensitiveness, and depression. Stress in the long run affects the immune system. It weakens the body's resistance to diseases. Research suggests an unambiguous association between the increase of disease rates and the appearance of stress.

The issue of depression and suicide is a major problem in Hungary. In the last century (excluding the last 5 years), our annual suicide mortality had been the highest in the world. In the last 15 years (and especially in the last 7-8 years) the suicide rate in Hungary has been falling steadily. (The peak of suicide mortality was 4600 persons in 1984.) This 30% decrease has been the most dramatic in the world, and obviously this tendency is the result of many factors. Recently, Hungary has lost its position at the top of the world rankings and now stands in 5th place. This position is still unsatisfactory, because the annual mortality rate per 100 000 people is one and half times more than in Austria, and triple that in England and the USA.

The overall mortality rate of middle-aged (55–64 year old) men in Hungary today is higher - even in absolute terms - than it was in the 1930s. Within this age bracket the death rate is extremely high among the lower socio-economic classes. The odds ratio of the incidence of death is 1.8 times higher among males aged up to 74 years with no high-school education compared to the same age groups with higher education. Some 40% of this difference can be accounted for by the self-destructive behavioural risk factors (alcoholism, tobacco smoking) being more prevalent in the lower socio-economic groups.

According to the results of the national survey (Kopp-Csoboth) in Hungary among 12640 subjects in 1995, 45% of the males and 26.6% of the females smoked. Among

the male and female cohorts under 45 years of age the rate was 47.9% and 31.9%, respectively. Among the males the number of daily cigarettes consumed and the volume of daily alcohol imbibed was inversely related to the educational level. This negative correlation was not so clear among the female sample. The health promotion programmes can only achieve their goals if they target the psychological and motivational background of self-destructive behavioural risk factors.

FINAL REMARKS

In recent decades, the morbidity and mortality crises which have characterised the period of transition in Hungary offer a great challenge to the behavioural sciences as well as to public health and biological research.

The oft-repeated Central Statistic Office (KSH) surveys indicate that health as something to value has become most important as a major value for the population of Hungary, above categories like family, money and being successful in a career.

In 2000 the “Society for Healthier Workplaces” made a survey on values among groups of employees (7 companies with 750 employees took part in the research). The results are shown in the following table.

Rank	Varied value label	Mean of values
1.	<i>Health</i>	<i>1.79</i>
2.	Family	2.14
3.	Money	3.93
4.	Well-paid workplace	4.03
5.	<i>Healthy lifestyle</i>	<i>4.67</i>
6.	Successful work	4.76
7.	Friends, nice colleagues	5.16

The results clearly show that health and healthy lifestyles head the list, above the leading value of earlier years. But it can be seen as a problem that the category of healthy lifestyle is only in 5th place. Therefore, the most important task is promoting health, giving information about healthy eating habits, living a healthy lifestyle and coping with stress. We need to learn how to analyse stressful situations and manage them.

REFERENCES

Ádány, R.: A Magyar lakosság állapota az ezredfordulón. Budapest. Medicina 2003.

Attkinson et al.: Introduction to Psychology. 1994.

Egészségesebb Munkahelyekért Egyesület: Munkavállalói vélemények. Budapest 2000.

Kopp, M. et al.: A depressziós tünetegyüttes gyakorisága és egészségügyi jelentősége. *Lede Artis Medicinae*, 1997.

Kopp, M. - Csoboth, Cs.: Smoking and alcohol abuse in the Hungarian population. 2003.

Plette, R.: A munkapszichológia gyakorlati kérdései. (*Practical Questions of Psychology for work*) Budapest. Medicina, 2002.

Statistical yearbook of Hungary, 2001. (KSH).

WORKSHOP 2A REPORT: The Impact of Transition on the Mental Health of Individuals

Coordinator: *Karl Kuhn, Germany*

Facilitator: *Thomas Kieselbach, Germany*

Rapporteur: *Helga Gumplmaier, Austria*

A rather small group of 10 people found their way to this workshop.

At first the facilitator, Thomas Kieselbach, gave a rather comprehensive introduction. He started with statements about transitions in general and then he gave us a more detailed analysis of a special example: occupational transitions on which he has been working for many years. He gave us a good analysis of the status quo and future perspectives of the labour market, outlining the challenges on the labour market, and the action which should be undertaken. To conclude, he gave an overview over the main results of an EU project he has lead. After this not so short introduction we discussed the main points of his presentation.

LIFE PER SE IS A PERMANENT TRANSITION

During our life cycle we always have to go through more or less smooth or stressing transitions. Birth is the first such transition; death is the last transition in our lives. Both of them, birth as well as death are *normative transitions* which happen to every person. Other examples for such normative cycles are the first day at school, the period around puberty, the first steps into working life, and eventually retirement.

Non-normative transitions are not predictable, they are not happening to everybody; examples are marriage, divorce, loss of a partner by accident and severe illness.

Stress potential of transitions:

- disruption of routines
- loss of security and predictability
- confrontation with inadequate resources
- fear of the future
- loss of social integration
- risk of social exclusion

There is a risk to mental health if the person cannot cope with these stress factors.

Challenges and risks of transition to individuals:

- Life transitions can enable the individual to explore new ways of life and free them from control and constraints by overcoming situations in which one is stuck without the chance for personal growth. They can help to overcome routines by entering new zones of innovation.
- The effective adaptation to and constructive coping with transitions require adequate personal and social resources. If they are lacking, transitions pose a great risk to the mental health of vulnerable groups as well as being a risk for social exclusion.

Dimensions of transitions:

The dimensions of transition are very helpful for judging the risk factors of transitions (Source: Nicholson, 1989)

- | | |
|-----------------|--|
| 1. Speed | <i>How often do they occur?</i> |
| 2. Amplitude | <i>How radical is the change?</i> |
| 3. Symmetry | <i>How much time adjusting vs. time performing?</i> |
| 4. Continuity | <i>Are there meaningful connections between transition phases?</i> |
| 5. Discretion | <i>How much autonomy in controlling the process?</i> |
| 6. Complexity | <i>Are multiple adaptations and adjustments required?</i> |
| 7. Propulsion | <i>Who started the cycle and why?</i> |
| 8. Facilitation | <i>Who/what helps progress throughout the cycle?</i> |
| 9. Significance | <i>Do adjustments change the individual or organisation?</i> |

ACTIONS WE NEED**General actions**

- Strengthening of personal resources and social resources accompanied by inclusive policies.
- Enabling people to cope with transitions in general, this action must start very early - already in school.
- Building up compensating institutional offers of help that are accessible, acceptable and problem-sensitive.
- In research, analysing the cycle of transitions: typology and dimensions, protective factors and vulnerability factors.

Actions especially for occupational transitions

- Employability as adaptability to future transitions in the labour market: Long-term employability policies by the social institutions and companies
- Creating awareness among employers: New Corporate Social Responsibility (CSR) going beyond the actual employment
- Re-evaluation of the meaning of employment (by widening the perspective to voluntary work/advocacy, integration in submerged economy as a buffer against the unemployment-stress)
- Better balance between insiders and outsiders of the labour market: e.g. sabbaticals, integration of learning periods into employment

WORKSHOP 2B REPORT: Impact of Transition on Societies and Organisations

Coordinator: *Karl Kuhn, Germany*

Facilitator: *Oldrich Vinar, The Czech Republic*

Rapporteur : *Michel Vallée, France*

To introduce this workshop, three questions were proposed to the participants:

- what is the function (characteristic) of transition for society ?
- what are the roles of the social institutions in transitions ?
- what are the relevant areas of social transition for mental health ?

Actually, transitions happen everywhere, in the whole world and in every circumstance. Even if the European actuality focuses on the transition of the accession countries, the transitions they are coming across are part of a larger and 'meta-global' context of transitions. 'Old' European countries are at the same time going through the same and other transitions; so the topic of transition must be studied globally and adapted to specific contexts.

Crucial issues in transitions are their frequency, speed and intensity. It seems that most people and populations are unable to keep up with the speed, intensity and diversity of changes. As a consequence we observe an intensified impact on individual and collective mental health. Whether this period is difficult or not, it is our reality, actual and inescapable. Actually, one can observe various dangerous attempts to escape. They may be unconscious, even irresponsible, costly and useless. Being reality, transitions form factually at an individual and collective level, a challenge to learn. How to accept and integrate this challenge?

If we compare ourselves with the metaphor of stress (and this choice is legitimate as stress concerns more than 50% of the population), we experience our transitions within a systemic combination of determinants, states of health, impacts on lifestyle, and effects on people, organisations and societies. That is to say, people live simultaneously through several transitions, and several vicious and virtuous circles, imbedded within each other.

In reacting to determinants, people may be hopeful or pessimistic; and this difference in attitude leads to quite different paradigms and consequent scenarios. Without referring here at all to the reality of somatic and psychic suffering or the rehabilitation and prevention processes, the way towards hopefulness and pessimism mostly depends on the perception and interpretation of situations.

This debate took place in the workshop, and one should not of course neglect these realities, and the effective actions needed. It was also stressed that a minimum level of ability to cope with the situation is needed, such as to enter into the "challenge to learn".

Nevertheless, and whatever be the state of the situation, it was agreed that hopeful or pessimistic scenarios depended mostly on perception and interpretation! Thus, if this is true, how do we see and act on the reality in a 'positive' way, at the level of

organisations and at the level of societies? Two essential conditions are needed. These two conditions are full of meanings and consequences:

A) - The need for a coherence in the roles of every actor in companies and institutions, of places to participate (it is known from most 'ex-western' countries since the seventies that false participation may be manipulation whereas people from 'ex-eastern' countries know "by heart"), and of global and holistic common values, although respecting their original differences.

B) - Conditions of credibility, which closely correlate with trust. Here the responsibility on politicians, the media, and all stakeholders (that is to say, "ourselves") is high. It was noticed by most participants that actually, in Europe, there is no model, no truth, no political or ethical authorities, to "trust", neither ideology nor religion after experiences of the old and near past. We can only agree on an idea of humanism not clearly defined! But, when more than 50% of the population (and in several contexts of increased stress more than 70%), appear to be involved, the question of transitions shows once more how mental health becomes a politically global issue.

How should this be done? Encountering such issues as 'accepting', 'integrating', speed of change as a challenge to learn' we need a simultaneous top-down process:

- **Down:** Near the reality of the field, mental health questions always ask for multidimensional models and practices. They can only be in transversality about understanding, approaches, ways of action, the professional and social status of involved actors.
- **Top:** At the level of European shared values, on a geopolitical scale, with trends and priorities clearly oriented by them.

Concretely, in regard to the global issue it might be reassuring to see that we 'have' already the materials, at least a good part of them. In fact there is already from recent years a lot of experience in Western, Eastern, Northern and Southern countries with models of good practice, funded at the EU, or national and regional levels. But we don't know how to capitalise on them, change them into shared knowledge, and by that transfer and disseminate them, in ways adapted to each cultural and socio-economic context.

THEME 3: NEEDED SUPPORTIVE INFRASTRUCTURE FOR MENTAL HEALTH PROMOTION AND PREVENTION OF COMMON MENTAL DISORDERS

Heinz Katschnig and Beate Schrank, University of Vienna, Austria

Key Presentation: Prevention of Mental Disorders and Promotion of Mental Health: Exploring the concepts

INTRODUCTION

If compared with “*treatment of diseases*” the concepts of “*prevention of diseases*” and “*promotion of health*” have arisen rather late in modern societies and have for a long time been neglected. The roots for this neglect, manifested in the lack of routine public financing mechanisms, do not only lie in the historically more pressing need of fighting already developed diseases and in the lack of knowledge how to prevent them, but also in the conceptual uncertainties surrounding the idea of “prevention” (differentiated today into concepts such as “primary, secondary, tertiary”, and “universal, indicated, selective” prevention, whose definitions are neither universally known, let alone agreed upon). If moving to the concept of “promotion of health” these definitional problems become even larger and the evidence base for actions gets smaller. In some sense one could say that treating diseases is a clear and hard business - the “enemy” is visible, whereas prevention and promotion are vague and soft with no clear “enemy” to attack. Also, the traditional *individual-centred* approach of medicine with its focus on the treatment of *single patients* is conceptually easier than the *public health* approach of prevention of disorders and promotion of health which is related to *groups and populations*.

These difficulties are potentiated if one tries to apply these already difficult concepts not to *physical* disorders and *physical* health but to *mental* disorders and *mental* health. There, the lack of a common understanding of what mental disorders are is an impediment to action (if one regards the many versions of international classification systems over the last few decades and the still often competing definitions of ICD-10 and DSM-IV), let alone the many different meanings of mental health.

Unfortunately, such a common understanding is only starting to emerge and, consequently the present paper has a cautionary tone in fully acknowledging the natural tension between the still unsatisfying state of knowledge in preventing mental disorders and promoting mental health and the perceived need for action. It begins with the traditional medical concepts of “disease” and “therapy” and gradually builds up the conceptually more complex issues of “prevention of mental disorders” and “promotion of mental health”.

FROM BASIC TO COMPLEX CONCEPTS

Societal actions are invariably tied to financing mechanisms. Such mechanisms do exist for medicine. The traditional target variables of medicine have since long been “diseases”, and the corresponding interventions are called “therapy”. In modern welfare

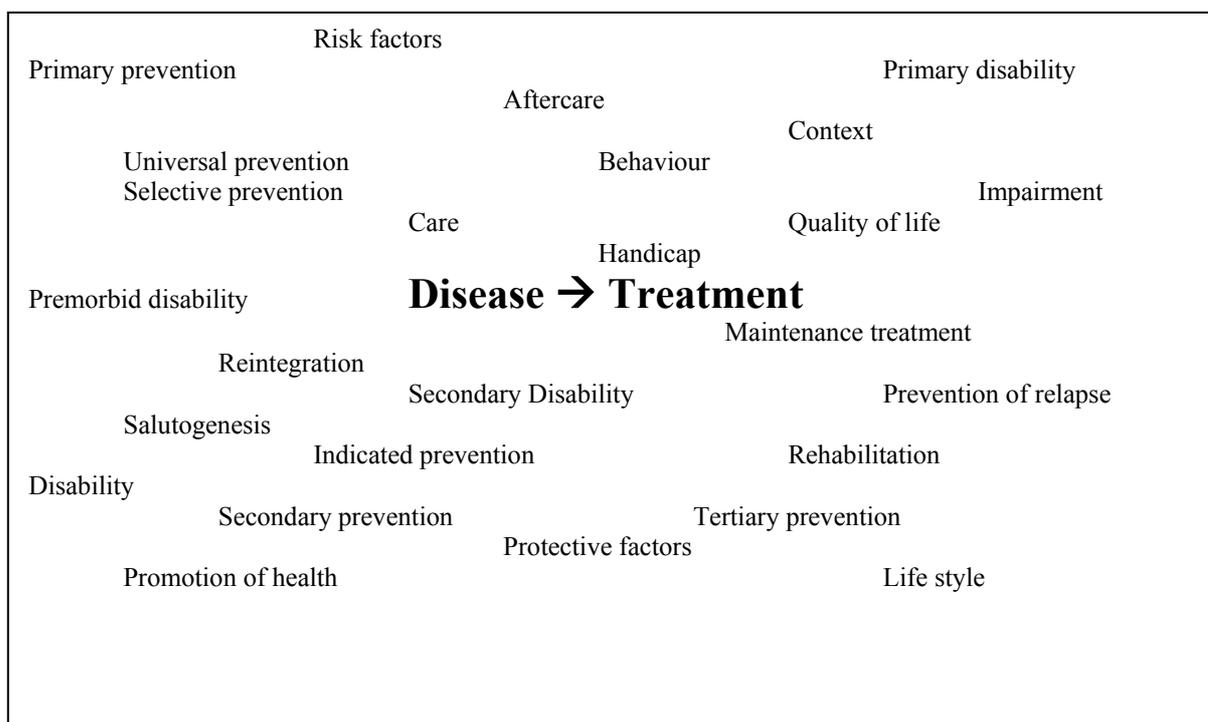
societies, the financing mechanisms for diagnostic and therapeutic medical procedures are relatively clear: Either health insurance systems (as introduced by Bismarck in Germany in 1883) or tax funded systems (initiated by Beveridge in 1948 for the UK) guarantee that medicine can be practiced, i.e. that medical doctors and related professionals have jobs and that a larger proportion of the population can afford medical treatment once a physical disease has developed. In short: Medicine, as a societal undertaking for treating diseases, exists not the least because financing mechanisms exist.

Already in this traditional world conceptual and practical difficulties arise, if the field of acute medicine is left behind and chronic diseases become a matter of concern – there the financing mechanism are less clear.

The simple sequence of “disease” and “therapy” has been steadily supplemented by other concepts over the last half century or so, first by “rehabilitation” which aims at restoring (as far as possible) the original health and functional state. The financing mechanisms for rehabilitation are again less clear, not the least because rehabilitation involves many social and other non-medical activities, but also because it has brought in a new target variable, namely disabilities.

Today a plethora of concepts and suggested activities makes the situation increasingly complex. In table 1 a selection of such new concepts and terms is intermingled into the “old” concepts. Each of these many terms and concepts seems to make sense. But in order to make them operational as a whole - in the same way as medicine has become operational - , a systematisation of this babel of terms is necessary – especially in view of the fact that public health actions have to be carried out in cooperation between the health sector and practically all non-health sectors of society.

Table 1: The babel of health states and health related states and corresponding actions



First, the concept of “disease” as the traditional target of medical interventions has been supplemented over the last decades by the concept of “disability” (disturbed functioning in daily life as a consequence of a disease), which has become a target of rehabilitation. Both the disease and the disability concept relate to a deficit in relation to the desirable normal state and are rather clearly defined. Therefore they are suited for actions. A good example for disabilities are walking difficulties after a stroke, where physiotherapy is usually financed. Concerning psychiatric disorders, loss of social skills in schizophrenia with social skills training as a rehabilitative measure is an example (with however no guaranteed financing in many places).

In a parallel development “normal”, i.e. desirable states, namely “health” and “quality of life” have been given increasing prominence, not only as outcome variables when preventing and treating diseases or preventing and “rehabilitating” disabilities, but as constructs in their own right (Table 2). The WHO (1948) definition of health as “a state of complete physical, psychological and social well-being and not merely the absence of disease or infirmity” is a forerunner of this development.

Table 2: Old and new undesirable and desirable health and health-related states

		Health and health-related states	
		Undesirable / abnormal state	Desirable / normal state
Domains	Symptoms	Disease	Health
	Functioning in daily life	Disability	Quality of Life

Health corresponds to disease, and quality of life to disability in this new movement towards stressing these “normal states”, which are considered as deserving being “promoted”. In this sense “promotion of health” aims at going even beyond the normal state in order to create a kind of especially good health, and as one must say logically, to improve quality of life beyond the “normal” values in a given society.

Table 3: Actions aimed at undesirable and desirable states

	Actions aimed at	
	Undesirable/abnormal state	Desirable/normal state
Traditional	Therapy of disease	–
New	Prevention of disease Prevention of disability Rehabilitation of disability	Promotion of health Promotion of quality of life

The corresponding actions aimed at the desirable/normal states are called “promotion of health” and, as we might say, also “promotion of quality of life”. Actions targeting the undesirable/abnormal states are called “prevention”, “therapy” and “rehabilitation”. Prevention and rehabilitation do not only relate to diseases (disorders) but also to disability (Table 3).

MENTAL DISORDERS AND MENTAL HEALTH⁵

The concept of mental disorders

Over the past decades, because of its negative connotations, the term “mental illness” has been replaced in the psychiatric literature and the corresponding diagnostic systems more or less completely by the plural “mental disorders”. This is also appropriate from a logical point of view, since a) there is no such thing as a *general* “mental illness” and b) the illness concept derived from physical medicine does not automatically apply to abnormal *mental* states, so that the neutral term “mental disorder” is more suitable. While these disorders are included in a *disease* classification, the “International Classification of *Diseases*”, they are practically all called *disorders* in Chapter F (Mental and Behavioural Disorders) of the ICD-10 (World Health Organisation 1992).

There is still controversy about the validity of the definitions of many specific mental disorders – reflected by the rapid succession of new versions of classifications – ,but the introduction of operational criteria has certainly improved the reliability of psychiatric diagnoses and contributed a great deal to the upgrowth of scientific research in epidemiological and biological psychiatry. The Diagnostic and Statistical Manual of Mental Disorders, in its fourth revision (DSM-IV), produced by the American Psychiatric Association (APA 1994), and the International Classification of Diseases, in its tenth revision (ICD-10), published by the World Health Organization (WHO 1992), are the spearheads of this development.

⁵ Some parts of the following text have been adopted or adapted from Katschnig et al (1999)

However, while already for many physical disorders no clear demarcating lines can be drawn, this applies even more to mental disorders, where we rather deal with a dividing fog than with a dividing line between the normal and the abnormal. The concept of “sub-threshold” disorders reflects the need of clinicians to sometimes go below the strict operational diagnostic definitions.

The World Health Organization estimates that several hundred millions of people suffer from such disorders world-wide. The World Health Report 2001 (WHO 2001) states that surveys conducted in developed as well as developing countries have shown that, during their entire lifetime, more than 25% of individuals develop one or more mental or behavioural disorders. In table 4 the life time and 12-month prevalence rates for the most frequent psychiatric disorders are presented, as they were found in a large epidemiological survey, the US National Co-morbidity Survey (NCS; Kessler et al., 1994). These and earlier estimates of the prevalence of psychiatric disorders have been criticized as being too high. Narrow et al (2002) have revised these rates “for more accurate projections of treatment need” and arrived at a total 12 month prevalence rate (of any disorder) of 18,5%. Recently, after repeating the NCS in 2001 and 2002, Kessler et al (2003) have confirmed at least for major depression the original high rates of their 1994 paper.

Table 4: Lifetime and 12-Month-Prevalence of Psychiatric Disorders (DSM-III-R)

	Male		Female		Total	
	Lifetime	12 mo	Lifetime	12 mo	Lifetime	12 mo
Disorders	%	%	%	%	%	%
Affective disorders						
Major depressive episode	12,7	7,7	21,3	12,9	17,1	10,3
Manic episode	1,6	1,4	1,7	1,3	1,6	1,3
Dysthymia	4,8	2,1	8,0	3,0	6,4	2,5
Any affective disorder	14,7	8,5	23,9	14,1	19,3	11,3
Anxiety disorders						
Panic disorder	2,0	1,3	5,0	3,2	3,5	2,3
Agoraphobia without panic disorder	3,5	1,7	7,0	3,8	5,3	2,8
Social phobia	11,1	6,6	15,5	9,1	13,3	7,9
Simple phobia	6,7	4,4	15,7	13,2	11,3	8,8
Generalized anxiety disorder	3,6	2,0	6,6	4,3	5,1	3,1
Any anxiety disorder	19,2	11,8	30,5	22,6	24,9	17,2
Substance use disorders						
Alcohol abuse without dependence	12,5	3,4	6,4	1,6	9,4	2,5
Alcohol dependence	20,1	10,7	8,2	3,7	14,1	7,2
Drug abuse without dependence	5,4	1,3	3,5	0,3	4,4	0,8
Drug dependence	9,2	3,8	5,9	1,9	7,5	2,8
Any substance abuse/dependence	35,4	16,1	17,9	6,6	26,6	11,3
Other disorders						
Antisocial personality	5,8	...	1,2	...	3,5	...
Nonaffective psychosis	0,6	0,5	0,8	0,6	0,7	0,5
Any NCS disorder	48,7	27,7	47,3	31,2	48,0	29,5

Source: Kessler et al, 1994

In terms of prevalence the dominating disorders are what are traditionally called "minor" psychiatric disorders, i.e. anxiety and mood disorders, as well as substance use disorders. Schizophrenia (subsumed in the table under "nonaffective psychosis") is clearly less frequent than these "minor" disorders, but since it starts early in life and often becomes chronic, it is nevertheless burdensome.

While the distress caused to patients and their families by these psychiatric disorders is justification enough for taking preventive action, this is even more so, since it is not uncommon that

- two or more of these disorders are present simultaneously (co-morbidity),
- these disorders complicate many (especially chronic) physical disorders and prolong their duration (e.g. increase the duration of a hospital stay),
- they are associated with an increased mortality, due both to suicide and natural causes,
- they are disabling in the fields of self care, personal relationships, family life, child rearing and work,
- they cause enormous direct and indirect costs (e.g. loss of productivity).

It has to be stated, though that the use of operational diagnostic criteria doesn't render justice to mental suffering and "mental ill health" and that psychiatrists are criticised for just demarcating their professional interests in using (and "overstating") the disease model of mental disorders. It is suggested that the disease model of mental disorders might need some reconsideration because, at least in some instances, it artificially "medicalizes" problems of everyday life (for an overview of this criticism see Katschnig 2001). In view of this criticism the public health approach of prevention of mental disorders and promotion of mental health might serve as a stimulus towards a development of a more comprehensive view of the field of mental health and mental disorders.

The concept of mental health

In a public health context the term "mental health" is now used as an umbrella term for both the normal state, i.e. "mental health" in the proper sense, and mental disorders. Unfortunately, not only is the borderline between mental health and mental disorders blurred by the introduction of this umbrella term, but also misunderstandings abound.

As a broad term designating the field of *mental* health as opposed to *physical* health, it would be advisable to add something like "field" or "issues", i.e. "mental health field" or "mental health issues". Within such a broad field a "positive" and a "negative" pole can be distinguished. In fact, the term "positive mental health" as opposed to "negative mental health" can be found in the literature. Most often, however, it remains unclear what is meant by "mental health", whether the *whole field* or just *positive* mental health (sometimes the term "mental health" even refers to mental disorders). If one talks about the promotion of mental health, one clearly means "positive mental health".

The situation is similarly confusing on the negative side, where terms like "ill mental health", "mental ill health", "mental health problems" or "negative mental health" are used. Obviously these terms include all states of not feeling or not being well psychologically, no matter whether or not this state would be called a mental disorder by psychiatrists. Often these negative mental health terms are used, when someone

clearly means mental disorders but wants to avoid this term because of its negative connotation in relation to stigma. Such uses blur the issue, like in the following example from Lahtinen et al (1999): “There are many false assumptions concerning mental health. It is, for instance, widely believed that mental ill-health cannot be treated or prevented. The worst social consequence of such false assumptions is the stigma of mental ill-health”. Here it is clear that “mental disorders” are meant, since it is them which carry the danger of stigmatization, while states of reduced psychological well-being are usually not stigmatized.

In two consensus monographs of STAKES (Lehtinen et al, 1997; Lahtinen et al, 1999) three concepts of “mental health” are distinguished: (1) the positive model, (2) the functional model and (3) the continuum model.

According to the *positive* model mental health refers to qualities such as life skills, the ability to manage changes and to actively influence the social environment, to positive self-esteem, assertiveness and enjoyment or a state of experienced well-being. These qualities are considered as values in themselves, not only as signs of absence of illness or disorder. This reminds one of the WHO (1948) definition of health in general, which, as stated already, is regarded as a state of “complete physical, psychological and social well-being and not merely the absence of disease or infirmity”.

According to the *functional* model, certain psychological qualities are considered protective (e.g. above average intelligence, good social competencies, well developed problem solving skills, internal locus of control orientation, high self esteem, feeling of coherence, close relationship with a parent who is responsive, a supportive social network). These factors can make it easier for people to stay healthy even during severely stressful times. According to this model mental health could be seen both as a protective factor (resilience), and as social capital. It is noteworthy that modern social psychiatry sees such factors as also present to a certain degree in persons suffering from mental disorders and regards them as healthy parts of their personality which are valuable for coping with their disorder and for their self-esteem.

The most traditional of the models, is called the *continuum* model in the STAKES report. It is in accordance with mainstream medical perspectives and in this model mental health and mental illness (or mental ill health) are seen as ends of the same continuum and mental health is defined as the absence of mental illness. By implication, the degree of mental health can be improved by reducing mental disorders. This model is opposed to the WHO (1948) definition of health, yet it is the favoured model within psychiatry (where the proper term would not be “continuum”, but “*discontinuum*” model - given the operational definitions with their clear borderlines).

Vaillant (2003) has recently pinpointed several pitfalls in research on mental health, such as equating average with healthy, failing to distinguish trait from state, and overlooking cultural norms. The most common pitfall is that different authors attach different meanings to the term “mental health”. Vaillant describes six such meanings, which in some sense differentiate the just described positive model (meanings 1 to 5) and coincide with the functional model (meaning 6). In projects of promotion of mental health several of these overlapping meanings can be found, and it is recommended to use Vaillant’s typology to know where one fits in (in the following descriptions Vaillant’s wording is partly directly used).

(1) Meaning one is “above normal”, represented somehow by the upper end of the Global Assessment of Functioning (GAF) Scale of DSM-IV (APA, 1994): “Superior functioning in a wide range of activities; life’s problems never seem to get out of hands; is sought out by others because of his or her many positive qualities; no symptoms”. As an example where this concept plays a practical role Vaillant mentions the selection of astronauts.

(2) A second concept of mental health implies “positive psychology” and is derived from Maslow’s (1970, 1971) concept of self-actualization and humanistic psychology. Optimism, self-efficacy, a positive cognitive style and future mindedness are ingredients of “positive mental health” in this view (Snyder and Lopez, 2002).

(3) The third model follows the concept of “adult maturity”, implying that greater maturity reflects greater mental health. In this concept mental health has different meanings in different life stages. Building on Erikson’s (1950) model of adult social development with the stages of identity, intimacy, career consolidation and generativity, Vaillant adds two more tasks to be accomplished in later life, namely “keeper of the meaning” and “integrity”, i.e. the task of achieving some sense of peace and unity with respect to one’s own life.

(4) “Social and emotional intelligence” is the content of the fourth meaning. It is the capacity to discern and respond appropriately to the moods, temperaments, motivations and desires of other people and includes accurate conscious perception and monitoring of one’s own emotions (Goleman, 1995; Gardener, 1993).

(5) The fifth meaning is mental health as “subjective well-being” which has an intuitive appeal as being *the* gist of positive mental health. There are several pitfalls though with this concept as outcome variable of activities of promotion of mental health. First, hypomanic, manic or dissociative states are correlated with subjective well-being but are not “healthy”. Also, after several decades of research on happiness and well-being it seems that subjective well-being has more effect on the environment than the environment exerts on it (Diener et al 1999). Finally, the concept of quality of life (see below) is intimately related to the concept of subjective well being (Katschnig et al 1997) and the question arises whether *quality of life* should be upheld as a concept which is different from the concept of *mental health*.

(6) The sixth meaning identified by Vaillant is mental health as “resilience”, which roughly corresponds to the “functional model” of the STAKES reports discussed above. It has to do with the coping mechanisms that humans use to overcome stressful situations. Three broad classes of such coping mechanisms can be distinguished: consciously seeking social support, conscious cognitive strategies that we intentionally use to master stress, and, finally, involuntary mental coping mechanism (often called “defense mechanisms” or “denial”).

Kovess and Beaudet (2001) provide a useful overview of instruments for measuring several of the above mentioned aspects of mental health.

DISABILITIES AND QUALITY OF LIFE AS COROLLARIES OF MENTAL DISORDERS AND MENTAL HEALTH

The concept of disability

Disabilities refer to deficits in functioning in daily life. Disabilities may be corollaries of diseases. However, they may also develop, although in a given person a symptom pattern does not qualify for a full disorder in an official classification system. Also, disabilities may persist although the disorder has disappeared. Thus, disabilities are partly independent from mental disorders and constitute an entity in its own right, deserving itself preventive activities.

As early as 1980 the WHO has published the International Classification of Impairments, Disabilities and Handicaps (ICIDH), whereby “impairment” relates to symptoms or impaired body functions, “disability” to impaired activities, and “handicap” to impaired social roles. In a major revision these “negative” terms were replaced by neutral ones. In the new “International Classification of Functioning, Disability and Health” (ICF, WHO 2002) “impairment” is replaced by “body functions and structures”, “disability” by “activities” and “handicap” by “participation”.

The most commonly used term to capture reduced functioning in daily life is still “disability”. When using this concept in an action oriented environment it is useful to distinguish three types of disabilities (Wing1963): Premorbid disability (present before illness onset), primary disability (impaired activity due to symptoms, e.g. thought disorders and depression which both disturb communication), and secondary disability, which arises due to ascribed roles, stigma, discrimination, hospitalism and self-stigmatization. Secondary disability is an important concept from the viewpoint of prevention, since many interventions are possible to reduce such secondary disability, which can be regarded as avoidable consequences of disease and would fall under the traditional concept of tertiary prevention (see below).

The “Global Burden of Disease” report (Murray and Lopez, 1996) shows that disabilities associated with mental disorders are comparable to those associated with physical disorders. In developed regions of the world, neuro-psychiatric conditions are the leading cause of disease burden, accounting for 22% of all “Disability Adjusted Life Years” (DALYs, a global measure for disability, which takes the duration of disability into account).

Table 5: Leading causes of disability-adjusted life-years (DALYs) in two World Health Organisation (WHO) regions (the Americas and Europe), estimates for 2000

DALYs	% total DALYs	% total
<i>The Americas</i>		
Unipolar depressive disorders	8.0	<i>Europe</i>
10.5		Ischaemic heart disease
Perinatal conditions	5.0	Cerebrovascular disease
6.8		
Violence	4.7	Unipolar depressive disorders
6.1		
Ischaemic heart disease	4.5	Alzheimer and other dementias
3.0		
Alcohol use disorders	4.3	Alcohol use disorders
2.9		
Road traffic accidents	3.2	Hearing loss, adult onset
2.6		
Cerebrovascular disease	2.8	COPD
2.4		
Congenital anomalies	2.5	Road traffic accidents
2.4		
Diabetes mellitus	2.3	Osteoarthritis
2.4		
Lower respiratory infections	2.3	Self-inflicted injuries
2.3		

Source: Üstün et al. 2004

Üstün et al (2004) have recently published a new analysis of DALYs for the 6 WHO regions in the year 2000. The results for the Americas and Europe are presented in table 5. In the Americas unipolar depressive disorders are the leading group in terms of being responsible for 8% of the total DALYs in that region, in Europe unipolar depressive disorder is third, followed by Alzheimer and other dementias (4) and alcohol use disorders (5); self-inflicted injury is at place 10. In sum: In Europe depression, Alzheimer and other dementias, alcohol use disorders and self-inflicted injuries account for nearly 15% of the total disability adjusted life years (DALYs) calculated for the European region of the World Health Organisation.

It is important to note that this analysis refers to all types of physical and mental disorders. Also the authors noted an increase from 1990 to 2000, when of the total number of years lived with disability (YLD) the percentage due to depression rose from 10.7% to 12.1%.

These results may help to make politicians and health administrators aware of the enormous importance of mental disorders, not only in terms of individual suffering, but also in terms of the societal burden which is finally reflected in enormous economic losses.

The concept of quality of life

Over the last two decades a new concept for non-medical aspects of diseases has emerged, the concept of quality of life (Katschnig et al 1997) . It is a neutral term, in contrast to “disability” and follows the trend already shown in the ICF above. As “Health related quality of life” it brings the subjective experience of persons suffering from specific disorders into the arena. For the field of mental health the best approach is to regard “quality of life” as a multidimensional concept, covering the three aspects of “subjective well-being”, “functioning” and “external resources”.

In some sense the quality of life concept understood in this way has many overlaps with “mental health”. Also here the term is used in a neutral fashion, designating a field of interest (with a plus and a minus pole, corresponding to good and bad quality of life), but also in a positive sense meaning per se a *good* “quality of life”. If it comes to measurement issues and empirical research, attention must be paid to many instruments used today, because there is often a “measurement overlap” between quality of life instruments and instruments measuring mental health or even mental disorders (Katschnig 1997; Katschnig and Angermeyer 1997).

PREVENTION OF MENTAL DISORDERS AND PROMOTION OF MENTAL HEALTH

Prevention of mental disorders

Among psychiatric clinicians and other mental health workers a certain reservation about the concept of prevention of mental disorders can be observed, let alone about the concept of promotion of mental health. While one reason for these doubts may be rooted in the lack of public health education among most clinicians, another reason might lie in the fact that in clinical practice treatment and prevention can often not be clearly distinguished. For instance, prevention of comorbidity and relapse prevention can also be regarded as treatment. Or: Since it is well established that anxiety disorders

are a frequent precursor of depression, the successful treatment of anxiety disorders can also be regarded as a measure for preventing depression.

The word prevention is derived from the Latin verb “*praevenire*”, which literally means to “arrive before someone or something else arrives” or “to act in anticipation of”. In Latin the word means “come before, anticipate, hinder”. (Preventive in the medical sense is recorded from 1646; Online etymology dictionary, <http://www.etymonline.com>.) In everyday language the term has received the connotation of acting in order to avoid something or to keep something undesirable from happening – in a general sense (such as a fire, an accident, an economic crisis) or in a more personal and situational sense (such as a pregnancy). Such preventive interventions can be of a structural nature (i.e. building safer cars or safer roads in order to prevent accidents) or directed towards individual persons or subgroups of persons (such as teaching better driving).

Logically, prevention means to reduce the risk that an undesirable event occurs. Usually this means that the risk factors which contribute to the occurrence of the undesirable event are known and also the factors which are protective. The increased risk for an undesirable event results from the interplay between risk and protective factors, and all preventive interventions must either reduce risk factors or increase protective factors. These risk and protective factors can be specific for a certain disease, or “general” in the sense that they refer to several diseases or to disease in general. Activities called “promotion of health” (see below) can be regarded as strengthening “general” protective factors.

In relation to diseases two meanings of prevention can be distinguished: a disease can be either prevented from developing at all, or one can prevent a disease from getting “worse”. The first concept is theoretically clear and has its basic example in the paradigm of immunisation/inoculation against infectious diseases. The second concept, to prevent a disease from getting worse or lasting longer than necessary, can mean (1) to treat it as early as possible (if effective treatments are available); in order to do this one would have to a) provide the therapeutic resources for those cases which have already been detected and diagnosed and b) detect undiagnosed cases as early as possible and treat them appropriately; preventing a disease from getting worse can also mean (2a) to tackle risk factors which make the disease worse (including iatrogenic ones, such as hospitalism and malpractice), which lead to negative consequences (like disabilities), or contribute to relapse, or (2b) vice versa, to use empirically proven interventions which prevent such negative consequences (such as relapse prevention in bipolar disorder through lithium).

While these basic possibilities for the prevention of diseases are quite clear-cut, the existing terminologies and classifications for these different types of interventions are not consistent and not consistently used. One classification is the traditional classification of “primary”, “secondary” and “tertiary” prevention, another one is the classification of “universal”, “selected” and “indicated” prevention. These different classifications do overlap to some degree, but are by no means identical.

The „primary, secondary and tertiary“ (P-S-T) concept of prevention is clearly related to a temporal perspective, i.e. these different concepts apply to specific stages before or during the development of a disease. The classification of “universal, selective and indicated” (U-S-I) prevention is related to both a temporal perspective and the target populations (universal and selective prevention are aimed at people who are not yet ill,

the first group being the general population, the second group being persons with high risk factors; indicated prevention being directed at persons who have already symptoms).

The “primary – secondary – tertiary prevention” classification (P-S-T)

In the World Health Report on Mental Health of the WHO (2001, p.64), primary prevention is equated with prevention in the proper sense, i.e. the prophylaxis of an illness. Astonishingly, secondary and tertiary prevention, have little to do with the common understanding of the term prevention, since secondary prevention is equated with treatment and tertiary prevention with rehabilitation. This goes back to a suggestion by the US Commission on Chronic Illness (1957). There prevention was classified into primary, secondary and tertiary prevention, whereby primary prevention was defined as prevention in the proper sense, i.e. the reduction of the incidence of a specific illness; secondary prevention as the reduction of the prevalence of an illness, and tertiary prevention as the reduction of the amount of disability resulting from a specific illness (see also Leavell and Clark 1965).

Building on these definitions and considering the types of preventive activities discussed above it is suggested here to use the concepts of primary, secondary and tertiary prevention in the following way:

Primary prevention = reducing the incidence of mental disorders by eliminating/reducing risk factors and/or strengthening protective factors (the latter also by actions/interventions conceived of as “promotion of mental health”)

Secondary prevention = reducing the prevalence of (already existing) mental disorders by appropriate treatment of known cases, but mainly - and more to the point of the concept of prevention - by detection of unknown cases and their appropriate treatment, especially by early detection of beginning disorders and early treatment (e.g. inpatients in general health services, such as primary care or general hospital wards - a specific example would be post partum depression)

Tertiary prevention = reducing the incidence and prevalence of “complications” of already existing disorders by preventing the development of disabilities and relapses (reduction of incidence), and by rehabilitation concerning existing disabilities (reduction of prevalence)

It is commonplace that, the further we come down this list, the more evidence based strategies are available (e.g. detection and early treatment by general practitioners of persons suffering from depression; relapse prevention in bipolar disorders; preventive work with high expressed emotion family members of persons suffering from schizophrenia).

In appendix 1 examples are provided for each of these types of prevention.

The “universal-selective-indicated prevention” classification (U-S-I)

Gordon (1987) has suggested a different classification for preventive activities for physical illnesses, which was adopted by the Institute of Medicine’s (IOM) Report on “Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research” (Mrazek & Haggerty 1994, from whom we are quoting here). It was based on the assumption that prevention of disorders and promotion of health are feasible without fully understanding causal mechanisms but by only observing empirical relationships. The classification relates to the *populations targeted* by preventive activities and comprises three types of preventive measures: “universal”, “selective” and “indicated”. In “universal” preventive programmes the general population is addressed; an example is prevention of smoking. “Selective” preventive measures are directed towards individuals who belong to a subgroup whose risk of becoming ill is above average, e.g. malaria prophylaxis for persons intending to travel into specific countries. In both “universal” and “selective” prevention the intervention is directed towards persons who are well.

In contrast, “indicated” prevention applies to persons who individually have been identified as having a risk factor, condition or abnormality that identifies them as being at high risk for the future development of a disease (e.g. individuals with already high blood pressure). Since the transition to a real disease is only probable, “indicated” interventions pose an ethical problem, because these interventions might be costly and also potentially harmful to the individuals concerned. These “risk factors, conditions or abnormalities” can also be seen as early symptoms (e.g. in a recent development in schizophrenia prevention, where early recognition is now promoted). This strategy would be subsumed above under “secondary prevention”.

The Institute of Medicine (IOM) has taken over Gordon’s classification but has made an important change to the definition in the just mentioned sense: Indicated prevention also concerns individuals with early symptoms and not only those with markers (Mrazek & Haggerty 1994).

Table 6: Cross tabulation of the P-S-T and U-S-I prevention classification

		Target group		
		Universal	Selective	Indicated
Temporal perspective	Primary	√	√	-
	Secondary	-	√	√
	Tertiary	-	-	-

In table 6 these two classifications are cross tabulated. It shows that primary prevention can be universal or selective (in the latter case if higher than average risk populations are selected for the primary preventive measure), secondary prevention corresponds to indicated prevention in the case of persons already known as suffering from symptoms (which, however, do not yet fulfil diagnostic criteria) but may also be subsumed under “selective” prevention in the case of screening for mental disorders among patients in general health services who are known to have a raised risk for mental disorders, which are often not detected in routine care (see above). Tertiary prevention has no

correspondence in the U-S-I system (unless one regards persons who are defined by an already existing illness as a target group for indicated prevention).

Effectiveness of prevention

Prevention programmes must also fulfil a number of criteria in order to have a chance to work: they must be effective (usually this means that the risk and the protective factors are known and that proven interventions exist; for an overview of the risk and protective factors of the most important mental disorders see Mrazek and Haggerty 1994); they must be cost effective, they must be acceptable to the targeted persons and they should have no negative effects (which would pose an ethical problem).

Concerning the effects of prevention programmes on the incidence of new cases of mental disorders Cuijpers (2003) has argued that “about 1000 controlled studies have examined the effects of mental health programs aimed at preventing mental health problems at school, substance use and abuse at school, work-related stress, distress among caregivers for the elderly, depression, aggression and behaviour problems in children, child abuse, and several other conditions. This considerable body of research has shown that some prevention programmes in mental health are capable of strengthening protective factors, such as social skills, problem solving skills, stress management skills, prosocial behaviour, and social support; that these programmes can reduce the consequences of risk factors, psychiatric symptoms and substance use; that they may have positive economic effects. Despite this large body of research, few studies have examined whether these prevention programmes are actually capable for reducing the incidence of new cases of mental disorders”. Furthermore, Cuijpers argues that one major reason why the prevention of new cases of mental disorders has hardly been examined is that very large numbers of subjects are needed to yield sufficient statistical power to be able to show significant effects on incidence. He states that this “power problem” is related to the lack of understanding of the exact pathways leading to mental disorders and to the very low specificity of most known risk factors, which implies that most subjects who are exposed to risk factor do not develop the disorder and that one such risk factor by itself is not sufficient to produce the disorder. In order to increase the statistical power in prevention research Cuijpers suggests (among other measures) to focus on populations with high incidence rates of mental disorders by concentrating on indicated prevention, on high risk groups with multiple risk factors and on target groups with multiple disorders.

Jané-Llopis et al (2003) draw somewhat less pessimistic conclusions in their meta-analysis of predictors of efficacy in depression prevention programmes. Also a project supported by the European Commission on mental health promotion and prevention strategies for coping with anxiety, depression and stress related disorders in Europe comes to a more optimistic conclusion laid down in ten key recommendations referring to children, working adults and old people (see Annex 2).

Anyhow: Preventive programmes aimed at primary prevention of mental disorders may have effects also if they finally do not prevent the development of a disease: they may delay the onset, i.e. they reduce the short term incidence of new cases. E.g., mothers who might become depressed while they have small children (which would be harmful to the children) might become depressed later on and then their depression might at least not be harmful to their children anymore. Also, delaying the onset of Alzheimer’s disease means delay in stress and reduction of problems of caregivers. Finally primary

preventive interventions while not preventing the disease from developing may render a disease less severe or shorten its duration.

Promotion of mental health and promotion of quality of life

Concerning the prevention of mental disorders the concept of “promotion of mental health” has its logical place as a way of strengthening the resilience of an individual against the development of mental disorders. In this sense “promotion of mental health” can be regarded as part of “primary prevention of mental disorders”.

While this use of the concept of promotion of mental health is probably acceptable to a wide range of mental health professionals, a more general use in the sense of increasing mental health above a kind of medium level is more debatable. Mental health would be equated in this sense with well-being or good quality of life, and this use approaches more the aims of politics in general in western democracies where repeated elections urge politicians to promise a better life. One of Lyndon B. Johnson’s election speeches is often quoted as being the historically first example of using the concept of quality of life in politics: "Goals cannot be measured by the size of our bank account. They can only be measured in the quality of lives that our people lead." After all, the “pursuit of happiness” is written into the Declaration of Independence as one of the “unalienable rights” of people. The concept of quality of life is only a different way of expressing happiness, well-being and positive mental health.

On a more technical level, the suggested general measure for the promotion of mental health include both structural, i.e. community oriented measures and interventions aimed at individuals or groups of individuals. The former comprise programs of creating healthy communities or healthy organizations (such as healthy hospitals, healthy companies), the latter include educational programs aimed at groups of people, e.g. in schools or in the workplace. The aim of such interventions are increasing positive mental health as outlined in the STAKES reports (Lehtinen et al 1997, Lahtinen et al 1999), by Vaillant (2003) and by Kovess and Beaudet (2001) and improving functional capacities of the individual to cope with stress (resilience).

Recommendations for activities on the European level, presented in detail in the following, underline the need for R&D activities such as policy surveys, mental health monitoring and assessment of mental health promoting programmes; specific practical efforts; and the need to foster European co-operation in mental health issues (Lahtinen et al 1999).

The STAKES reports provide a comprehensive list of suggested activities of “promotion of mental health”, which are quoted here from Lahtinen et al (1999).

- *Enhancing the value and visibility of mental health*

- Establishing large scale public information campaigns on mental health
- Starting mental health impact evaluation in all administration
- Identifying EC action linked with mental health and providing a supportive information exchange capacity
- Integrating mental health aspects to all health promotion programmes
- Including mental health instruction in school education thoroughly
- Emphasising mental health in all professional training

- *Empowerment, participation and Information Society*

Enhancing participatory, community-based mental health promotion
 Raising awareness concerning strengths-based approaches and effective forms of self- and peer-help.
 Establishing innovative projects to develop ‘good telematic content’ and ‘good telematic interfaces’
 Evaluating the risks of marginalisation resulting from increased use of information technology
 Reorienting mental health services and promotion in line with the developing Information Society
 Setting up a network focusing on the telematics of social inclusion and mental health promotion.

- *Towards mental health promoting working life*

Raising employers’ awareness of the importance of mental health and its promotion in the work place
 Disseminating information on practices in work place mental health promotion, e.g. by
 Identifying common goals and enhancing the positive aspects of the work process and environment
 Recognising the balance between job demands and occupational skills
 Enhancing social skills training and possibilities for collaboration and joint opportunities
 Developing the psychosocial climate at the work place
 Providing counselling for special groups, e.g. carried out before organisational or other changes
 Applying strategies focusing on enhancement of working capacity and early rehabilitation’

- *Unemployment, underemployment and re-employment*

Evaluating comprehensively real effects of unemployment
 Preventing stigmatisation of unemployment
 Supporting re-employment through job creation
 Supporting re-employment by developing the physical and mental resources of the unemployed
 Searching actively intermediate statuses between work and unemployment
 Developing multimodal programmes focusing on unemployment leading to marginalization

- *Support and protection of children, young people and families with children*

Developing written strategic plans on promoting the mental health of children and young people
 Increasing knowledge of the pathways leading to healthy development or marginalisation
 Collecting data on the extent of child exploitation and creating protection for the children affected
 Sharpening the focus on children’s needs in all health promotion programmes targeted at adults

Focusing on self-esteem, non-violent behaviour; and good communication and social skills in education
 Collecting and disseminating information on programmes supporting early parent-child interaction

- *Enhancing quality of life of elderly people*

Preventing stigmatisation of old age and discrimination of elderly people
 Supporting independent living by policy and programme measures
 Developing programmes promoting self-support by intellectual and physical measures
 Developing effective and feasible measures of preventive action

- *Promoting mental health of alcohol and drug abusers*

Developing measures focusing on prevention and reduction of combined substance abuse
 Developing tolerant services for mentally ill intoxicant users who are out of the scope of rehabilitation efforts
 Supporting research and development regarding the co-occurrence of intoxicant misuse and psychiatric disorders

- *Supporting research and development*

Emphasising transnational comprehensive evaluation of activities in promotion of mental health
 Emphasising long-span implementation research looking at factors associated to effectiveness and at quality
 Establishing mental health policy surveys and a policy data base
 Studying and developing the role of health care and social services in promotion of mental health
 Enhancing information exchange between the researchers, administrators and implementers
 Emphasising dimensions with European relevance like equity, participation and experienced quality in all R&D action

- *Development of information and dissemination systems concerning mental health*

Establishing a comprehensive mental health monitoring system by e.g.
 Collecting information on existing mental health indicators and their definitions
 Collecting information on existing mental health information systems and analysing their quality, coverage and validity
 Developing a mental health monitoring system for the use of the Member States and the Commission
 Testing the dimensions of the mental health monitoring system in pilot projects
 Establishing a high-capacity network for the collection, dissemination and analysis of relevant information

The IOM report “Reducing risks for mental disorders” (Mrazek and Haggerty, 1994) out rightly renounces to discuss at any length the issue of “promotion of mental health”. The report states though that enormous amounts of money are spent publicly and

privately in so-called mental health promotion programs, but the evidence that they achieve their goal is inconsistent, not the least because the definitions of what mental health is varies a lot among these programs. The IOM report, though, outlines a lengthy research agenda on the topic, but one wonders how this can be ever accomplished.

CONCLUDING REMARKS

There are different degrees of evidence supporting the discussed concepts and actions. While health and quality of life, as well as promotion and prevention, have more positive and optimistic connotations than disease, disability, treatment and rehabilitation, the latter are clearly more evidence based than the former. Concepts with a positive connotation (promotion, health, quality of life) are important from a PR perspective, for the self-esteem of persons affected by mental disorders, and from an EU policy perspective, but they are vaguer than the negatively tainted concepts of disease, disability, treatment and rehabilitation. The concept of prevention lies in between in both aspects: it is less vague than the concept of promotion and it still carries a positive connotation: If it is expanded from primary prevention, to also meaning secondary and tertiary prevention, than it brings a positive aspect to the field of disease and disability. We suggest to concentrate the always scarce resources on the elaboration of the field of prevention of mental disorders and the related disabilities, not forgetting at the same time that activities of promotion of mental health and of quality of life should become an integral part of a mental health care system which emphasises the participation of citizens and their empowerment.

Appendix 1

Examples for primary, secondary and tertiary prevention of mental disorders (from Katschnig et al 1999)

Primary prevention

A recent report “Primary Prevention of Mental, Neurological and Psychosocial Disorders”, published by the World Health Organization (1998b), emphasises that the primary prevention of mental and neurological disorders often falls outside the usual remit of mental health professionals (often outside the health sector altogether – involving legislators, the media and many others). The report discusses the primary prevention of mental retardation, epilepsy, suicide and burn-out in health workers/care givers– conditions with a high incidence or prevalence; connected with substantial impairments, disabilities and handicaps to the individual and burden to others and for which efficient measures exist. Judging from the large number of pages devoted to mental retardation (46 of 102), this is the condition for which the best empirical basis is available for primary prevention. The reader is referred to the WHO report which provides an elaborate discussion on the primary prevention of the four mentioned disorders. In pointing out possible areas for primary prevention, the following discussion goes beyond these four examples, but cannot present its examples in the same depth.

A certain proportion of cases of organic brain disorder and mental retardation are consequences of physical disorders or trauma (such as malnutrition; infectious diseases which affect the brain, e.g. measles encephalitis; road accidents). The prevention and adequate treatment of these physical disorders constitutes a primary preventive activity for psychiatric disorders. Examples are:

- immunisation of women against viral infections,
- improvement of maternal care during pregnancy and delivery, including education about the detrimental effects of cigarette smoking and alcohol,
- screening for inborn metabolic disorders in new-born infants (e.g. for phenylketonuria), in order to prevent brain damage.

In a few instances (e.g. Huntington’s chorea), genetic counselling can be regarded as a primary preventive strategy, although this has complex ethical implications. Prevention of cerebrovascular disorders by reducing tobacco smoking and hypertension is another example.

There is no firm evidence that preventive psychosocial actions in childhood have a sizeable effect on the reduction of the incidence of non-organic adult psychiatric disorders (such as anxiety, mood disorders and schizophrenia). Targets suggested for such interventions include child abuse which seems to be linked (among others) to later post traumatic stress and borderline personality disorders. Since abused children, when parents themselves (often at a very young age), have increased likelihood of repeating their parents’ behaviour (towards themselves in the past), intervention programmes might be effective in this risk group. Psychiatrically ill parents are also discussed as a possible target group for behavioural interventions aimed at the prevention of mental disorders in their children. Finally, it has been shown that emotional and behavioural problems in children after parental divorce, school changes or stressful medical

procedures, may be prevented by intervention programmes. It is unclear though, whether such interventions prevent adult psychiatric disorders.

It is now clear that traumatic events in adulthood can lead to severe psychiatric disorders. Post traumatic stress disorder is prototypical of these disorders, but anxiety and mood disorders also have a raised incidence after traumatic events. Awareness of the possibility of the development of these psychiatric consequences after traumas as diverse as traffic accidents, rape, sudden death of a loved one or natural disasters, and early help with coping with the trauma, might reduce the incidence of later psychiatric disorders.

Suicide is another possible target for primary prevention. Suicide rates vary from country to country, but even in countries with low to average rates, the total numbers of deaths are very high, often exceeding deaths from road traffic accidents. An essential strategy for preventing suicides is the early recognition and early treatment of the large number of psychiatric disorders with a raised suicide risk. Disorders belonging to this group are anxiety disorders, depression (including the recurrent and the bipolar form, and also depression in the elderly, especially elderly men), substance abuse and schizophrenia. A number of Governments, including Finland, Norway, Sweden and the UK have begun to construct national strategies to tackle suicide. Suicide strategies need to be cross-departmental or pan-governmental as a range of sectors are involved, not only health agencies. Suicide reduction strategies need to be multi-factorial in approach and include several core elements:

- educating primary and secondary health and social care professionals about the assessment and management of suicidal risk,
- supporting high risk occupational groups (these will vary but may include groups such as doctors, nurses, farmers, vets and pharmacists),
- reducing access to the means of suicide (e.g. safety measures relating to weapons and medicines),
- auditing all suicides to learn the lessons for prevention,
- research into causes and effective prevention,
- working with the media to ensure more responsible reporting of suicides.

For the prevention of alcohol and drug abuse, early recognition and treatment of anxiety and mood disorders seems to be essential (given the high co-morbidity).

The debate whether violence can be prevented, by reducing violent features in the media and the availability of weapons, is not yet settled and further research is necessary. The effect on violent deaths and suicides of recently introduced new legislation in some European countries should be studied. The reduction of violent acts by psychiatric patients living in the community is more a matter of the provision of adequate specialised services, dealt with in this report under the heading of tertiary prevention.

Secondary prevention

Psychiatry has made tremendous advances in its ability to diagnose reliably, and adequately treat, mental disorders. New pharmacological, psychotherapeutic and socio-therapeutic techniques have been developed over the past forty years and the principal efficacy of most of these treatment methods is now beyond doubt. What remains unresolved is the task of bringing such treatments to those who need them, both at an early stage and once a disorder has fully developed, i.e. the effectiveness of these treatments in whole populations is still not achieved.

One reason for this deficiency is the delay in receiving adequate professional help for mental disorders at an early stage. This is mostly due to:

- lack of knowledge
- fear of stigma
- geographical, temporal and financial inaccessibility of services
- legal factors and
- disorder related lack of insight (in psychotic disorders).

Lack of knowledge and fear of stigma are the most important barriers to early recognition and early treatment. Recent surveys of the general population in Austria, Germany and Australia have shown that, among the general public, there is still a tremendous lack of knowledge about the nature and possibilities to treat mental disorders (Jorm et al 1999). Such low "mental health literacy" has especially unfavourable consequences for professionals who deal with large numbers of people at risk of mental disorders (such as teachers or the police). Psycho-educational strategies should aim to provide relevant information about mental disorders and their treatment, educating people to recognise the secondary effects of medications and treatments, or identify symptoms at an early stage of a developing disorder by:

- teaching teachers to recognise social phobia in teenage school children,
- developing better understanding of schizophrenia, which usually develops in the late teens or early twenties,
- highlighting the difference between transient depressive reactions and depressive illness,
- antenatal education about postnatal depression .

One of the most powerful psychological factors preventing help-seeking at an early stage is the stigma attached to mental disorders and to those using psychiatric services. The phenomenon of stigma is partly related to lack of knowledge, but cannot be reduced to cognitive factors.

There are two strategies to deal with the effect of stigma on the delay of help-seeking. One is the reduction of stigma by complex measures, ranging from anti-stigma campaigns in the media, educational campaigns among school children and the inclusion of mental disorder issues into school curricula, at both primary and secondary level, to the reduction of financial discrimination of psychiatric services and the reduction of legal discrimination of psychiatric patients. Anti-stigma campaigns have to include not only education but also go beyond cognitive aspects to consider emotional factors, such as fear. The World Psychiatric Association is currently carrying out a schizophrenia anti-stigma campaign along these lines.

The second strategy is the establishment of low-threshold and non-stigmatising points of entry to professional help. It is generally agreed that general practitioners are the optimal point of entry for this purpose, in non emergency situations. Since patients admitted to non-psychiatric services in general hospitals have a risk (up to 30%) of suffering from mental disorders, the establishment and extension of psychiatric consultation/liason services is an important means of early recognition and treatment of patients suffering from mental disorders. Specialised services for psychiatric emergencies and crises should be available around the clock and geographically easily accessible. They should be based in general hospitals, with crises beds, day-patient, out-patient and mobile components.

Next to educating the public and reducing stigma, the single most effective measure for secondary prevention of high prevalence mental disorders is to educate, support and resource primary care physicians and services. Epidemiological studies show that large proportions of patients attending primary health care services suffer from anxiety disorders, depression and alcohol problems. Co-morbidity between these disorders is high, early recognition and adequate treatment of one of them may prevent the development of the co-morbid condition.

Typically, anxiety disorders – if not recognised and treated adequately – may lead to alcohol abuse on the one hand (alcohol being an effective anxiolytic agent) and to depression on the other. Depression, in turn, may lead to alcohol abuse, and alcohol abuse, with its many associated psychosocial problems, may lead to depression. A recent WHO multi-site study across the world showed that in both developing and developed countries, around one third of patients presenting in primary care suffer from these psychiatric problems, and that the most common of all chronic disorders (physical or psychological) is depression (Sartorius et al 1996). Even more remarkable, and cause for alarm, is the finding that only every second of these patients was recognised as suffering from a psychiatric disorder by the primary care physician, even fewer were offered treatment.

Primary care physicians must be trained to assess, diagnose and manage these common mental disorders, including how and when to refer to specialists. This means ensuring adequate attention to common mental disorders during the undergraduate, postgraduate and continuing education of doctors. Primary care physicians need to maintain close links with specialist psychiatric services so that they can access regular support for their work and feel confident about their ability to refer more severe and complex disorders.

While it is important that primary care physicians recognise all psychiatric disorders at an early stage, the common lack of resources suggests concentration on anxiety disorders, depression and alcohol in a first stage. For public health, this restriction is also justified because these disorders are by far the most prevalent, create a substantial amount of disability and have effective intervention strategies linked to them. Primary care physicians should certainly also be able to recognise eating disorders, obsessive compulsive disorders, schizophrenia, mania, drug dependence, dementia and others at an early stage of their development. These disorders are far less prevalent, however, and for some the link between mild manifestations and development of the full disorder is less clear. For instance, it has recently been shown that mild cognitive impairment is not necessarily a precursor of dementia.

Tertiary prevention

The concept of tertiary prevention is used in a broad sense here. It includes not only the prevention or reduction of disabilities and improvement of the quality of life of patients suffering from mental disorders and their families, but also the reduction of the duration of the disorder by adequate treatment and the prevention of relapse.

Personality disorders, schizophrenia, bipolar disorders, treatment resistant depression and anxiety disorders, mental retardation and substance abuse are the most relevant disorders – but not the only ones, by far - for tertiary prevention. In order to prevent the development of disabilities and to improve quality of life, reduce the duration of the disorder and the risk of relapse, these disorders require the provision of psychiatric services according to the principles of modern community psychiatry, such as

continuity of care, co-ordination, empowerment and inclusion of the family. In short, the development of comprehensive local specialist health and social services is necessary, where an adequate provision for active co-operation is offered to those affected by mental disorders and their families.

For many countries, appropriate legal and financial provision has to be made in order to guarantee the implementation of these principles – for some this will mean fundamental legal changes and changes in the system of financing health care.

Countries vary in their capacity to resource a comprehensive range of specialist local health and social services, and even the richest will never be able to afford sufficient psychiatric specialists to deal with all mental health problems. There must, therefore, be an appropriate balance of specialist and primary care services to allow specialist services to target those with the greatest needs.

Research has demonstrated the long term damage caused to health and social functioning by prolonged institutionalisation. Most countries are attempting to care for people with severe mental illness in their own homes or in homely environments, as close to home as is compatible with the health and safety of the patient and the safety of the public.

In many regions the principal resource is still a large psychiatric hospital, often remote from much of the population it serves. In this situation, efforts are needed to start outreach community clinics. The hospital resource should be used as imaginatively as possible, for example, for people with long term severe mental illness: creating half way houses from existing buildings on the site which may not presently be used to best effect.

Functional needs, which should be met in people with severe mental illness, are food, housing, health care, leisure activity, occupation, family relationships and social networks. The structures which are put in place to satisfy those needs depend on the resources available. The involvement of the local community is essential, and often the only possible resource, but its ready availability to people with mental illness depends on the extent to which stigma is attached to people with mental illness and those who care for them.

Some countries and regions already provide local comprehensive services, including:

- crisis intervention services with outreach teams, telephone hot-line and crisis beds
- acute beds in general hospitals for episodes of acute and severe illness,
- 24 hour nursed long stay accommodation, in homely units, for people with enduring severe mental illness needing regular supervision of medication and daily monitoring of their mental state, but not requiring continuous presence of medical staff,
- supported housing,
- domiciliary services,
- opportunities for daytime activities,
- occupational rehabilitation services.

De-institutionalisation and re-integration are especially important in Europe for those patients who have spent a long time in large institutions. Rehabilitation programmes

including prevocational and vocational services, hostels, foster families and the like should be promoted.

Multidisciplinary teams are needed to care for clients in hospital, residential and home settings. The term “community care” should therefore be taken to refer to a range of local services including in-patient care as well as support at home. Round the clock medical and nursing care will always be required for those in acute episodes of very severe illness, and a small group of people will need continuing nursing care for many years.

Health professionals (doctors, nurses, psychologists and occupational therapists) will have to work closely with social workers, voluntary workers, advice and housing workers, probation officers, the police, and other relevant agencies to ensure proper co-ordination of care. Police officers, for example, should know how to deal with a deluded psychotic patient and how to connect with the community psychiatric service.

All efforts should have the basic aim of providing a decent quality of life – including as extensive autonomy as possible - to all patients, including the severely disordered, and their families. Patients should occupy the least restrictive slot in the system, which is often the most cost effective.

Advocacy and self-help groups should be encouraged and supported. “Empowerment” and “participation” of patients and their families, both in planning services and in managing psychiatric disorders on a daily routine basis, should become a guiding principle.

References

American Psychiatric Association (APA): Diagnostic and Statistical Manual of Mental Disorders – 4th edition (DSM-IV). American Psychiatric Press, Washington 1994 (Third edition revised –DSM-III-R, 1987).

Commission on Chronic Illness: Chronic Illness in the United States. Vol I. Harvard University Press, Cambridge MA 1957 (quoted in Mrazek PJ, RJ Haggerty, National Academy Press, Washington DC 1994)

Cuijpers P.: Examining the Effects of Prevention Programs on the Incidence of New Cases of Mental Disorders: The Lack of Statistical Power. American Journal of Psychiatry; 160(2003)1385-1391

Diener E., E.M. Suh, R.E. Lucas, H.L. Smith: Subjective well-being: three decades of progress. Psychol Bull 125(1999)276-302

Erikson E.: Childhood and Society. WW Norton, New York 1950

Gardner H.: Multiple Intelligences: The Theory in Practice. Basic Books, New York 1993

Goleman D.: Emotional Intelligence. Bantam Books, New York 1995

Jané-Llopis E., C. Hosman, R. Jenkins, P. Anderson : Predictors of efficacy in depression prevention programmes. Meta-analysis. British Journal of Psychiatry 183(2003)384-97

Leavell H.R., Clark H.G.: Preventive medicine for the doctor in his community: an epidemiological approach, 3rd edition. McGraw-Hill Book Co., New York 1965

H. Katschnig: Psychiatry and Sociology. In: N. J. Smelser and P. B. Baltes (eds.): 2001 International Encyclopedia of the Social & Behavioral Sciences, Volume 8. Pergamon, Oxford; pp 12277-12283.

Katschnig H., H.F. Baro, M. Bauer, G.N. Christodoulou, B. Ivarsson, R. Jenkins, M. Kastrup, V. Lehtinen, M. Naiditch, J.G. Sampaio-Faria, A.H. Schene, M. Tansella, J.L. Vazquez-Barquero, Wash.: Priority Topics for Public Mental Health in Europe. Chapter 9, in: Weil O., M. McKee, M. Brodin, D. Oberlè (eds.) Priorities for public health action in the Europ. Union. Société française de santé publique (1999) pp.103-121

Katschnig, H., H. Freeman, N. Sartorius (eds) Quality of Life in Mental Disorders. John Wiley & Sons, Chichester 1997, second edition in press.

Katschnig H.: How Useful is the Concept of Quality of Life in Psychiatry. Chapter 1 in: Katschnig, H., H. Freeman, N. Sartorius (eds) Quality of Life in Mental Disorders. John Wiley & Sons, Chichester 1997, second edition in press.

Katschnig, H., Angermeyer M.C.: Quality of Life in Depression. Chapter 11 in: Katschnig, H., H. Freeman, N. Sartorius (eds) Quality of Life in Mental Disorders. John Wiley & Sons, Chichester 1997, second edition in press.

Kessler R.C., P. Berglund, O. Demler, R. Jin, D. Koretz, R. Merikangas, A.J. Rush, E.E. Walters, P.S. Wang: The Epidemiology of Major Depressive Disorder. Results from the National Comorbidity Survey Replication (NCS-R) JAMA 289(2003)3095-3105

Kessler, R.C., K.McGonagle, S.Zhao, C.B.Nelson, M.Hughes, S.Eshleman, H.U.Wittchen, K.S.Kendler Lifetime and 12-Month Prevalence of DSM-III-R. Psychiatric Disorders in the United States. Archives of General Psychiatry 51(1994) 8-19.

Kovess V., M.P. Beaudet : Concepts and Measurement of Positive Mental Health. Psychiatria Fennica 32(2001)Suppl.2,14-34

Lahtinen, E, V.Lehtinen, E.Riikonen, J.Ahonen: Framework for promoting mental health in Europe. Stakes, Helsinki 1999

Lehtinen, V., E.Riikonen, E.Lahtinen (eds): Promotion of Mental Health on the European Agenda. STAKES, Helsinki 1997.

Maslow, A.H.: Motivation and Personality (2nd ed.) Harper and Row, New York 1970

Maslow, A.H.: The Farthest Reaches of Human Nature. Viking, New York 1971

Mrazek P.J., R.J. Haggerty: Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. National Academy Press, Washington, DC, 1994

Murray, C.J.L., A.D.Lopez: The Global Burden of Disease in 1990: Final results and their sensitivity to alternative epidemiological perspectives, discount rates, age-weights and disability weights. In: Murray, C.J.L., A.D.Lopez (eds.) The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected to 2020. Harvard University Press, Cambridge 1996, pp 247-293.

Narrow W.E., D.S. Rae, L.N. Robins, D.A. Regier: Revised Prevalence Estimates of Mental Disorders in the United States. Archives of General Psychiatry 59(2002)115-123

Snyder C.R., S.J.Lopez: Handbook of Positive Psychology. Oxford University Press, New York, 2002

Üstün T.B., J.L. Ayuso-Mateos, S. Chatterji, C. Mathers, C.J.L. Murray: Global burden of depressive disorders in the year 2000. British Journal of Psychiatry 184(2004)386-392

Vaillant George E: Mental Health. Am J Psychiatry 160(2003)1373-1384

Wing JK: Rehabilitation of psychiatric patients. Brit J Psychiatry 109(1963)635-641

World Health Organization : World Health Report 2001 : Mental Health – New Understanding, New Hope. Geneva 2001

World Health Organization: Constitution of the World Health Organization. Basic Documents, Geneva 1948.

World Health Organization: The ICD-10 Classification of Mental and Behavioural Disorders. Chapter F. Geneva 1992

World Health Organization: Towards a Common Language for Functioning, Disability and Health ICF. Geneva 2002

J. Czeslaw Czabala, Institute of Psychiatry and Neurology, Poland

Response 1: Implementation of National Mental Health Promotion Programme; the Case of Poland

Professor Heinz Katschnig presented an excellent overview of the current state of art on mental health promotion and prevention of mental disorders. It is quite clear from his presentation and from the literature that we know a lot about the concepts, mental health indicators, the good practices in the field, and about the policy. What we need now is the implementation of the policies into the practice in the European countries. In some of the countries such an implementation has already been started. Let me give you an example from Poland.

RECOMMENDATION ON MENTAL HEALTH PROMOTION

The Polish Government in 1996 adopted the recommendation on mental health promotion which is based on the Mental Health Act, issued by the Polish Parliament in 1994. The main goals of mental health promotion have been specified as:

- Promotion of knowledge on the importance and conditions of mental health development and its maintenance;
- Development of the institutions facilitating consultation, counselling, and early interventions;
- Building of the environmental conditions, supporting development and maintenance of mental health.

The main activities aimed on the achievement of these goals should include the following strategies:

1. Development of appropriate knowledge and skills in the society, needed for self-development and self-actualisation, coping with stress and environmental demands.
2. Development of and introducing educational curricula in schools, aimed at enhancement of problem solving problem skills and coping with stress.
3. Development of educational programs on mental health promotion and their introduction into the curricula of under- and postgraduate training of professionals involved in teaching and upbringing, treatment and care provision, re-socialisation and rehabilitation, management and organisation.
4. Introduction of educational programs in work places, enabling the development of healthy relationships.
5. Providing different forms of psychological, educational, marital and family counselling, vocational guidance, etc., as well as improvement of such services provision in the hitherto existing facilities, such as for e.g. child guidance clinics or social welfare units.

6. Providing psychosocial support for children and adolescents who are at risk of mental ill-health.
7. Organising and promoting the development of various forms of social support, especially self-help groups, for people with mental disorders.
8. Establishing of crisis intervention centres for people suffering from emotional crises and for families experiencing difficult life situations.
9. Establishing of provincial and communal centres providing counselling, guidance and psychosocial support to people at risk for mental health.
10. Providing professional training for those professionals who are involved in mental health promotion, counselling and other psychosocial support.
11. Support for research on psychosocial factors promoting enhancement and maintenance of mental health, and on factors detrimental to mental health.

The National Council on Mental Health Promotion was appointed by the Ministry of Health in 1998 to supervise and monitor the mental health promotion policy, mental health program development and its implementation. Members of the Council represents different governmental agencies (Ministry of Health, Ministry of Social Welfare, Ministry of Education, Ministry of Defence, Ministry of Internal Affairs) and different professions: psychiatrists, psychologists, pedagogues, sociologists, academics and clinicians. Council has started with the development of the National Mental Health Promotion Program. Unfortunately, in 2001 its activities have been stopped due to the lack of support from the new government.

IMPLEMENTATION AND MONITORING OF THE NATIONAL MENTAL HEALTH PROGRAM

The first draft of the National Program on Mental Health Promotion was prepared. It was focused on three themes, proposed in the Report on the "Promotion of Mental Health on the European Agenda (Lehtinen et al., 1997):

1. The development of the person's ability to deal with thoughts and feelings - management of life and emotional resilience,
2. The development of the person's ability to deal with the social world,
3. The development and maintenance of healthy communities.

The implementation of the Program means the activities and indicators which we have seen as the most important are shortly described below.

To develop person's ability to deal with thoughts and feelings

The methods are:

1. Education:
 - parents
 - at schools
 - society (mass-media)

- professionals involved in upbringing, teaching, treatment and care, re-socialisation and rehabilitation, management and organisation.
2. Counselling:
- psychological
 - educational
 - marital and family
 - vocational guidance

The feasible indicators could be the following:

1. For education:
- No. of publications for parents
 - No. of educational programs
 - No. of parents attending the educational programs
 - Quality of schools' educational curricula with regards of being aimed on enhancement solving problem skills and coping with stress
 - No. and quality of learning programs focused on development of children's abilities to deal with thoughts and feelings
 - No. and topics of mass-media programs related to mental health promotion
 - Educational campaigns
 - No. of subjects related to mental health in the training of professionals.
2. For counselling:
- No. of existing counselling centers in the regions
 - No. of counselling interventions for children, adolescents, parents, people at risk, etc.

To develop the person's ability to deal with the social world

The methods are:

1. Education
2. Counselling
3. Familiar and social support
4. Crisis intervention

Feasible indicators could be the following:

Familiar support:

- No. of single parenting families
- No. of divorces
- No. of siblings
- Subjective feeling of belonging.

Social support:

- No. of friends
- No. of meetings with friends

Institutional support:

- access to financial support
- access to the institutional support in the case of temporal or long lasting disability.

Crisis intervention:

- No. of crisis intervention centers
- No. of clients
- Availability of different crisis interventions

Development and maintenance of healthy communitiesThe methods are:

1. Raising awareness about the importance of community conditions for mental health.
2. Building local policy on:
 - safety environment
 - poverty prevention
 - support for disabled children and adults
 - living conditions and social support for elderly persons
 - prevention of unemployment
3. Self-help activities

Feasible indicators could be the following:

1. For awareness raising:
 - No. of local experts, representatives of communities and decision makers, involved in building mental health promotion policy
 - Quality of the local programs on mental health protection
 - No. of local mass-media programs related to mental health promotion and mental health policy
2. For policy development:
 - No. of leisure time facilities for children and young people
 - No. of crime and violence incidents
 - No. of people living in poverty

- No. and quality of social assistance programs for disabled, elderly and other groups at risk
 - Activities on unemployment prevention.
3. For self-help activities:
- No. of self-help groups on the local level
 - No. of volunteers involved into programs of mental health promotion
 - No. and kinds of NGOs involved in the development of the local policy on mental health.

We are aware that we need to work more on the National Program and find the way how to be much more precise when going for implementation and looking for networks which could get involved in the process. We would like to use the expertise of the European networks, which have been dealing with these problems for many years and are much more experienced in the field. It would also seem that building a European Strategy as it had been proposed by the Consortium working on project “Mental Health Promotion and Prevention Strategies for Coping with Anxiety, Depression and Stress Related Disorders in Europe (2001-2003)” would be an utmost importance for further developments, especially in new EU member countries.

Leo De Graaf, Mental Health Europe, The Netherlands

Response 2: Challenges in Mental Health Promotion and Prevention

INTRODUCTION

Elaborating on the theme of the Bilbao Conference “Mental Health in Europe: New Challenges, New Opportunities” and responding to the presentation given by Prof. H. Katschnig, this presentation aims to take stock of the present situation and future opportunities in the field of Promotion and Prevention. This approach was inspired by an awareness of the overwhelming task that promoters and preventers of mental health have set themselves, comparable to the missions of Hercules to kill one monster after the other or that of Sisyphus endlessly rolling uphill a large rock, losing grip just before the top of the hill was reached. However, the situation is not that gloomy, because, on the other hand, there are also some very encouraging developments that can be mentioned.

Before going into this balance of aggravating and facilitating factors, first a few words will be said about definitions. The presentation will continue with some comments about the role of NGOs and users and end with conclusions and needed actions. As the terms “Promotion of Mental Health and Prevention of Mental Disorders” will be mentioned frequently, in the rest of this paper a shorthand term will be used: “Promovention”.

DEFINITIONS

In the literature about promovention it is striking how many different definitions are used. In many papers Mental Health is equated with mental well-being. And well-being itself is sometimes, e.g. by Seligman, equated with happiness. If increasing happiness in

the population would be the aim of promotion the ambition or pretension would indeed be very high and the risk of failure correspondingly large.

In other papers the term (promotion of) quality of life is preferred, which again is a very ambitious objective, and at the same time very general and unspecific. Other authors prefer to stress the importance of increasing the resilience of people to cope with the vicissitudes of life. This objective is better delineated, but it has the disadvantage that it can only be checked under certain circumstances, i.e. after something unfortunate has happened.

Generally, disagreement about the definition of a phenomenon points to a disagreement on the meaning and content of that phenomenon. If that is the case with promotion, it would mean that there are different sorts of promoters and preventers, although they share the same name. This lack of consensus on the definition (and probably on the basic idea) of promotion is hampering progress in the field of promotion and deserves critical attention.

FACTORS THAT LIMIT THE IMPACT OF PROMOTIVE INTERVENTIONS (AGGRAVATING FACTORS)

Very large target group

In recent years much attention has been paid to the large numbers of people that are suffering from mental health problems: Katschnig reports a 12 month prevalence of 29.5% and a lifetime prevalence of 48.0% of mental health problems. However, the number of people who carry an increased vulnerability could be even higher, maybe even substantially higher, so that, even if promotion of Mental Health limits its interventions to those people that are at a higher risk (and not choose to consider the whole population as the target group as some promoters propose), at least a majority of the population belongs to the target group. Taking into account the limited resources, both human and financial, that are available for the promotion of Mental Health, the tasks are tremendous.

Heredity

After a few decades in which the influence of heredity on mental disorders was treated as if of little importance or, by some people, flatly denied, it is clear that in recent years the importance of heredity is much more widely accepted and the balance in the ever recurring nature-nurture debate is tipping to the nature-side of the scale. The most prevalent opinion nowadays is that for most mental disorders some hereditary vulnerability is a prerequisite for the appearance of the disorder, if external circumstances are favourable for such actualisation. The degree of vulnerability varies enormously: from 1% for schizophrenia in the general population to 100% for individuals carrying the allele for Huntington's disease.

Promotion is possible and worthwhile because of the important role of specific circumstances that are a prerequisite for the outbreak of the disorder, also for individuals with a hereditary risk. That gives possibilities for intervention by preventing these circumstances from taking place. That is the good news. The bad news is that the hereditary risk as such is left untouched, so that again and again new generations with the hereditary risk are born.

Zero-sum developments

Some developments that are propagated by promotion because of their beneficial effect on the decrease of risk factors or the increase of protective factors are in many cases found to also lead simultaneously to the increase of other risk factors or the decrease of other protective factors. For instance: economic improvements which decrease the risk factor of deprivation can increase other risk factors like stress, and sedentariness.

Cultural changes like emancipation can increase the protective factor of autonomy, but at the same time also increase the risk factor of loss of support. On balance the gains on the one hand can be undone by the losses on the other. This is what I call a zero-sum development. In setting up promotion-programs, attention should be paid to this phenomenon.

Disasters

Many promotion-programs are strenuous and prolonged. Clear examples are programs for people that are exposed to traumatic situations in order to prevent the development of post-traumatic disorders. These traumatic situations can be caused by natural or by man-made disasters.

It is very frustrating to see that, whilst teams are working for years to prevent or mitigate the consequences of, for example, a civil war in a certain country, some generals in a neighbouring country start a new civil war, causing a vast amount of risk factors for the population. In the Dutch language there is a saying “Mopping the floor, whilst the tap is still running”, which means that it is useless to combat an undesirable situation if one can not stop it at source, but treating only the final consequences.

Therefore it is important to develop strategies to forestall the massive “production” of risk factors, because otherwise promotion will never catch up with the overload of situations that threaten our mental health.

Long-term and widespread developments that massively increase the number of risk factors

Several developments that are beyond the control of promotion are taking place in the world or some parts of the world that, because of their widespread character, influence the lives of many people in a fundamental way and can cause a large increase of risk factors or decrease of protective factors.

Examples are:

- Individualisation: the process that an increasing number of people are planning and executing their life independent from the lives of other people. This means a large increase in autonomy and a better internal locus of control, which is considered beneficial for good mental health. At the same time it can lead to a loss of social support, a weakening of being embedded in a reliable, intimate social structure and a higher risk of becoming lonely. Some people can handle such situations much better than other people. So some people will benefit from individualisation and experience it as a relief, but other people will suffer from it. These people will form a new high risk group.

- Modernisation: the process that people, due to outside influences (media, education, political programmes) drop their traditional opinions and way of life and adopt opinions and lifestyles of a different culture, in most cases the western culture. Usually this shift from one culture to another is partial, so that a mix of “traditional” and “modern” ways of life is formed which can be very stressful. One example: eating disorders, like anorexia nervosa and bulimia until recently were limited to western countries. Recently cases have shown up in Eastern Europe, South Africa and other parts of the world outside the USA and Western Europe.
- Globalisation: the process in which the network of economic, financial, technical and cultural relationships between all parts of the world is intensifying. This process has several consequences. One was mentioned before: modernisation. Another consequence is the increase of international migration, leading to the settlement of many migrants in countries that are foreign and sometimes hostile to them. It is found that a higher percentage of migrants are admitted to psychiatric hospitals than was admitted in their country of origin. Many explanations are brought forward, but it is not unreasonable to suppose that this increased prevalence of psychiatric morbidity is at least partly due to the stress of living in a foreign and hostile country.

The summing up of all these disadvantageous factors and developments might sound discouraging. And I must admit that I have great admiration for all those workers in the field of promotion who enthusiastically and energetically continue with their programmes, unshaken by the vastness of their tasks. But the picture is not that gloomy, because a number of favourable developments and conditions can also be mentioned.

Some of them have already been mentioned, like the increase of economic prosperity in some countries (like China and India), reducing the risk factor of deprivation. And processes like individualisation, which gives opportunities for many people who can cope with the sequels and benefit of increased autonomy. But on top of these already mentioned developments a few more favourable developments and conditions are discernible. They are very diverse and are sometimes seen to strengthen each other.

INCREASING ACKNOWLEDGEMENT OF THE IMPORTANCE OF MENTAL HEALTH

Health

For many years the attention of the media, the politicians and the general public on mental health was marginal in comparison with the attention given to physical health. Gradually this is changing. Good examples are the publication of the WHO sponsored World Health Report 2001 “Mental Health, New Understanding, New Hope”, the Public Health Programme of the EU, in which Mental Health is one of the priorities, and Standard One of the National Service Framework of the British Government, which prescribes to “promote mental health for all, working with individuals and communities” and to “combat discrimination against individuals and groups with mental health problems, and promote their social inclusion”. And although a real appreciation of the importance of mental health is still lacking for many politicians and governments, it seems there has arrived a turning point that can be decisive for the future of promotion.

Scientific Progress.

Many people executing promotive programmes have evaluated these programmes and made them evidence-based. The programmes were also scrutinised and screened by researchers and found to be solid. Clemens Hosman, working in the Universities of Nijmegen and Maastricht, the Netherlands, states in 2000: "Over the past three decades, between 1 000 and 2 000 outcome studies have been published on prevention and promotion in the mental health, substance use and related fields. They differ in their methodological rigour, but hundreds have been carefully done". At the moment he is working on an extensive database for evidence-based programmes, which can be used elsewhere in the world.

Allies

For a long time only a small group of enthusiastic idealists were committing themselves to the issue of promotion. Now it seems that the picture is changing. Earlier the endeavours of the WHO, the EU and the British Government were already mentioned.

After publishing the World Health Report 2001 and the accompanying Atlas, the WHO is now working on a follow-up programme mhGAP (Mental Health Global Action Programme) of which promotion and prevention will be important parts. Among other activities, the WHO is preparing a publication in which a large number of best practices in the field of promotion of mental health from all over the world will be presented.

But there are many more allies. Many people working in the reconstruction of dilapidated neighbourhoods or combating criminality or reducing the drop-out rates in schools are doing work that is very much akin to promotion or has side-effects that favour the decrease of risk factors. Many of these people hardly realise the important role they play in promotion. They should be recognised and acknowledged.

An ally of a very different kind is academic psychology. A few years ago a new branch of psychology was born called Positive Psychology. One of the leading figures is Martin Seligman, well known for his description of depression as "learned helplessness". He became dissatisfied with only studying the repair of what has gone wrong in the psychological life of people and wanted to know more about those factors that increase the well-being or happiness of people. This shift of interest can lead to the discovery of important protective factors and therefore become very helpful for promotive programmes.

Some social developments in regard of risk factors

The affluent society.

Earlier it was mentioned that the increase of prosperity leads to the decrease of deprivation as a risk factor. But that is not the whole story. It can also be observed that the more affluent a society becomes, the more prevention-minded and promotion-minded such a society becomes. Maybe not all of us are aware of the large amount of attention, energy and money we already spend on prevention and promotion in our daily lives.

Activities like saving money, taking out insurance, inoculating against influenza, building a social security system, taking measures against pollution of the environment, setting up agencies to control our foodstuffs etc., are all examples of preventive and promotion measures we take to reduce the risks of the vicissitudes of daily life. Only a

small part of all these activities is invested in our mental health, which is very surprising, taking into account the importance of the good working order of our mental faculties for our functioning and our pleasure in daily life. But it is to be expected that, alongside the acknowledgement of the extent of psychological malfunctioning, the further increase of our prosperity will lead to more attention for prevention and promotion in the field of psychological functioning and strengthen the support for promotive programmes.

Decreasing acceptance of/increasing sensitivity to violence.

In recent years the media have paid much attention to incidents of violence and have given the impression that, generally speaking, violence is on the increase. This is also the feeling of the public and the politicians. However, in a recent study in the Netherlands and Germany it was found that the supposed increase has more to do with a raised tendency to call some act a violent act and to register and prosecute it as such. This seems to point to an increased sensitivity for violence, which would be in accordance with the theory of civilisation of Norbert Elias.

If this thesis is correct it could lead to a decreasing acceptance of all forms of violence and consequently to a decreasing impact of the consequences of violence. Other phenomena seem to point in the same direction, like the abolition by law of the smacking of children, and the combating of bullying that is being adopted in many countries nowadays.

In the international context the (slowly) developing control mechanisms for international conflicts could have the same effect.

THE ROLE OF NGOs AND USERS IN PROMOTION

Taking into account the comprehensiveness of promotion of mental health, governments, politicians and professionals will never be able to organise sufficient impact to meet the challenge. NGOs have to be involved to make the endeavour successful. Promotion of mental health, being a multifarious field, NGOs of divergent background are needed, like NGOs in education, housing, care and law. Within the NGOs those representing (ex-)users of psychiatric services and other people with mental health problems have a special place as experts on the influence of protective and risk factors.

The NGOs should :

- participate in the formulation of a definition of Promotion and Prevention
- advise on priorities in programmes
- monitor the planning and execution of programmes
- scrutinise the outcome of programmes
- reflect on the prejudices of researchers

CONCLUSIONS

1. The combination of the enormous size of the target group and the large number of risk factors makes it necessary to use, on top of the programmes on micro- and meso-levels, also interventions on the macro, i.e. political, level. So, to have a lasting impact, additional instruments have to be developed.
2. A possible new instrument could be Mental Health Impact Assessments (MHIA). In Europe, MHIAs could be applied in the case of, for example:
 - New European legislation about migration
 - The implementation of the decision to make Europe the most competitive region of the world
 - The way that cultural changes are handled in the accession countries.

SOME NEEDED ACTIONS

1. An authoritative committee of researchers and professionals in the field of promotion of mental health should come up with a generally accepted definition for promotion of mental health.
2. Professionals and researchers should develop specific expertises that enables them to draft mental health impact assessments
3. All of the present stakeholders in promotion should re-label much of the work that is done by other professionals and NGOs in the fields of education, justice, housing, care, etc. as actually being part of and belonging to promotion of mental health and prevention of mental disorders, so that it can be researched and valued as such.

WORKSHOP 3A REPORT: Implementation of the Policy Recommendations for Mental Health Promotion and Prevention of Depression, Anxiety and Related Disorders

Coordinator: *Ville Lehtinen, Finland*

Facilitator: *Andres Lehtmet, Estonia*

Rapporteur: *Juha Lavikainen, Finland*

The facilitator of the workshop, Dr. Andres Lehtmet opened the workshop by introducing the participants to the theme, for example by presenting the priorities outlined in the report "Framework for Promoting Mental Health in Europe" and describing the central parts of the draft policy report of the EC-funded project "Mental Health Promotion and Prevention Strategies for Coping with Anxiety, Depression and Stress-related Disorders in Europe". The full version of the draft policy report had been disseminated to all participants of the conference as part of the general background material.

As the most essential objectives of action, Dr. Lehtmet highlighted the development of better concepts, improved methods of evaluation, and sets of indicators for mental health promotion. In addition, there is a need to raise awareness concerning the best models of mental health promotion, and to focus mental health promotion efforts on children and adolescents. Moreover, development of telematic methods for supporting mental health promotion should be continued and equality issues need to be taken into account in the field of mental health.

After the introduction, the workshop participants were invited to discuss and express their opinions on four different questions which had been outlined prior to the conference.

The questions were:

1. How to apply the strategies of needed actions both on national and regional levels?
2. How to stimulate the needed interdisciplinary and intersectoral collaboration?
3. How to cover the life-span?
4. What kind of support is needed from different stakeholders?

The workshop proceeded by addressing the above questions sequentially, although it was clear that the questions are overlapping and complementary.

NEEDED ACTIONS

Concerning the application of strategies of needed actions, it was mentioned that even the regional level can be too large to manage efficiently. Therefore, the local level, such as part of a city, was mentioned as an appropriate target level. Connected to this, it was highlighted that interdisciplinary action needs to be tailored to the needs.

There was also a call for operationalising the concepts in order to find out "what to do and how to do it". In conjunction with this argument, it was highlighted that a lot of information has already been collected on the so-called best practices (for example in the EC-funded project mentioned above).

With regard to the next steps, the implementation of the strategies will be started with existing networks and the action plan will be decided together with the partners who will take part in the new project. A good example of concrete measures would be the organisation of national seminars. The need to translate the messages into political language was also emphasised.

STIMULATING COLLABORATION

As to question 2, the workshop fully agreed that promotion and prevention work cannot be dealt with by the health sector alone.

The workshop constructed the following list of potential interdisciplinary collaboration partners in the area of mental health promotion and prevention of mental disorders:

- The Media
- The Public at large
- Professionals in prevention
- Mental health services
- Health care services
- Social services
- Social insurance
- Labour organisations and trade unions
- School/education
- Church
- Police/prisons
- Self-help groups
- Consumers
- Families
- Pharmaceutical industry

When it comes to the implementation of the strategies, it will, however, be very difficult to include all possible sectors. This led to a general discussion of **responsibilities** and **co-ordination** of promotion and prevention actions. Here, one view was that an accountable entity would be needed for the above purpose. On the other hand, it was maintained that different forums may be beneficial in formulating the action plans. Therefore, cooperation should be facilitated and it could be worthwhile to investigate the current forms of cooperation, namely where and how people work together.

COVERING THE ENTIRE LIFE-SPAN

The necessity of covering the entire life-span, including childhood, youth, adult life and later life, was more or less self-evident. It was underlined that:

- the main focus should be on children;
- specific emphasis should be put on transitional periods;
- the growing number of older people poses new challenges.

Here, it was also noted that at each age, there are problems on both the societal and the economical level. It was felt that children need to be able to build skills, e.g. problem-solving skills, for life and parents need to be supported in acquiring and improving parenting skills.

The workshop also brought to the fore the challenges posed by trauma and abuse. The raised life expectancy also challenges us to find innovative ways to promote the mental health of older people.

SUPPORT FROM DIFFERENT STAKEHOLDERS

As to the support from the different stakeholders, this workshop started by complementing the list of current stakeholders in promotion and prevention. These were:

- International bodies (European Union, Council of Europe, WHO, ILO, etc.)
- State level
- Regional governments
- Local governments
- Social partners
- Different public sectors
- NGOs, advocacy groups, users
- Insurance companies
- Communities
- Individuals
- Pharmaceutical industry
- Research institutions and research companies

The role and interests of the pharmaceutical industry were discussed in this context. It was noted that their interests are most often in the consumers rather than, say, prevention. A real challenge would be to guide these companies in the "right direction". Funding issues were connected to the above and the role of the service users, families, and employers are highlighted here as well.

FINAL REMARKS

In the reporting session, the general conclusion was that strategy development is still an ongoing process. Within this process, it is essential that:

- the local level is included when discussing the different levels of necessary actions;
- better concepts are developed, evaluation methods are improved and sets of indicators for mental health promotion are fine-tuned;

- the governments' awareness concerning the best practices of mental health promotion is raised;
- concentrated mental health promotion efforts focus on children and adolescents.

Finally, it needs to be noted that the implementation of policy recommendations is a long-term process that is of interest to a large number of different stakeholders. Further elaboration is required to carry out the results and recommendations that have been obtained and formulated.

WORKSHOP 3B REPORT: Monitoring mental health to support its promotion and the prevention of mental disorders

Coordinator: *Ville Lehtinen, Finland*

Facilitator: *Viviane Kovess, France*

Rapporteur: *Peter Breier, Slovakia*

GENERAL ISSUES

The workshop was attended by 19 participants. V. Kovess introduced the issue of monitoring mental health. Various organisations work on the selection of proper mental health indicators – the WHO, Eurostat, OECD, EC. Until now, efforts have not been satisfactory as the collection of data is very difficult and the data are hardly comparable across countries.

Professor Kovess listed the main categories, which should be including in monitoring:

1. Demographic and socio-economic factors
2. Health status which includes mortality, as well as disease specific and generic morbidity
3. Determinants of health (which should include positive factors)
4. Health systems with subcategories: a) prevention, health protection, and health promotion, b) health care resources, c) health care utilisation, d) social services and welfare, e) expenditure, f) health care quality indicators

The discussion in the group revealed the obstacles faced when trying to obtain comparable data across Europe. The entire set of indicators is not gathered in most of the European countries. In addition, the data are even difficult to compare within one country due to the different ways in which they are gathered on different levels (e.g. on federal and republic levels, or even regional differences).

The possible methods of gathering relevant data were also discussed. The group agreed that it is important to include mental health aspects in general health surveys. It was stressed that even if it is difficult to harmonise surveys in all countries, it is useful to collect information which can be comparable not only at one time but also from the long-term perspective. From the dynamic point of view even imperfect data can reveal trends inside a country, and also serve as trend comparisons between different countries. However, it is necessary to be careful to in interpreting causal relationships between data trends.

There are two types of collected data: 1) Routinely collected data on selected indicators, 2) Data collected by surveys done within general health surveys, as physical and mental health are closely linked.

One of the greatest obstacles is that many countries have already developed their own indicators to monitor their systems, and these are not comparable with other countries. It was proposed that a core set of data should be mandatory for all countries as it is e.g. with the data on illicit drug consumption and policies in Europe. Each country could then add their own indicators according to its needs, and, thus, will be able to continue to evaluate its own system. It was also proposed that there should be studies to compare countries which are close to each other (geographically, with similar health care systems, or on the basis of language similarity). This could help to study the effect of different policies, too. It can be expected that by working on these comparative studies the problems will ameliorate with time and the comparable data could be better realised.

KEY RECOMMENDATIONS

The key recommendations from the group were as follows:

- There is a need to collect data on mental health that will allow monitoring and comparison of mental health across the EU
- The data have to be of two types: routinely collected data by approximately 10 selected indicators and data to be collected by a population survey
- Countries may be compelled to gather the data: within a time-frame, following specifications including design and instruments
- A centre, closely related to the network of epidemiologists and mental health workers, should be set up in order to properly interpret trends across time and their relationships with interventions.

THEME 4: PREVENTION OF PREMATURE MORTALITY AND ABUSE PROBLEMS

Iveta Bluka, Health Promotion Centre, Latvia,

Prevention of Premature Mortality and Abuse Problems

INTRODUCTION

The enlargement of the EU will increase the current population of 375 million by 170 million, thus bringing together 545 million people within a new political and economic trading zone. Background information gathered over the last three decades and current health data show that this new grouping will unite a population with not only a diverse range of health profiles, but also 28 quite different health systems.

From infant mortality to overall life expectancy rates, countries differ quite substantially. These differences are to a large extent related to social stress, mental ill-health and destructive life styles. Especially in societies and populations undergoing stressful change, these differences are attributable to a cluster of stress-related factors, including depression and suicide, addiction, violence, risk-taking behaviour and lifestyles, and cardiovascular and cerebrovascular morbidity and mortality.

All candidate countries report significantly higher mortality rates than those in the EU. As in the EU, non-communicable diseases, namely cancer, cardiovascular diseases and injuries, represent the bulk of morbidity and mortality. For both heart ischemic disease and injuries, the death rate in the candidate countries is about double that of the EU, while cancer mortality is slightly above that rate.

Cardiovascular diseases continue to be one of the leading causes of premature mortality.

It is highest in Latvia, Estonia, and Hungary. High cardiovascular mortality in Estonia, Latvia and Lithuania is determined by ischemic disease (overall rate in these three countries is 327/100 000)

Only Slovenia reports figures slightly above the EU average. The Czech Republic has gone from having one of the highest ischemic heart disease mortality rates to having one of the lowest levels in the region (183 compared with the average rate of 227 among all).

The so called "health gap" between the east and west of Europe has been well documented. The gap refers to the sharp divide in mortality patterns between the two regions. This will be the major issue for the EU as, despite considerable diversity among candidate countries, there remains a substantial and clearly avoidable health gap between the Member States and the accession countries. In 1998, overall life expectancy in the EU was 78.2 years compared to 72.5 in the candidate countries.

However, the candidate country Slovenia has mirrored, to a large extent, the EUs' steady progress in reducing mortality. Slovenia has shown a relatively steady increase in life expectancy, from just over 72 years in 1985 to a level of about 76 years at present.

In contrast, countries such as Slovakia, Poland and Bulgaria have generally shown stagnation or even some decrease in the life expectancy.

Mental health problems are increasing significantly. Of the 10 leading causes of disability world-wide, five are mental disorders: unipolar major depression, alcohol dependence, bipolar depression, schizophrenia and obsessive-compulsive disorder. Depression alone accounts for 4.1% of the total, ranking fourth among the leading causes of disease burden. By 2020 it is expected to be the second leading cause of DALYs lost, second only to ischemic heart disease. In many European countries the mortality from suicide now exceeds that from road traffic accidents. The burden is even greater when taking into account the association with other conditions, such as depression and cardiovascular diseases.

SUICIDE MORTALITY

Suicide is one of the leading causes of injury worldwide with an estimated 10–20 million attempted suicides and 1 million completed suicides each year. In the last 45 years suicide rates have increased 60% worldwide. Suicide was estimated to represent 1.8% of the total global burden in 1998, and 2.4% in countries with market and former socialist economies.

In the European region, injuries and other external causes of death (such as accidental poisoning, suicide and homicide) are thought to account for a substantial proportion of all deaths. They also account for a large part of the overall burden of disability and ill health in the region.

Europe alone sees 700 000 suicide attempts per year and approximately 45 000 completed suicides. Although suicide rates are higher in some EU countries than in others, they do not reach the levels seen in Eastern Europe. The mortality rates due to suicide and self-inflicted injuries range from 11 to 36 per 100 000 population in European countries. Suicide rates in the European region vary 10-fold among young females but 40-fold among young males, with very different trends in different countries, ranging from a 40% decrease to an 80% increase over the 15 year period.

Suicide figures have risen during the 20th century. It is easy to guess that the secularisation, urbanisation and increasing availability of suitable drugs have contributed to this.

Suicide in the EU

The EU has achieved significant health gains over the past three decades since the previous report on health status in 1992. However, there is still a significant level of preventable morbidity and mortality before the age of 65 years.

Suicide is an important contributor to life-years lost in the EU. However, differences between various countries and nations in regard to suicide behaviour can be enormous (Schmidke 10). Several factors may influence this variation: socio-demographic factors, ethnic differences, religious beliefs and affiliations, attitudes towards suicide, legislation regarding suicide, coping strategies, prevention strategies, and the reliability and validity of death certification and reporting. The latter is particularly relevant because practices in recording the cause of death can be influenced by legal, moral and cultural factors.

In general males had considerably higher suicide rates than females. The literature review suggested that suicide rates in the northern EU countries are higher than the rates in the Mediterranean countries such as Spain, Portugal, Italy and Greece. The Nordic countries have a common pattern with relatively fewer suicides among older people and relatively more suicides among people below the age of 45 years when compared to the UK and the Catholic countries of Europe. But the total number of suicides differs rather a lot between the Nordic countries, with Finland and Denmark sitting at the top of the European rankings, while Norway and Iceland report only half as many suicides, and Sweden lies somewhere in-between.

Age-standardised suicide rates for the individual countries showed that Finland had the highest suicide rate for the latest available year, while Greece had the lowest. Significant downward trends over time occurred in Austria, Denmark, France, Germany, Greece, the Netherlands, Portugal, Sweden and the UK while significant upward trends were observed in Ireland and Spain. No significant trend was observed for suicide rates in Belgium, Finland, Italy and Luxembourg.

A decline in male suicide rates was observed for 10 of the 15 EU countries while 13 countries reported a decline in female rates over the study period. A significant downward linear trend in male mortality was observed for Austria, Denmark, France, Germany, Netherlands, Portugal and Sweden. Significant upward linear trends in male suicide mortality were observed in Ireland and Spain while no significant trend was observed for Belgium, Finland, Greece, Italy, Luxembourg and the UK.

Suicide mortality is higher over- rather than under-65 years of age. Under the age of 65 the lowest mortality cluster of countries includes Greece, Ireland, Italy, Portugal, Spain and the UK, and the highest mortality clusters includes Belgium, Finland and Luxembourg. For males and females under or over the age of 65 years the overall EU trend is currently downwards. Although the trends vary from country to country, in both sexes under 65, the trend is still upwards for Ireland and Luxembourg.

While a decrease in suicide rates in general has been reported from most EU countries, rates in young adults (15–24 year olds) have been on the increase for almost half the EU countries. Although a decline was also observed in suicide rates in the older age groups, suicide mortality was highest in the age bracket of the over 65's.

Depressive illness is thought to be the most important predictor of suicide among the elderly, and social isolation has also been highlighted as an important contributor. The treatment gap is still considerable. In primary health care settings, 50% of depressions are unrecognised, despite the fact that 30% of the consultations with general practitioners are for mental health problems.

PREMATURE MORTALITY IN THE CANDIDATE COUNTRIES

The accession of up to 13 new members in the next decade is the most important development now facing the EU. The total population for the candidate countries was nearly 105 million people in 2000 – about 28% of the current population of the EU. The average birth rate has consistently been below the death rate, leading to a natural decline in total population. Fertility has been below replacement level for a number of years.

Health status in the candidate countries improved generally until the early 1970s, but then stagnated. Death rates overall, and those due to the major causes, began to fall in the 1990s, and life expectancy increased.

Dramatic economic and social changes through the 1990s were associated with low birth rates, net emigration and falling populations, particularly those of working age persons. Demographic change has increased the proportion of older people, though not yet as dramatically as in the EU. This particularly affects Bulgaria, Estonia and Latvia. Populations in the EU, in contrast, are generally rising slowly.

The experience of the CEE applicant countries in the 1990s has been very different, with marked falls in national income during the process of transition away from socialist systems. The economies in almost all cases have now been growing for several years (Bulgaria and Romania are exceptions with a rocky recent period) but there is clearly enormous catch-up growth to be made if typical levels of EU income are to be reached. Only Slovenia had income per head in 1997 as high as the bottom limit of the EU-15 range – and only in Poland had the GDP grown to exceed its 1989 level (several other Central European countries were nearly there but Bulgaria and the Baltic states were still 25-45% down) In Romania, Lithuania, Latvia and Bulgaria, national income per head in 1997 was less than a third of the EU-15 average. The differences within the CEE group are much larger than those among the EU members.

Life expectancy in older age groups (45 and 65 years) is also below the EU level. Only Slovenia and the Czech Republic are approaching the life expectancy of some EU countries. Estonia, Latvia and Lithuania experienced particular mortality problems during the social transition of the late 1980s and early 1990s, and now have the lowest life expectancy in the group, followed by Romania, Hungary and Bulgaria. The gender difference in life expectancy is larger in this group of countries than in the EU, but in both the gap has narrowed in recent years.

Deaths due to external causes are particularly common in Estonia, Latvia and Lithuania, with high levels of road traffic deaths, homicides and suicides. Mortality from suicide is relatively high in Latvia, Hungary and Slovenia. All the candidate countries have high rates of accidental and violent deaths. Estonia, Latvia and Lithuania have the highest rates, with trends that mirror both overall and cardiovascular mortality. This particular pattern of mortality seems to be associated with high alcohol consumption in these countries.

Road traffic deaths in Estonia, Latvia and Lithuania are among the highest in the entire region. These were over twice as high in Latvia as in the EU in 1998, at 27 against 10.7 standardised death rate per 100 000 respectively. Trends in these countries are associated with alcohol consumption. In contrast, rates in Bulgaria are lower than in many countries in the EU.

Homicide rates are generally also higher than in the EU, particularly for women. Homicides are particularly common in Estonia, Latvia and Lithuania. Several other candidate countries (Slovenia, Czech Republic, Poland, Slovakia and Hungary) have homicide rates lower than those in Finland (the highest EU country).

Suicide rates are high in Estonia, Hungary, Latvia, Lithuania and Slovenia, while they are similar to the EU average in the other candidate countries. Suicide rates for men are consistently higher than the EU average, with much less uniform pattern for women. In the Baltic States during the 1980s and early 1990s, the trend for male suicide followed the trend in overall mortality and the mortality rates for cardiovascular diseases and external causes, reflecting the social disruption and the trends in other alcohol-related deaths. Though this trend was not seen among women, it dominated the overall trend, as

male suicide rates are significantly higher than female. Romanian, Polish and Slovak women have relatively low suicide rates, below several EU countries.

SITUATION ON DATA COLLECTION ON SUICIDES

Suicide mortality rates varied markedly between countries for reasons that remain unclear. Deficiencies in routine data need to be addressed. These include different methods of data collection, the lack of suicide method-specific data, inconsistencies in recording standard demographic variables and the paucity of data on risk factors. The main deficiency in parasuicide data was the virtual non-existence of data on a national level. Possible remedial measures include the standardisation of recording and reporting suicide events and suicide methods in all member states, and the establishment of national parasuicide registers following Ireland's example. In the absence of adequate EU-wide data on suicide epidemiology, effective prevention of suicide is likely to remain elusive.

In all EU countries, mortality data are collected as part of routine vital statistics. The main sources identified for these data were the WHO-Euro, European Statistical Office of the EC (EUROSTAT), the European Public Health Information Network (EUPHIN) and the national statistical agencies of each member state.

Comparing rates between countries is difficult because of concerns arising from a variety of definitions, and methods for recording, coding and reporting. Some countries investigate deaths that may possibly be due to suicide thoroughly while others tend to classify such deaths routinely as accidents. The reasons for such differences between countries are largely unknown although one hypothesis is that suicide is less socially stigmatised in some countries than in others. A study investigating religious influences on the rates of suicide worldwide reported that religious differences between countries influenced the accuracy of suicide data returned to the WHO (Kelleher, Chambers et al 1998). A comprehensive analysis suggested that the average reporting rates for countries with "religious sanctions" against suicide tended to be lower than those without.

Some countries require a suicide note, while others require a decision on intent made by the coroner. An investigation into the reliability and sensitivity of suicide certification (Rocket & Thomas, 1999) revealed that some countries (Austria and the Netherlands) generate suicide data of excellent quality for all age groups and gender. However, others such as Finland, Greece, Ireland and the UK reveal potential misclassification within certain subpopulations, especially the 15-24 and 75 and older age groups.

The Netherlands, Belgium, France and Portugal have at some stage incorporated parasuicide as part of the data collected by sentinel practice networks. Suicide and parasuicide were included in morbidity surveillance via sentinel general practitioners in Belgium.

The conclusion is that the most urgent priority is to develop a standardised approach across the EU to the defining, recording, coding, classification and reporting of suicide and parasuicide. The means of committing suicide should be specified in routine national data. Risk and exposure variables should be included in routine suicide data.

Notwithstanding the current deficiencies in data, continued monitoring of epidemiological trends in place and time in the EU is necessary to inform the development of preventive policies and activities. In this regard, the establishment of

parasuicide databases in each member state is particularly important. Research of an analytical and evaluative nature is especially urgent to help improve the evidence base for the clearer identification of high-risk groups and environments, and the implementation of effective suicide and parasuicide prevention.

Networking between organisations in the field of suicidology is difficult to achieve without an adequate infrastructure. Therefore, we would urge the EC to support the creation of such an infrastructure.

ALCOHOL CONSUMPTION

Each year over 55 000 young Europeans die from the effects of alcohol abuse: one in four deaths in European men aged 15-29 years is related to alcohol. In addition, between 40% and 60% of all deaths from injuries are attributable to alcohol. Alcohol is directly and indirectly implicated in various types of assault, criminal behaviour, unintentional injury, violence, homicide and suicide. The European Region has the highest rate of alcohol consumption in the world, but the average recorded consumption of 7.3 litres of pure alcohol per person in 1998 hides considerable differences between countries, from a low of 0.9 litres to a high of 13.3 litres per person. Nordic countries show stable levels of alcohol consumption, except Sweden, which is experiencing a decrease. Consumption is increasing in Latvia and Lithuania, while Estonia shows a slight decrease. Among 15 EU countries, Ireland is the only country where consumption is increasing considerably, although it is increasing to a lesser extent in Greece, Luxembourg and Portugal. In the CEE countries consumption is increasing in the Czech Republic, Romania and the former Yugoslav Republic of Macedonia.

The Czech Republic, Slovakia, Slovenia and Hungary report the highest levels of alcohol consumption, associated with the high levels of cirrhosis also found in these countries. The highest mortality associated with chronic liver disease and cirrhosis is currently reported in Hungary, Romania and Slovenia, all significantly higher than the EU average.

Motor vehicle deaths, seemingly associated with high alcohol consumption, increased quickly in most candidate countries, particularly in Latvia and Lithuania.

Today, it is well known from individual-level studies that the percentage of suicides connected to alcohol abuse is high. According to a recent review of research findings by Russow (1996) it was shown that a history of alcohol abuse and heavy drinking was present in between 10 to 54 percent of suicides. Moreover, in the majority of studies reviewed, an excess mortality from suicide of 5 to 10 percent was estimated for samples of alcoholics. The absolute number of yearly deaths associated with alcohol abuse is in excess of 8659 for men and 2248 for women.

Available data suggest that the highest levels of alcohol-related deaths are observed in Danish males and the lowest in Luxembourgian males. The highest levels among females are observed in Greece and the lowest in Spain. In some Member States there is a significant alcohol effect on the suicide rates of males (Finland, Sweden, Austria, Belgium and Portugal) and females (Sweden, Austria, Belgium, The Netherlands and Germany). Per capita consumption is a key factor in explaining changes in cirrhosis mortality for men and women and for different age groups. Alcohol also contributes to cancer of the mouth and of the oesophagus. Sustained drinking progressively increases the risk of raised blood pressure and stroke and the possibility of ischaemic heart disease.

However, the strength of this connection may differ between countries, or more specifically, between drinking cultures with different characteristics. By comparing individual level studies from different countries one cannot explore this question since such studies are seldom similar enough for any meaningful comparisons in this respect. Moreover, although the individual-level findings certainly suggest that the alcohol-suicide link can be found in most countries, these kinds of study are particularly vulnerable to selection effects, i.e. the possibility of an underlying factor that increases the risk for both alcoholism and suicide. (Norstrom 1988)

Any associations between the age-standardised suicide rates and annual alcohol consumption (litres per person) for each country were investigated by computing the relevant correlation coefficients. A significant positive correlation was observed between the two variables for Austria, France, Germany and Ireland. In fact Irish suicide rates and annual alcohol consumption showed the strongest association. When the trend of alcohol consumption in Ireland was observed it was apparent that the consumption of alcohol had increased dramatically over time compared to the other EU countries. On the other hand, Swedish suicide rates correlated negatively with the annual alcohol consumption suggesting that as the suicide rate decreased an increase was observed in the consumption of alcohol.

SUICIDE PREVENTION

Suicide has been referred to in the context of improved detection of depression. Any preventive measure that reduces the incidence of depression should also reduce suicide rates as approximately 1 in 6 of all depressed patients end their life by suicide.

Suicidality can be treated. There is evidence that lithium treatment of bipolar disorder significantly reduces suicide rates. In fact, lithium may have specific anti-suicidal effects on people with this disorder since these effects may be separate from its antidepressant and anti-manic effects. Rates are reduced only while the patients take lithium; after discontinuation of treatment, the rates begin to rise to levels similar to those seen prior to lithium treatment.

Medication alone is not sufficient for treating mental disorders or suicidality, nor are treatments equally effective across individuals and diagnoses. Psychotherapy provides a necessary therapeutic relationship that reduces the risk of suicide. Cognitive-behavioural approaches that include problem-solving training seem to reduce suicide attempts and suicidal ideation more effectively than treatment with typical or non-directive therapy.

Patients are at much greater risk of suicide in the weeks immediately following discharge from the hospital. Patients who continued care either through community services or with pharmacotherapy had lower suicide rates.

Psychological autopsy studies reveal that only 6-14% of depressed suicide victims were adequately treated and only 8-17% of all suicides were under treatment with the prescription of psychiatric medication. There are significant barriers to receiving effective mental health treatment. About two thirds of people with diagnosable mental disorders do not receive treatment. The stigma of mental illness deters people who need treatment from seeking it. The fragmented organisation of mental health services and the cost of care are among the most frequently cited barriers to mental health treatment.

Physicians are reticent to talk to their patients about suicide; they often do not ask about intent or ideation, and patients do not often report it by themselves. The goal of suicide treatment in specialty care is to develop and implement a treatment plan, which includes monitoring of medication efficacy and safety, as well as discharge planning. Primary care has become a critical setting for detection of the two most common risk factors for suicide: depression and alcoholism. Currently, only about 30-50% of adults with diagnosable depression are accurately diagnosed by primary care physicians.

Recommendations for suicide reduction:

1. The National Institute of Mental Health (or other responsible organisation) in collaboration with other institutions should develop and support a national network of suicide research and suicide prevention across the life cycle.
2. National monitoring of suicide and suicidality should be improved (long-term studies of health behaviour, mental health interventions, genetic studies of mental disorder)
3. Tools for recognition and screening of suicidal patients should be developed and disseminated.
4. Programs for suicide prevention should be developed, tested, expanded and implemented through funding from appropriate agencies. (11)
5. Prevention programs that have shown success within selected populations should be expanded.
6. Pilot programs for coping and resilience training as part of the curriculum for school-aged children should be implemented, evaluated, and scaled up when feasible.
7. Long-term public education campaigns and media training should be evaluated.

A reduction of alcohol use would also likely reduce the suicide rate, as around a quarter of all those who successfully complete suicide are dependent on alcohol. Secondary prevention—reduction of alcohol availability is a political and legal decision that affects alcohol consumption in the whole population, but making those who are at special risk a target for more intensive intervention is more cost-effective and in most cases preferred to general health promotion. Intervention of an educational nature has helped to reduce subsequent alcohol consumption. A combination of patient education and counselling can also help change people's behaviour and prevent dependency. Primary care has a potential role to promote alcohol screening programs and train staff to provide advice and counselling.

DRUG RELATED MORTALITY WITH IN EU

Drug related deaths also create serious social concern. Problem drug users suffer a high overall mortality rate mainly due to overdoses, but also due to AIDS, accidents, suicides, violence etc. The impact of acute drug-related deaths becomes evident when it is considered that each year between 7 000 and 8 000 such deaths are reported by EU countries. The real number of cases is probably higher. Opiates are present in most overdose deaths, although the presence of additional substances is frequent. The mortality of opiate users, in particular injectors, is up to 20 times higher than the general population of the same age. The mortality of injectors is 2 to 4 times higher than non-

injectors and (until recently) the mortality of drug users infected by HIV was 2 to 6 times higher than non-infected users. With recent improvements in HIV treatment, this difference might be decreasing.

From a long-term perspective of trends in EU countries (15-20 years), a marked increase of drug-related deaths was observed during the 1980s and early 1990s. During recent years the number of acute deaths has stabilised at this higher level. However, it is worrying that some EU countries report recent increases after a period of stabilisation and decrease. These overall trends may be explained by the expansion of heroin injection in many European countries during the 1980s and 1990s.

DRUG RELATED MORTALITY IN THE CANDIDATE COUNTRIES

Even if data quality and availability differ a lot between candidate countries and the resulting picture is rather patchy, we can hypothesise that, in the last decade, candidate countries have experienced accelerated growth in problem drug use and treatment responses similar to that experienced by the EU Member States over the last 35 years. Since the illicit drug market is clearly part of the “global” market, a process of 'westernisation' of the previously closed national scenes of all candidate countries is occurring, with local specifics increasingly being eroded.

The treatment response in most candidate countries is also beginning to mirror the EU model, with substantial involvement of recognised non-governmental organisations (NGOs) and other bodies.

Problem drug users represent a very small minority of the whole population, compared with people who have never used any illicit drug in their lifetime or with people who currently use illicit drugs.

EU enlargement could create a new – even if not totally unknown – situation, as drug users differ significantly between the Member States and Accession Countries, whereas the general trend in problem drug use in the EU is stable and the population of problem drug users is ageing (especially users of opiates, the majority of accession countries are still situated in the rising part of the curve and problem drug users are younger, on average).

Heroin, which is generally perceived as the most dangerous and the most harmful illicit drug, together with other opiates, is the prevailing drug for problem drug users in almost all candidate countries. The only exception is the Czech Republic, where the traditional domestic amphetamine still plays a major role; however heroin use is increasing rapidly. This heroin trend is common for all the Candidate Countries.

ATD abuse is also present to a lesser extent (5-10%) in problem drug users seeking treatment in Slovakia, Hungary, Latvia, Lithuania and Estonia. The use of cocaine is insignificant in the candidate countries. Solvent abuse represents a challenge for most of the candidate countries. Quantitative data generally fails to provide a reliable picture of the phenomenon, because the affected population is mostly extremely young, socially marginalised and consequently hidden. The treatment facilities and services have not succeeded in reaching the population at risk.

Last but not least, it is important to stress the need to improve data gathering and monitoring systems in all candidate countries. Compared to the EU Member States, the average level of data quality and availability is substantially lower, though with a few

exceptions. The political support of each government is a priority, as, without quality data, it is impossible to evaluate interventions and policies – the priority target of the EU Action Plan on Drugs.

SUBSTANCE ABUSE PREVENTION AND MENTAL HEALTH PROMOTION

The health promotion approach dominates prevention, integrating prevention measures: community-wide projects in schools, youth clubs, workplaces etc., and public information campaigns, following WHO principles on health promotion. The focus of all promotional work should be on healthy lifestyle promotion and life-skills development, implemented in compulsory school curricula with its vision of a healthy and confident society, free from alcohol and drug-related harm.

Prevention strategies apply a two-pronged complementary preventive strategy: the broad (population-targeted interventions and the life-skills approach), and the narrower (specific action targeting high-risk groups). The broad strategy aims to identify and strengthen factors that promote healthy lifestyles and facilitate the development of autonomy, responsibility and critical sense. High-risk group interventions focus on a framework offering alternatives to drug use. Specific interventions also provide solutions for youths engaged in risk behaviours, and may include accessing drug services.

Local initiatives and face-to-face communications are essential, accompanied by a holistic approach to co-ordinating programs and services at local level, involving communities in the development and delivery of local strategies, and focusing action where it is most needed.

There are evidence-based studies on programs for young people, on alcohol and pregnancy and on the effectiveness of community and workplace policies. There is a special need to reach young people, low income and vulnerable groups, black and minority ethnic groups and older people. Harm reduction should be an integral part of drug policy in every country. It considers the legal frameworks for substitution and maintenance programs. It is essential that the countries concerned continue to reinforce their policies, institutions and co-ordination mechanisms and allocate additional resources to this end.

It should also be underlined that the efforts of the candidate countries to align their actions in the drug field with those of the EU and its Member States are worth not only recognition, but continued support.

REFERENCES

1. Health Status Overview for Countries of Central and Eastern Europe that are Candidates for Accession to European Union.

WHO Regional Office for Europe. European Commission 2002

2. David H. Stone, Parveen Chishti and Carolyn Roulston

Final Report of the European Review of Suicide and Violence Epidemiology (EUROSAVE) Project. European Commission, 2002

3. Mats Ramstedt, Alcohol and suicide in 14 European countries

Stockholm University Centre for Social Research on Alcohol and Drugs, 2001

4. J. Micklewright, K. Stewart, Child Well-Being in the EU – and enlargement to the East, UNICEF Innocenti Research Centre, Florence, 2000

5. Reducing Suicide : A National Imperative. The National Academy of Sciences, USA, 2002

6. Mental Health in WHO's European Region, WHO and Regional Committee for Europe, 2003-09-22

8. The European Health Report, 2002

9. Public Health Approach on Mental Health in Europe, 2000

10. WHO, Europe, 2002. Suicide Prevention in Europe. The WHO European Monitoring Survey on National Suicide Prevention Programs and Strategies.

11. Wasserman D. Editor : Suicide – an Unnecessary Death. Martin Dunitz 2001

Danuta Wasserman, Department of Public Health at the Karolinska Institute, Sweden

Response 1: Mental Health Can Be Improved and Suicide Prevented

RELIABILITY AND VALIDITY OF THE DATA

According to WHO estimates for the year 2020 approximately 1.53 million people will die from suicide and approximately 10-20 times that number will attempt suicide. Suicide is among the foremost single causes of death in Europe, and the one involving the most years of life lost. Therefore it is not advisable to use only suicide and attempted suicide rates, but there is also a need to calculate Disability Adjusted Life Years (DALY's) and Potential Years of Life Lost (PYLL). In the age group 15-44, suicide is the most common cause of death in Sweden, more common than death due to traffic accidents, as well as in many other European countries. The reliability and validity of data on suicide and attempted suicide is however questionable. For many reasons suicide as a cause of death can be hidden behind a) traffic accidents; b) violent deaths; c) alcohol and drug intoxication; d) mental disorders; e) drowning accidents etc.

All of the above-mentioned causes of death can include suicide, and misclassification depends on local traditions, rules, attitudes, religion, and knowledge. The suicides can also be misclassified and hidden in the diagnosis of uncertain causes of the death. This diagnostic category varies between different European countries, within different regions in the same country, between different ages and between different sexes. This only reinforces the gravity of the global picture of suicide, because many suicides are underreported due to improper diagnosis. The same applies to attempted suicide. There is however, reliable data from the MONSUE project.

MONSUE – The Monitoring of Attempted Suicide and Suicide has been carried out since 1989. In 2003, the following European countries are involved in this project: Austria, Belgium, Denmark, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Latvia, the Netherlands, Norway, Poland, Slovenia, Spain, Sweden, Turkey, and the United Kingdom.

The goals of the MONSUE project are:

- Assessment of frequency and risk factors in suicidal behaviour and its repetition
- Developing proposals for the implementation of strategies to reduce this behaviour
- Determination of groups at risk, methods, “hot spots” and individual and social causal factors and their changes over time
- Determination of protective factors
- Testing the effect of specific measures

Due to the magnitude of the problem among young people, the WHO / EURO Network on Suicide Research and Prevention initiated the SAYLES's project in 2003. The goals of the SAYLE (Saving Young Lives in Europe) project are to compile:

- Evidence based EU/WHO guidelines of recommended care for young suicide attempters in Europe
- Evidence based EU/WHO guidelines for school personnel on how to prevent mental ill-health and suicidal behaviour among school children

- Information material to parents and significant others about how to support young suicidal persons and how to prevent suicidal behaviour
- Implementation and scientific evaluation measurements

STRESS-VULNERABILITY MODEL IN SUICIDE PREVENTION

Below, I will only briefly summarise some thoughts about suicide prevention, thoughts that are fully developed in the book *Suicide, an unnecessary death*, (ref.1). According to the stress-vulnerability model, genetic makeup as well as acquired susceptibility contributes to a person's constitutional predisposition. This constitutional predisposition is called diathesis, which is thought to be the crucial determinant of whether suicidality is manifested under the influence of stress as a result of for example acute psychiatric or somatic illness, severe abuse of alcohol and drugs, pressing social problems, or family crisis. The stress-vulnerability model can be supplemented by the broader model of development of the suicidal process in order to provide a better understanding of the interaction between suicidal people and the people around them, as well as the role of environmental factors that contribute to the person's vulnerability being held back (protective factors) or in some negative circumstances (risk factors) expressed in suicide or attempted suicide (ref. 2).

STRATEGIES IN SUICIDE PREVENTION

Suicide, attempted suicide, and suicidal thoughts have been subject to powerful sanctions, both religious and legal. Questions of suicide are surrounded by taboo and feelings of shame and guilt. There is ambivalence towards suicide and suicide prevention among politicians and policy makers. Suicide is often seen as a very specific problem or as such a complex matter that nothing can be done about it. This is all in sharp contrast to existing evidence, which shows that suicide, and attempted suicide can be prevented.

In suicide prevention, work strategies can be pursued through health-care services (health care perspective) directed at the general population (public health perspective). The health care strategy includes identification, diagnostics, treatment, access to health services etc. The public health strategy involves: policies, knowledge, attitudes, controlling access to means of suicide, and responsible media reporting etc. (ref. 3)

EXAMPLES OF SUCCESSFUL SUICIDE PREVENTION

1. There is evidence that **effective treatment of major psychiatric disorders** (depression, bipolar disorder, schizophrenia) can bring about a reduction in the rate of suicide and attempted suicide. However, it is important to closely and carefully follow up side effects of medication and especially anxiety and acathisia. Monitoring the blood for concentrations of medicines as well as simultaneous psycho-social and rehabilitation measures should be used routinely in suicide prevention. There are a great deal of obstacles, such as poorly functioning health care systems, constant reorganisation, economic restrictions, poor knowledge, and negative attitudes towards suicidal patients and suicide prevention. However, training of staff in psychiatric clinical work can improve knowledge, change negative attitudes towards suicidal patients, improve the climate in the work and give co-workers better self-esteem (ref. 4.).
2. **Cognitive Behavioural Psychotherapy (CBT) and Dialectical Behavioural Therapy (DBT)** have been effective in reducing the repetition of suicide attempts.

There are also reports that show that regular follow-up after a suicide attempt can reduce the repetition of suicide attempts. Hawton et al (ref. 5) showed, while scrutinising several randomised control trials, that repetition of attempted suicides could be decreased when emergency help was easily accessible.

3. **Reduction of alcohol consumption** during perestroika in the former USSR has been shown to be a very effective suicide preventive programme for men (ref. 6). Suicide for men decreased by 40% in the years 1984-1986, especially for men in the workforce. All 15 republics of the USSR showed a decline of suicide, while in Europe during the same time period the decrease in suicide was as small as only 3.0%. Alcohol restriction also influenced decreased mortality from undetermined causes, either accidental or intentional. Death due to accidental alcohol poisoning, violent death, external injuries, and homicide also decreased. Other researchers have shown that during perestroika the decrease in mortality due to cardiovascular and respiratory diseases could be assigned to alcohol restriction (ref. 7).
4. **Controlling the environment** through gun possession regulations, detoxification of car emissions or domestic gas, control of the availability of toxic substances including drugs and medication, as well as responsible media reporting about suicide have clear suicide preventive effects (ref. 8). There is also some evidence that suicide preventive programmes in schools can decrease suicide and attempted suicide (ref. 9). The WHO has published a document, "Preventing Suicide: A Resource for Teachers and other School Staff"(ref. 10), which has been translated into several languages and can be ordered from the WHO office in Geneva.

CONCLUSIONS

In suicide preventive work it is important to:

- Continuously disseminate knowledge
- Combine psychosocial, cultural, and biological (genetic) factors in research
- Create national institutes

The national suicide preventive programmes exist in several countries, and details are available in the European monitoring survey on suicide preventive programmes and strategies carried out by NASP on behalf of the WHO Regional Office in Copenhagen (ref. 11).

It is important to remember in suicide preventive work that many obstacles stem from the strong taboo on suicide that still exists and the distress it arouses and has aroused throughout history. The silence, ambivalence and negligence encountered make it difficult to approach the problem of suicide in an open and scientific way. Suicide is still associated with shame, uneasiness and guilt. As a result, suicides are not only concealed in the statistics as other causes of death or recorded only as injuries without mentioning even the word self-inflicted, but also due to the taboo. This reinforces the view that suicide is predestined or impossible to prevent or treat, which is not true. Of course still more evidence and better studies are needed, but the evidence from suicide preventive studies both from the health care and from the public health perspectives, gives encouragement and hope.

REFERENCES

1. Wasserman D (ed). Suicide – An unnecessary death. Martin Dunitz 2001.
2. Wasserman D. A stress-vulnerability model and the development of the suicidal process. In: Wasserman D (ed). Suicide – An unnecessary death. Martin Dunitz 2001.
3. Wasserman D. Strategy in suicide prevention. In: Wasserman D (ed). Suicide – An unnecessary death. Martin Dunitz 2001.
4. Ramberg I-L. Promoting Suicide Prevention – An evaluation of a programme for training trainers in psychiatric clinical work (doctoral dissertation). Karolinska Institutet 2003.
5. Hawton K, Arensman E, Townsend E, et al. Deliberate self-harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *BMJ* 1998;**318**:441-447.
6. Wasserman D, Värnik A, Dankowicz M, Eklund G. Suicide-preventive effects of perestroika in the former USSR: the role of alcohol restriction. *Acta Psychiatr Scand* 1998;**suppl 394**:1-44.
7. Leon D A et. al. Huge variation in Russian mortality rates 1984-94: artefact, alcohol, or what? *Lancet* 1997;**350**:383-88.
8. Leenaars A. Controlling the environment to prevent suicide. In: Wasserman D (ed). Suicide – An unnecessary death. Martin Dunitz 2001.
9. Wasserman D, Narboni V. Examples of suicide prevention in schools. In: Wasserman D (ed). Suicide – An unnecessary death. Martin Dunitz 2001.
10. World Health Organization. Preventing Suicide: a resource for teachers and other school staff. Mental and Behavioural Disorders, Department of Mental Health, World Health Organization 2000.
11. World Health Organization. Suicide Prevention in Europe, The WHO European monitoring survey on national suicide prevention programs and strategies. WHO Regional Office for Europe, Copenhagen. World Health Organization 2002.

Lubomir Okruhlica, Center for Treatment of Drug Dependencies, Slovakia

Response 2: Prevention of Abuse Problems

SITUATION

The prevention of abuse problems is an important part of the European Commission Public Health Action Programme 2003-2008. One of the aims of this Conference is to start dialogue on the issues of mental health between the existing and forthcoming Member States. Important issues are the new mental health threats encountered in the Central and Eastern European Countries, many of them being in the accession process to the EU. Drug abuse deserves special attention in this respect. In the course of the European Commission's consultations it has clearly emerged that young people's welfare and autonomy are influenced primarily by factors like health and drugs. Empirical studies show that the spectrum of ill-health is starting to change even among young people, and that a trend towards the spectrum of illnesses for adulthood can be anticipated. Today, the major health problems affecting young people are no longer the typical infectious diseases but, instead, chronic illnesses, psychosomatic illnesses and emotional disturbances. Besides the "modern-day" risks in the shape of consumption of "hard" and "soft" drugs, careless sexual behaviour and the associated risks of infection, the "conventional" risks, including alcohol consumption, tobacco consumption and risky behaviour in sporting and leisure-time activities, also have a significant impact on the physical and psycho-social health of young people.

Nonmedical use of psychoactive substances is a significant factor contributing to ill-health in Europe. Poly-substance use was an important trend in the last decade. It also means that a combination of licit and illicit drugs as a cause of health damage is occurring frequently. When analysing the "health gap" mortality between EU and candidate countries, then high tobacco consumption is playing a significant role, too, besides illicit drugs and alcohol. The (lifetime) prevalence of legal drug consumption (tobacco and alcohol) in the candidate countries is extremely high and the age of onset both of alcohol use and first drunkenness is very low when compared with the EU Member States.

Europe, and especially Central and Eastern Europe, has the highest consumption of alcohol in the world. Alcohol abuse often leads to a deterioration of social and family ties and, at the same time, reduces individual self-control and provokes depression, which is the primary cause of suicide. However, the scale of harm caused by alcohol is much wider. It contributes to a whole range of social, psychological and physical problems. Let me mention a few very severe harms such as RTAs, family disruption, aggressive behaviour, insomnia, depression, anxiety, amnesia, attempted suicides, suicides, hepatitis, pancreatitis, cirrhosis, liver cancer, gastritis, diabetes. These are related to heavy drinking with or without dependency, as well as to excessive drinking (e.g. binge drinking). Overall, the WHO estimates that in developed countries alcohol accounts for 10-11% of all illnesses and deaths each year. Between 40% and 60% of all deaths in the European Region from intentional and unintentional injury are attributable to alcohol consumption. The link between the trend in alcohol consumption and the three mortality indicators (standardised death rate for liver cirrhosis, injuries and

poisoning, and RTAs) was demonstrated by regional overview of the countries in the WHO report (2001).

Among the 15 EU countries, Austria, France and the Netherlands were experiencing a decrease in alcohol consumption, which was consistent with a decrease in all the mortality indicators, whilst Denmark and Finland had stable levels. In central and Eastern Europe: Latvia shows a consistent increase in both alcohol consumption and all of the mortality indicators. In Lithuania, considerable increase in cirrhosis and external causes suggest increasing alcohol consumption. In Hungary and Poland there is an increase in liver cirrhosis, but consumption is decreasing. Alcohol consumption is increasing in the Czech Republic, while the mortality indicators are stable or decreasing.

Serious depression is frequently associated with heavy drinking. Victims are not necessarily people with alcohol dependency. Depressed mood is present in most people with alcohol dependency, particularly in the immediate post-intoxication period. Part of it is undoubtedly the result of some of the life consequences of drinking, including isolation from family and friends who will no longer accept the drinking behaviour. This leads to a spiral of loneliness and dysphoria. In addition, the neuro-chemical disturbances induced by "heavy" bouts of drinking lead to a depressed mood ("alcoholic sadness"), which is temporary and will clear after two or three weeks of abstinence. However, some alcoholics have a primary depression which is present even in periods of prolonged abstinence. Studies of inpatients with alcohol dependency have shown that about 15% of women and 5% of men who met criteria for alcohol dependency have affective disorder as a second diagnosis. Suicide is a particularly common problem associated with alcohol dependence and has been estimated to be as high as 32 times the risk of the general population (Sexias, 1982). Next to advancing age, alcohol (and other drug) dependence is among the greatest risk factors for suicide. Men are more likely to commit suicide than women. The lifetime risk for completed suicide among people with alcohol dependency is between 5% and 15%.

Substance-related depression is particularly high among users of psychoactive substances with depressant effects such as opiates, alcohol and benzodiazepines. The results of studies among patients entering drug treatment show that more than half of them had scores indicating depression on depression rating scales. Substance-induced ("secondary") depression may dissipate rapidly, however it is as dangerous as, or more so than, major depressive disorder in terms of the risk of suicide and self-injurious behaviour.

The rate of comorbidity is high when completed suicides are investigated. Patients with medically more severe suicide attempts had a statistically higher prevalence of substance-induced mood disorder than the patients who had less severe suicidal attempts. Moreover, the majority of the patients with substance-induced mood disorder do not meet the criteria for substance dependence, because alcohol can dysregulate the mood independently of use, which suggests that some individuals are at risk for depression regardless of the chronicity of use. Studies show a conservatively estimated rate of about 30% lifetime prevalence of substance-induced depression among cocaine users with dependence.

The impact of acute drug-related deaths becomes evident when you consider that each year between 7 000 and 8 000 deaths are reported in the EU countries. It is worrying that some EU countries recently reported an increase after a period of stabilisation or decrease. Most countries consider that there is some level of under-notification, which

in some cases is significant. This is the case of the candidate countries as a whole, where reporting systems on this specific cause of death are just in the phase of preparation and early implementation. A European standard protocol has been developed by EMCDDA to report cases from general mortality registries. Basically, it is possible to differentiate between acute drug-related deaths and overall mortality among problem drug users. Suicides are part of acute drug-related deaths.

Most victims of overdoses are young males, in their 20s or 30s, who have been using opiates for several years. Injection represents a major risk factor. A clear ageing trend among victims is observed in most countries. The mortality of injectors is two to four times higher than non-injectors and (until recently) mortality of drug users infected by HIV was two to six times higher than that of non-infected drug users. It is difficult to distinguish unintentional overdose from suicidal activity. For the time being, deaths due to intoxication by cocaine, amphetamine or ecstasy without the presence of opiates are infrequent in Europe. However several countries (Spain, France, Italy, the Netherlands and the United Kingdom) have reported a national or local increase of cases where cocaine is found.

Since methadone maintenance has become quite widespread in recent years, circumstantial toxicological findings of methadone are more frequent among drug users who die due to accidents, AIDS and suicides. A few local studies suggest that some acute deaths may be caused by methadone diverted to criminal markets. Despite these problems research shows that substitution treatment reduces the risks of drug-related death among programme participants. The combined use of opiates with other depressant substances such as alcohol or benzodiazepines may increase the risk of overdose. The problem of widespread misuse of benzodiazepines and their IDU in combination with heroin was a typical problem of central European countries in the 1990s. High availability of these sedatives on criminal markets was one of the reasons.

RESPONSES TO THE QUESTIONS WHICH HAVE EMERGED

How do we apply the strategies for necessary actions on regional, national and European levels? The Commission of the EU, the Directorate General responsible for the administration of the Public Health Action Programme, has shown interest and attention in mental health issues. The EU has foreseen the far-reaching impact and consequences of the enlargement process in its recent documents, e.g. the Programme of the Community Action in the Field of Public Health 2003-2008. A good example of the increasing collaboration between the EU and the WHO is the European Alcohol Action Plan (EAAP) 2000-2005 (WHO Regional Office for Europe); the European Union drugs strategy (2000-2004) drawn up by EMCDDA and Europol with six main targets in the EU action plan on drugs (2000-2004). One of the six main targets of the EU action plan on drugs is: "to reduce substantially over five years the incidence of drug-related health damage (HIV, hepatitis, TBC etc.) and the number of drug-related deaths." These are the main frameworks indicating responses to the problem at a European level.

The EAAP aims to reduce the harm caused by alcohol

Nevertheless, alcohol use by individuals and in the community cannot and should not be isolated from other factors, not least the use of other psychoactive substances. The opportunities for EAAP implementation depend largely on economic, social and cultural factors in the communities. It is useful for a group of countries with similar geographical and cultural traditions and economic conditions to work together. There

are five overall objectives and ten strategies and actions on how to achieve them: (a) generate greater awareness of, provide education in, and build up support for public health policies that address the task of preventing the harm that can be done by alcohol; (b) reduce the risk of alcohol-related problems that may occur in a variety of settings such as the home, workplace, community or drinking environment; (c) reduce both the breadth and depth of alcohol-related harm such as fatalities, accidents, violence, child abuse and neglect, and family crisis; (d) provide accessible and effective treatment for people with hazardous and harmful alcohol consumption and those with alcohol dependence; (e) provide greater protection from pressures that encourage drinking for children, young people and those who choose not to drink.

All these principles are interconnected. More specific for the public health field, the prevention of premature mortality and abuses problems is following selected strategies: so that by the year 2005, all countries of the European Region should:

- Develop public awareness of the harm that can be done by alcohol and the consequences on the health and well-being of individuals, families and communities;
- Create support for public health policies;
- Provide children and young people with effective skills to make healthy choices and to be confident in their ability to withstand the pressure of under-aged drinking.

By the year 2005, all countries should have a comprehensive broad-based alcohol policy; a system of reporting on alcohol consumption and for monitoring and evaluating the implementation of alcohol policy and the harm that can be done by alcohol.

The EU Drug Strategy

The EU Drug Strategy made it clear that prevention of drug abuse should address both licit and illicit drugs. More attention should be paid to the connection between an early start with smoking tobacco, an early introduction to alcohol and initial use of illegal drugs. The European Council meeting in Helsinki on 10-11 December 1999 endorsed the European Union Drug Strategy 2000-2004 that covers all European Union drug-related activities and sets the main targets. These targets include substantial reduction over five years of the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug related deaths. The European Union Action Plan on drugs 2000-2004, endorsed in June 2000 at the European Council meeting in Santa Maria da Feira, transposes the strategy into concrete actions. The Member States, according to technical tools and guidelines provided by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA), should give reliable information on the five key epidemiological indicators, one of which is "drug related deaths and mortality of drug users". Similarly, very important from the perspective of Public Health Action Programme is also another harmonised epidemiological indicator: "drug-related infectious diseases (HIV, hepatitis)".

The EMCDDA annual report on the state of drug problems in the EU and Norway 2002 stated that scientific evidence indicates that methadone maintenance has substantial protective effect on mortality from opioid overdose and mortality from all causes. Innovative approaches to prevent and manage cases of overdoses were reported from Belgium, Germany, Finland, Norway and the United Kingdom. They include such things as the training of drug users to protect themselves against overdosing and to better manage overdoses they witness; training in naloxone administration as well as basic resuscitation techniques; and the development of specific prevention information materials. In the latter, the government launched an action plan to prevent drug-related

deaths in November 2001. Similar activities have been launched in candidate countries, especially in the Czech Republic, Slovakia, Slovenia and some Baltic countries, where NGOs and their street workers have predominantly been involved.

Preventing the spread of infectious diseases has a significant impact on prevention of premature mortality among users of psychoactive substances. Major evidence-based responses to prevent the spread of infectious diseases among drug users are community-based out-reach schemes, drug treatment - in particular the prescription of methadone or other substitution drugs (which has considerably expanded in the EU and candidate countries over recent years), - hepatitis immunisation, access to sterile injection equipment and the use of information and training. Some outreach services are available in all EU and candidate countries, but the degree to which the staff of drug agencies set off and bring their services to where the clients are varies considerably between and within countries. Candidate countries, in general, have to catch up with the EU countries in these efforts. A positive exception is Slovenia.

Special programmes that provide access to sterile needles are of major importance for minimising the rate of HIV and other blood-borne viral infections in drug users, and syringe exchange programmes, through drug agencies and pharmacies or vending machines exist, in all EU countries and, after some delay, now also exist in all candidate countries. Systematic efforts are under way in Germany, Ireland, the Netherlands, Portugal, Austria, Finland, the United Kingdom and Norway, as well as Slovakia and the Czech Republic; to make the hepatitis B vaccination more accessible and to achieve full immunisation among a higher percentage of drug users. Vaccination against hepatitis A is also recommended. Harm preventing and reducing programmes, which are vital for public health, are still facing serious obstacles in many communities in the candidate countries

Treatment as a response to the problem of drug use is stressed in the EU Action Plan. It can significantly reduce morbidity and mortality also due to reduction of suicides as it was mentioned above. The comprehensive offer of treatment modalities, their availability and accessibility is crucial. Therapeutic psycho-education, substitution treatment, drug-free programmes, specialised medical facilities for users with double diagnosis, treatment programmes for dependencies (also substitution) in prisons, and aftercare are the major treatment modalities, which should be developed and provided. The past five years have seen a considerable increase in the availability of treatment facilities in the EU and candidate countries. On the whole, medically assisted treatment appears to have grown more rapidly than drug-free treatment. However, there are still reports from Greece and Portugal, for example, that the treatment supply does not meet the client demand. The candidate countries have in common the later onset of the drug epidemic (compared to the EU countries), as well as a lag in the development of specialised treatment programmes both in quantity and also in the spectrum of provided treatment services. In this respect they have a lot in common with Greece and Finland where opiate use started about the same time as in majority of Central and Eastern European countries. Another specific feature is the close to zero prevalence of HIV among intravenous drug users in central European countries and Slovenia. Poland is an exception; it has a relatively high proportion of infected persons among drug users.

There is no candidate country, which can comply with demand of fully developed prevention and treatment system for drug using population. Neither the availability nor accessibility of treatment services is sufficient. For instance, there is generally a smaller number of patients with opiate dependence in substitution programmes in comparison

with the EU average. Maintenance treatment with methadone in prisons started only recently as a pilot programme in Slovenia, and may be soon in the Czech Republic, but not in the other countries. Late introduction and insufficient development of substitution and other harm reduction programmes is associated with a higher prevalence of HIV among drug users in Poland and Estonia. Slovakia has one large methadone maintenance programme but only in the capital city. Similar problems with accessibility are typical for most of the candidate countries. The availability of existing treatment and harm reduction programmes is threatened by cuttings on public service expenditures. People with alcohol and drug related problems are becoming an easy target. In Slovakia, for example, there have surfaced suggestions to radically reduce the provision of these health insurance funded services as a possible means of imposing fiscal restrictions.

Future plans for implementation

The importance of co-ordinated action was acknowledged in an international agreement in 1987 by the United Nations comprehensive multidisciplinary outline of future activities in drug abuse control. Subsequent international agreements by the United Nations and the European Union have identified co-ordination as a cornerstone of a balanced and comprehensive drug policy, most recently in the 198 United Nations Declaration on the Guiding Principles of Drug Demand Reduction (UNGASS). Within the EU, the need for both national and international co-ordination is widely accepted. The European Union drug strategy 2000-2004 reaffirms the importance of co-ordination and provides a mandate for improvement.

An EMCCDA report published in 2001 defined co-ordination within the field of drugs as the task of organising or integrating the diverse elements comprising the national response to drugs with the objective of harmonising the work and, at least implicitly, increasing effectiveness. In October 2001, the Council's Horizontal Working Party on Drugs examined the 'Report on identification of criteria for evaluation of the European Union Strategy on drugs (2000-2004)', drawn up by the EMCDDA and Europol. It offers an analysis of each of six targets of the EU action plan and underlines monitoring and evaluation constraints. Article 1.1.3 calls on the Council to provide regular opportunities for those responsible for drugs at a national level to meet and exchange information on national developments and to increase cooperation. So far as national strategies are concerned, the trend established over the past few years to translate drug policy frameworks into an action plan, drug strategy or policy document has continued, although a gap between the written strategy and its implementation still remains. The PHARE Technical Assistance programme (2001/2002), and its twinning with the EU and candidate countries in the field of drugs and drug policy, has proved an effective programme.

The European Convention, a meeting to draft a new treaty and overarching constitution for the EU, offers an excellent opportunity to strengthen co-ordination on drug policy at a European level. The principle that action on drugs should be comprehensive, balanced and co-ordinated is already recognised at the EU level and implemented in many countries, but it lacks a legal basis. There remains considerable scope for further approximation of national drugs policies and strategies, and for greater co-ordination between countries.

The prospect of the enlargement of the EU, embracing up to 10 new countries and 75 million more inhabitants presents new challenges. Drug abuse in these candidate countries, including opiate injection, is now approaching similar levels to those seen in the EU Member States. Whilst recreational drug use gives rise to some concerns, the

increase in opiate and meta-amphetamine injection is a much more serious problem, because of the associated spread of infectious diseases, overdoses, suicides and social deprivation. The existing co-ordination between the EU Member States and its bodies such as EMCDDA and the candidate countries, and future member states, should continue and be further strengthened.

In this way, it is possible to accelerate the introduction of effective harm preventing and reducing programmes into the candidate countries, where for instance “the window of the opportunity” is still open, e.g. concerning HIV/AIDS infection among intravenous drug users, but where the introduction of methadone substitution is slow. The implementation of new treatment approaches/substitution in prison environments is another possible example of positive measures.

All EU countries have endorsed the principle that co-ordination is an essential element in national drug policy. In every state there is a cross-departmental ministerial committee that acts as the forum for co-ordinating top-level policy. At the next tier down many countries have established central co-ordinating units to implement policy and provide technical advice to ministers. The candidate countries are creating similar organisational structures. These units should operate and make the gap between documents and praxis narrower. It is possible that horizontal intersectoral "action groups" (bodies, which are known from the other types of epidemics) constituted from administrators and experts from different sectors, could complete this structure and act as a more flexible and dynamic instrument in the transfer of strategic objectives into real life.

The transfer of good practices is an important objective, which is congruent with the European drug strategy and with the European Alcohol Action Plan, and it applies not only to candidate countries, but also to different communities across the whole of Europe. Emphasis should be given to the need for an evaluation of the experiences gained, and identifying the best practices with a view to ensuring the consistency and continuity of the Community's action in this field. An active promotion of evidence-based interventions can make important contributions despite the scarcity of the resources.

WORKSHOP 4A REPORT: The Prevention of Premature Mortality

Co-ordinator: *Andrej Marusic, Slovenia*

Facilitator: *Lars Mehlum, Norway*

Rapporteur: *Maja Zorko, Slovenia*

The following questions were put to the workshop beforehand:

A Recent changes in premature mortality statistics (focusing on suicide): how to apply the strategies of necessary actions at a regional, national and European level?

B Different parts of society need to be involved: how to stimulate the needed interdisciplinary and intersectoral collaboration, and how to cover the entire life-span?

C What goals should the emerging European Union have for suicide prevention for the next five-year period?

HOW TO APPLY THE STRATEGIES ON DIFFERENT LEVELS?

The experiences from several pioneering, ongoing⁶ and developing⁷ national strategies for suicide prevention indicate the importance of:

- defining responsibilities for national co-ordination;
- terms of reference given by federal authorities;
- interdisciplinary basis and ownership;
- multisectoral involvement;
- creation of suicide prevention networks;
- specific goals and practical measures;
- evidence-based strategy;
- including actions that are open to monitoring and continual evaluation;
- continual revisions and updates of the strategy;
- establishing resource centres.

The Suicide Prevention Strategy for England (2002) is a good example, demonstrating the main goals and objectives for action that should be met by every suicide prevention programme. The programme activities of the suicide prevention strategy are based on six goals:

1. To reduce suicide risk in key high risk groups

- the group must have a documented statistical increase in the risk of suicide;
- the actual numbers of suicide in the group must be known;

⁶ Finland (1992-), Norway (1994-), Sweden (1995-), Greenland (1997-), Denmark (1999-), Australia (1999-), Canada, USA (1999), England (2002), Scotland (2002)

⁷ Slovenia, Germany, Belgium, China

- evidence exists on which to base preventive measures;
 - there must be ways of monitoring the impact of preventive measures that have been implemented.
2. To promote mental well-being in the wider population by targeting:
- socially excluded and deprived groups;
 - ethnic minority groups;
 - alcohol and drug misusers;
 - victims of violence and sexual abuse;
 - children and young persons under 18 years of age;
 - women during and after pregnancy;
 - older people;
 - those bereaved by suicide.
3. To reduce the availability and lethality of suicide methods such as:
- firearms;
 - pharmaceutical drugs;
 - poisonous substances;
 - car exhaust;
 - bridges and high places.
4. To improve the reporting of suicidal behaviour in the mass media.
5. To promote research on suicide and suicide prevention.
6. To improve epidemiological monitoring of suicides to track the progress of suicide prevention actions.

Past experiences show that developing an infrastructure is of high importance. The provision of high quality epidemiological data on suicide and nonfatal deliberate self-harm is crucial and can be provided only through standardised approaches to defining, reporting, recording, classifying and coding. An establishment of resource centres in charge of research, monitoring trends, supervision and education is needed. National centres now exist in many countries with some countries also having regional centres. Furthermore the establishment of a European Centre was discussed.

It was concluded that national suicide prevention strategies should be supported by:

- a) establishment of national resource centres for suicide research and prevention;
- b) networks on national, regional and local levels:
 - International: IASP, IASR, WPA (WFMH, MHE and more);

- European: EUR/WHO Network for suicide research and prevention, European biennial suicide research conferences;
- National networks - various dimensions;
- Regional networks (examples: Sweden, Norway);
- Local networks.

c) international collaboration.

INVOLVING DIFFERENT PARTS OF SOCIETY

The continuum of different phases and risk factors of the suicidal process is accompanied by the continuum of responsibility, - from the generalised to the specialised, and from the public to the experts (Figure 1). Thus, suicide prevention cannot only be the responsibility of the health care system or experts, but requires a much wider approach, which includes different parts of society (Figure 2).

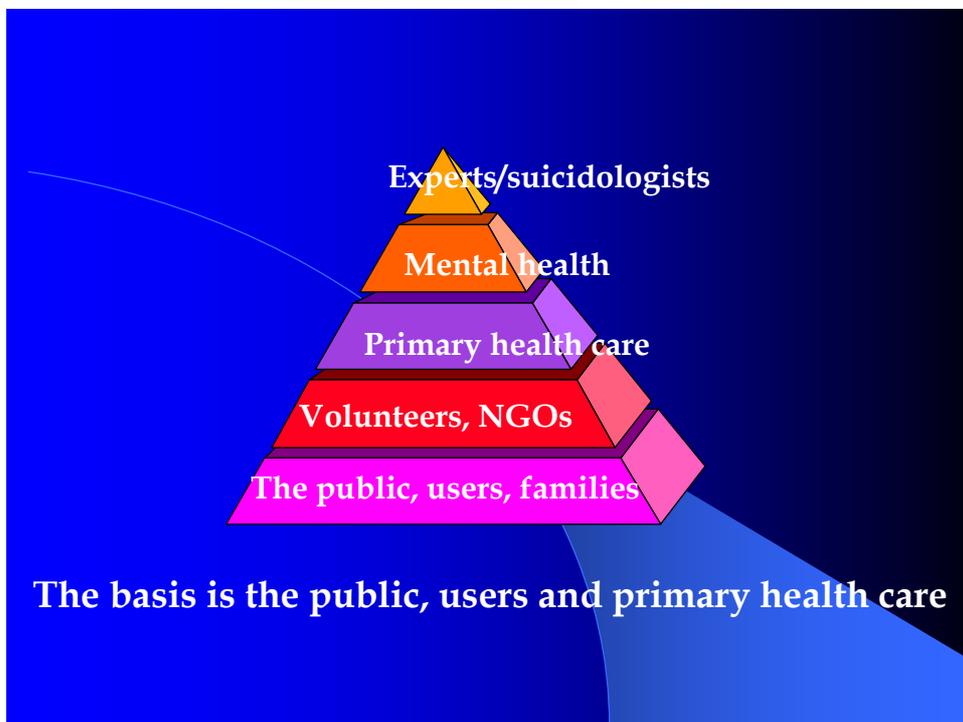


Figure 1. Suicide prevention in different phases of the suicidal process (Mehlum, 2000).

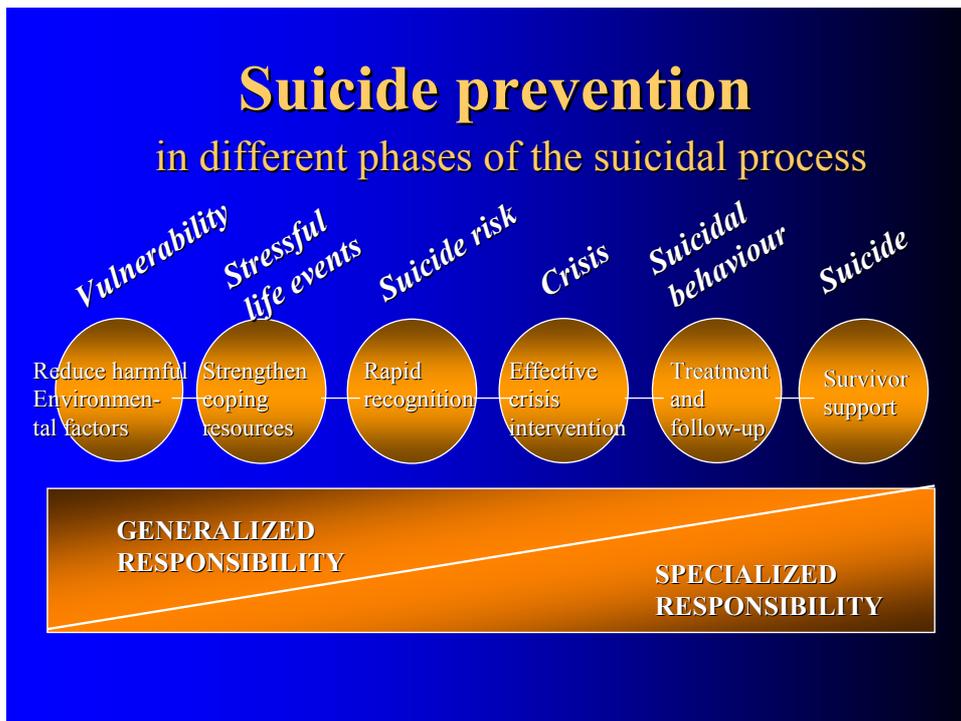


Figure 2. Different parts of societies that are involved in suicide prevention (Mehlum, 1999).

CONCLUSIONS AND RECOMMENDATIONS

C1 For the European Union to require of each member state that national health plans must address the need for suicide preventive measures.

C2 For the European Union to recommend the establishment of national suicide prevention strategies for:

a) increasing public awareness about suicide:

- that suicide is a major public health problem;
- that suicide prevention is a responsibility of the whole society, not only of experts, mobilising interdisciplinary and intersectoral collaboration;
- mobilising/empowering the public and users through:
- IASP/WHO World Suicide Prevention Day (celebrated for the first time on the 10th September 2003);
- National/regional suicide awareness days;
- First-aid/Band-aid concept (Living Works, VIVAT, Other);
- mobilising/empowering NGOs suicide prevention in partnerships with professional agencies for suicide prevention through:
- crisis support/intervention: Crisis centres/telephone services (Samaritans and numerous similiar organisations);

- bereavement support: Survivor associations (SPES, LEVE etc.);
- suicide prevention advocacy (SPAN, IASP);
- fundraising for research and development (AFSP).

b) reducing suicide rates in key high risk groups through

- treatment of depressive disorder and bipolar disorder;
- more targeted preventive treatment for patients with schizophrenia and risk of suicide;
- improved follow-up treatment of suicide attempters;
- improved treatment for patients with double diagnoses of substance abuse and mental disorder;
- establishing support/treatment for suicide survivors.

d) limiting the access of and lethality of suicide methods.

e) improving the reporting of suicidal behaviour in the mass media.

C3 Establishment and maintenance of a European database of good practices/ methods in suicide prevention across sectors of society and national borders

C4 Establishment of a resource centre for:

- epidemiological surveillance and evaluation of trends;
- improvements in the quality of epidemiological data;
- evaluation of suicide preventive strategies and measures.

C5 The European strategy should be regarded as an evolving strategy regularly updated with the emergence of new challenges and new evidence based methods.

REFERENCES

Department of Health. National Suicide Prevention Strategy for England. London, Department of Health, 2002.

Mehlum L. (ed). Back to life. Suicide Prevention in theory and practice. Kristiansand: Norwegian Academic Press, 1999: pp 469.

Mehlum L. Unpublished manuscript. Suicide Research and Prevention Unit, University of Oslo, 2000.

WORKSHOP 4 B REPORT: Prevention of Alcohol and Drug Abuse Problems

Co-ordinator: *Andrej Marusic, Slovenia*

Facilitator: *Pier Paolo Pani, Italy*

Rapporteur: *Marianne Sipilä, Finland*

The specific questions to be answered:

1. What priorities in intervention should be used for the general population?
2. What priorities in intervention should be used for high risk groups?
3. Different parts of society need to be involved: how do we stimulate the much needed inter-disciplinary and intersectoral collaboration?

The prevention of abuse problems is an important part of European Commission Public Health Action Programme 2003-2008. Europe, and especially Central and Eastern Europe, has the highest consumption of alcohol in the world. Alcohol and drug abuse often leads to a deterioration of social and family ties and, at the same time reduces individual self-control, and provokes depression, which is the primary cause of suicide. The scale of harm caused by alcohol and drugs is wide. It contributes to a whole range of social, psychological and physical problems.

GENERAL POPULATION

The focus of all promotional work should be on healthy lifestyle promotion and life-skills development. More knowledge and education about alcohol and drugs should be given on: the use, abuse, consequences, dependence, effects on brain, etc. The information should be conveyed frankly and seriously.

The development of psycho-educational preventive interventions and programmes are needed: e.g. having different public information campaigns, following the WHO principles on health promotion. The health promotion approach should dominate prevention and different prevention measures should be integrated. In the community, extensive projects in schools, youth clubs, workplaces, the army etc. are needed. Examples of these could be: 'Have a View on a Healthy and Confident Society', 'Be Free from Alcohol and Drug Related Harm!'; or, 'It's Your Choice and Decision – Have a Free Urine Test!' It would also be a good strategy to have well-known people like movie stars or other famous people tell openly about their experiences of using drugs or alcohol.

The collection of good quality data at a general and local level is needed. Even though much has been done, further development in this direction would help to assess the national and regional needs, and to monitor interventions and their impact in an evidence-based context. There is also a need for the standardisation of data across countries and for co-ordination both at a local and general level.

Stigmatisation and discrimination connected with substance use should be overcome. This is essential for increasing information and knowledge about substance abuse, predisposing factors and concomitant illnesses. It is important to use available and

effective treatments in order to enhance social participation, to prevent abuse, to break through the existing barriers to available interventions, and to involve societal resources in prevention and treatment.

HIGH RISK GROUPS

Who are in the high-risk groups? Perhaps there should be some kind of general test to evaluate high risk groups? A lot of research has been done and many reports published on the risks involved in alcohol and drug use. Specific interventions and treatments have been developed, and they provide solutions for people with risky behaviour. Still, more has to be done.

More attention should be paid to the connection between an early introduction to smoking, alcohol, and the use of illegal drugs. More attention should be made to the monitoring of experimental drug use at sports events, other public events, and beer or wine festivals. Parents who use alcohol or drugs are increased the health risks to their children. There is a need to minimise alcohol- and drug-related problems in a variety of settings such as the home, workplace, community or drinking environment, in order to reduce accidents, family crises, violence, child abuse and neglect.

Effective methods to prevent substance abuse should be included in alcohol and drug strategies:

- *Increasing knowledge and resistance* of users and abusers by providing information on the prevention and treatment of drug related harm.
- *Information, education and provision of psycho-educational programmes* can be a helpful step before treatment for high risk groups.
- *Effective treatments* for substance abusers should be implemented. The treatments should be flexible enough to fit to different settings and to the use of different drugs. Preventing and treating related morbidity and mortality (overdose, infectious diseases, psychiatric disorders etc.) is important. By adding some psychosocial intervention, the outcome can be still more favourable. Non-pharmacological psychosocial interventions have still to show their efficacy.
- Special programmes that, for example, provide access to sterile needles are important.
- Offering rehabilitation for drug users is part of an optimum comprehensive programme.

All countries should have a comprehensive broad-based alcohol policy, including a system of reporting on alcohol and drug consumption for the monitoring and evaluation of alcohol policy implementation and the harm that can follow alcohol or drug use. Special focus should be on adolescents, the ageing population, prisoners, minorities, immigrants, recreational drug users, motor vehicle drivers etc.

INTERDISCIPLINARY AND INTERSECTORAL COLLABORATION

Local initiatives and face-to-face communication are essential, accompanied by a holistic approach in co-ordinating programs and services at local level. It is important to involve communities in the development and delivery of local strategies, and in focusing the action where it is most needed. Harm reduction should be an integral part of drug policy in every country. It includes the legal framework for substitution and maintenance programs.

All EU countries have a intersectoral ministerial committee that acts as the forum for co-ordinating national policy. The candidate countries are creating the same organisational structures. These units should operate and make the gap between documents and praxis narrower.

Administrators and experts from different sectors should cooperate and work in intersectoral collaboration. They should share responsibilities via mechanisms of shared project budgeting. It should include all actors and stakeholders, like NGOs, university departments and public health facilities owned by the local community.

The principle that action on drugs and alcohol should be comprehensive, balanced and co-ordinated is already recognised at the EU level, and is implemented in many countries, but it still lacks a legal basis. Thus, there remains considerable scope for further approximation of national drug policies and strategies and for greater cross-national co-ordination. The prospect of the enlargement the EU, embracing up to 10 new countries and 75 million more inhabitants presents new challenges for the future. The mechanisms for co-ordination between the EU Member States and its bodies, such as the EMCDDA, and the candidate countries (and any new member states that may later join) should continue and even be strengthened further.

REFERENCES

Annual report on the state of the drugs problem in the EU and Norway. EMCDDA, 2002.

Report on the drugs situation in the candidate CEECs. EMCDDA, 2002.

The European Health Report 2002. Copenhagen, WHO Regional Office for Europe, 2002.

Upanne M, Hakanen J, Rautava M. Can suicide be prevented? Finland: Stakes, 1999.

World Health Organization: Alcohol in the European Region - consumption, harm and policies, WHO Regional Office for Europe, Copenhagen, 2001.

CONCLUDING PRESENTATIONS

Eero Lahtinen, Ministry of Social Affairs and Health, Helsinki, Finland

Future Prospects of the European Mental Health Agenda

The future depends on whether we will be able to keep mental health on the agenda; our own, the national, the EU25 and the global agenda. I think that I have been asked to talk about the future because I have had some connection with the mental health agenda since the mid-1990s. Therefore, I will present a few quite personal reflections on the issue.

First, I would like to emphasise the importance of the continuous development of an understandable conceptual and operational framework, and the importance of using that framework to systematically fill in the gaps in data information we need to get decision-makers to be supportive of mental health work and to deal with mental health issues as effectively as possible. My personal view is that following the public health path will be the most effective strategy here. We should focus on issues that make the work of mental health so unique, especially prevention and promotion. The themes I would like to suggest are resilience, concepts, monitoring and interventions. In addition, we should work more and more on mental health economics, where - I think - we have already made immense progress in a very short time. But we need more in order to convince decision-makers all over the world.

Second, I think we should try to avoid an unnecessary polarisation between the different stakeholders at different levels:

- Between international organisations such as the WHO and the EU: they both have their own roles, but their efforts should be complementary as far as possible.
- Between continents: Europe - North America or Australia: a lot is done currently on the other side of the world - with Australia being especially advanced. We do not need to independently reinvent the wheel on every continent.
- Between countries, regions, organisations and people: There will be enough to do for everybody in this domain, wherever they are. In order to make progress we need, naturally, to have our own agendas, but making efforts together makes 1 + 1 to be more than just 2.
- Between the policy and administration level vs. NGOs and users and carers. If we want to have sustainable development, the process must be participatory and empowering, not an activity imposed from the top down. This is not always easy, but it is absolutely necessary.
- Between promotion, prevention, treatment and rehabilitation. Mental health work needs all these components, and they are complementary. This is perhaps the most important lesson we should learn from general health promotion.

Third, we need to keep the political momentum that we have already achieved going. Ministers come and go, but we stay. We need to repeatedly educate new ministers on the basics about mental health work to get them committed. I am happy, for instance, to

tell you that the new Finnish Government and its Health Minister are still committed to this issue. A particular challenge is that we will have a new Commission and a new European Parliament next year. We all need to do everything in our power to sensitise the new Commissioner and the new MEPs on mental health issues. There, I would say, we are very much in the hands of, not only the coming presidencies of the EU, but increasingly also the positions of the accession countries. We might not yet be ready to debate on a Council and European Parliament recommendation on mental health with the aim of further raising its importance by providing a concrete tool for country level lobbying, but we are not far away.

I do not know any other example in the field of public health and especially health promotion where so much progress has been possible in such a short time, while having such a continuous and close link with the political sphere. We have seen conclusions and resolutions at the top political level, but we have also seen a growing evidence- and knowledge base and more and more information on good practices. And that is because you have made this possible, your work, your innovations and your commitment.

In terms of mental health promotion, coming from the field of general health promotion, I must say that we might even be able in a few years to show the way to general health promotion, because we seem to be getting a very solid, multidimensional and balanced basis for future progress in our work. But that requires that we:

- respect different science domains as providers of evidence, another lesson to be learned from the mistakes of general health promotion;
- avoid a conscious medicalisation of mental health promotion; and
- in the first place, keep alive the unique togetherness and collaboration of those who have been, and will be, active in this field.

Andrej Marušič, Institute of Public Health of the Republic of Slovenia

There is No Public Health without Public Mental Health

When Tyrer and his colleagues tried to locate the early foundations of public mental health they had to look back to the middle of the nineteenth century. Since both public and mental health medicine became identified as a discipline within medicine the major concerns facing public health doctors were those relating to epidemics of disease such as the cholera epidemics. Accordingly, the first role of public health became one of social reform. The only mental health component of these reforms was an indirect one, as improvements in the productivity and spending of money for the relief of the poor led to improvements in moral and mental behaviour. In the early twentieth century public health was preoccupied with prevention, hygiene, the surveillance of communicable diseases and the administration of health facilities. One of the reasons why mental health did not figure highly on public health agendas was the absence of mental health indicators, broadly in line with the popularity of psychoanalysis. Most recently, mental health indicators have been developed, which in turn has presented an important opportunity for the public mental health to develop further.

As Kendell (1997) has pointed out, public health has traditionally been concerned with the primary prevention of disease, either by eliminating its causes or by enhancing host resistance. Unfortunately, the majority of mental disorders have not yet proved susceptible to this approach. Measures like introducing dietary intervention to eliminate pellagra, the widespread use of penicillin to eliminate general paralysis of the insane, and neonatal screening programs to detect phenylketonuria and congenital hypothyroidism also prevent the related mental disorder. Amniocentesis and contemporary ultrasound diagnostics have the potential to reduce the incidence of Down's syndrome. In the same way, a wide range of safety measures and legislation intended to minimise the risk of accidents have effectively reduced the incidence of post-traumatic stress disorder. Evidence might show that improvements in obstetric care will lead to a lower incidence of schizophrenia! There are several other opportunities for prevention which are not yet properly exploited, for example, the detection of postnatal depressions by a questionnaire followed by counselling; the prevention of puerperal psychoses in high-risk pregnant women; the prevention of pathological bereavement reactions, and possibly of post-traumatic stress disorders, by early interventions.

Of course, prevention is not the only aspect of public (mental) health. Another important aspect of public (mental) health has been covered by Kleinman and Becker (1998), when they presented the concept of sociosomatics as opposed to psychosomatics. According to this concept, social contexts are integrated into mind and body understandings. Mind and body interactions are reframed as mind and body in a social context. A direct impact of the social context upon bodily or illness experience is therefore expected: psychophysiologic processes are shaped by social forces, and patterns of symptoms are identified as local idioms of distress and cultural syndromes. This concept is also relevant to the cross-cultural understanding of mental health, which is becoming increasingly important with the ongoing enlargement of the European Union.

With the potential for such a wide spectrum of activities, we first need to agree about the name of a public health discipline covering mental health issues. It is true that public health medicine consists of what used to be called social medicine, epidemiology and hygiene. Nevertheless, we should not use any of the following names: social psychiatry, psychiatric epidemiology or mental hygiene as none of these would cover the whole spectrum of public health responses to mental health needs. On the other hand, the name public mental health will do!

At the moment, we have already recognised that mental health problems are of major importance to all societies and to all age groups. We have agreed that mental health problems are a significant contributor to the burden of disease and that the related loss of quality of life can cause human suffering and disability and increase social exclusion and mortality. Furthermore, the stigma attached to mental health contributes negatively to equality and societal inclusion. Hence, we need to: collect good quality data on mental health (valid and reliable across time and across Europe); support the analysis of the mental health situation based on research and an assessment of needs; develop, implement and evaluate actions to prevent mental disorders and to promote mental health; allow access to treatment, the labour market, education and other public services for (re)integration of people with mental disorders into society; and to enhance the visibility of mental health and to raise awareness of the real burden of mental disorders.

One wonders if the European Union's Community Action in the Field of Public Health is good enough to effectively cover all the above presented tasks! It probably does not treat public mental health globally enough as it only provides compartments for mental health under the health determinants section. Furthermore, division into compartments is neither evidence- nor value- based; e.g. depression comes under mental health and suicide under injury prevention.

In terms of *health information*, **mental health information** should also be covered by the development, co-ordination and the dissemination of mental health information and monitoring systems, by reporting and analysing mental health issues and producing public mental health reports, and by improving access to and transfer of data at an EU level. Whereas *health determinants* have already covered some **mental health determinants**, *health threats* have been almost mental health free. These should also cover at least the following areas affecting **mental health threats**:

- the surveillance development and integration (e.g. the rights of people with mental disorder continue to be violated in the EU, e.g. exemplary actions by the associations like Geneva Initiative);
- the safety of new illicit drugs;
- the building of targeted capacity is also relevant to mental health (e.g. for those events that adversely affect large numbers of people, like September 11th 2001).

As a great degree of support and co-ordination will be needed, the European Union should start thinking about agencies to cover public mental health. We have already seen the effectiveness of EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) in Lisbon. A similar agency could cover other relevant public mental health concerns, e.g. suicidal behaviour. About 70% of deaths due to suicide occur in the age group 25 to 64, which are, from a socio-economic point of view, the most productive years. They impose great economic burdens on society due to lost future productivity. Suicides claim substantially more life-years and more personal income loss during the age interval from 20 to 64 years than any of the two “major killers”, i.e. cardiovascular diseases and cancer. The average number of years of lost productivity due to suicide is

twice the number due to cerebrovascular disease and ischemic heart diseases. For example in Slovenia, which has one of the highest suicide rates in the world, around 30/100.000/year, deaths from suicide in 2001 accounted for the greatest loss of future income (Šešok et al, 2004):

- the first leading cause of Future Lifetime Income Lost;
- the first leading cause of Valued Years of Potential Life Lost (VYPLL);
- the second leading cause of Working Years of Potential Life Lost (WYPLL) with an average number of 21.7 years per person who died prematurely;
- the second leading cause of Premature Years of Potential Life Lost (PYPLL) (29.7 years per person who died prematurely);
- the third leading cause of Premature Death (rate 15.9 per 100.000 inhabitants 0-64).

Would it be too daring to think of agencies like EMCSAS - the European Monitoring Centre for Suicide and Attempted Suicide?

REFERENCES

Kendell R (1997). How psychiatrists can contribute to the public health. *Advances in Psychiatric Treatment*, 3, 188-96.

Kleinman A & Becker AE (1998). "Sociosomatics": The contributions of anthropology to psychosomatic medicine. *Psychosomatic Medicine*, 60, 389-93.

Retterstol N (1993). *Suicide - A European Perspective*. Cambridge University Press: Cambridge.

Šešok J, Roškar S & Marušič A (2004). Burden of suicide and ... have we forgotten the open verdicts? Editorial. *Crisis* 25, 2, in press.

Annex 1

CONFERENCE PROGRAMME

Thursday, 9 October, 2003

08.00 - Registration

09.00 - 10.15 Opening Session:

Chairpersons: *Ville Lehtinen (FIN) and Agustin Ozamiz (ESP)*

Opening Addresses by

- *Mr Gabriel M^a Inclán Iribar*, Regional Health Minister, Basque Government
- *Mr Horst Kloppenburg*, European Commission
- *Dr Wolfgang Rutz*, European Regional Office of the WHO
- *Mr José Maria Abrego de Lacy*, Rector of the University of Deusto
- *Mrs Vappu Taipale*, Director General of the National Research and Development Centre for Welfare and Health, STAKES

10.15 - 10.45 Keynote speech: Enlargement of the EU from the Point of View of Health-Related Issues,

Clive Needle, EuroHealthNet

10.45 - 11.15 Coffee Break

11.15 - 12.30 Plenary Session: Identifying and Tackling the Economic Impacts of Mental Health Problems

Chairpersons: *John Henderson (UK) and Aleksandra Kalasic (SCG)*

- Key Presenter : *Martin Knapp (UK)*
- Responder 1: *Silvia Evers (NED)*
- Responder 2: *Mojca Dernovsek (SVN)*

12.45 – 13.45 Lunch

14.00 - 15.15 Plenary Session: Impact of Transitions on Mental Health

Chairpersons: *José Guimón (ESP) and Karl Kuhn (GER)*

- Key Presenter: *Dainius Puras (LIT)*
- Responder 1: *Agustin Ozamiz (ESP)*
- Responder 2: *Richard Plette (HUN)*

15.15 - 15.30 Break

15.30 - 18.00 Four parallel workshops:

- **1a** and **1b** on economic and social impact of mental ill-health
- **2a** and **2b** on impact of transitions

19.30 - Reception: Bascaian Foral Government (Diputación Foral de Bizkaia)

Friday, 10 October, 2003

09.00 - 10.00 Reports from the workshops by the workshop rapporteurs

Chairpersons: *Odd Steffen Dalgard (NOR) and Pascale van den Heede (BEL)*

- General discussion

10.00 - 11.15 Plenary Session: Promotion of Mental Health and Prevention of Common Mental Disorder: Strategies for Needed Actions

Chairpersons: *Helena Silfverhielm (SWE) and Gabor Gombos (HUN)*

- Key Presenter: *Heinz Katschnig (AUT)*
- Responder 1: *Jan Czabala (POL)*
- Responder 2: *Leo de Graaf (NED)*

11.15 - 11.45 Coffee Break

11.45 - 13.00 Plenary Session: Prevention of Premature Mortality and Abuse Problems

Chairpersons: *Galia Petrova (BUL) and Ray Xerri (MAL)*

- Key Presenter: *Iveta Bluka (LAT)*
- Responder 1: *Danuta Wasserman (SWE)*
- Responder 2: *Lubomir Okhrulica (SVK)*

13.15 - 14.15 Lunch

14.30 - 15.30 Round Table Session: Enhancing the User/Carer Involvement in Mental Health Policy Development in Europe: How to cope with the new challenges?

Chairperson: *Rachel Jenkins (UK)*

Participants:

- *Hilkka Kärkkäinen (FIN), GAMIAN*
- *Inger Nilsson (SWE), EUFAMI*
- *Cyril Höschl (CZE)*
- *Bairbre NicAongusa (EIR)*

15.30 –15.45 Break

15.45 –18.15 Four parallel workshops with a break

- **3a** and **3b** on needed infrastructure for promotion and prevention
- **4a** and **4b** on prevention of premature mortality and abuse problems

20.30 - Conference Dinner

Saturday, 11 October, 2003

09.30 - 10.45 Reports from the workshops by the workshop rapporteurs

Chairpersons: *Ona Davidoniene (LIT) and Charles Pull (LUX)*

- General discussion

10.45 - 11.30 Coffee Break

11.30 - 13.00 Concluding Session

Chairpersons: *Leen Meulenbergs (BEL) and Angelo Barbato (ITA)*

- *Ville Lehtinen (FIN)*: Presentation of the draft for the conclusions and recommendations
- General discussion
- *Eero Lahtinen (FIN)*: The future prospects of the European Mental Health Agenda
- *Andrej Marusic (SLO)*: There is no public health without mental health
- *Horst Kloppenburg (EC)*: Closing remarks

Closing the conference

by *Dr Rafael Cerdán*, Vice Minister of Health in the Basque Government

Annex 2

LIST OF PARTICIPANTS

First name	Surname	Organisation	Country
AMADDEO	FRANCESCO	DEPT OF MED & PUBL HLTH, SECT PSYCHIATRY	ITALY
ANGELIDIS	GEORGIOS	PSYCHIATRIC HOSPITAL OF PETRA OLYMPUS	GREECE
ARTUNDO	CARLOS	WHO EURO	SPAIN
AYUSO	JOSE LUIS	HOSPITAL DE LA PRINCESA	SPAIN
AZUETA	IZASKUN	UNIVERSITY OF DEUSTO	SPAIN
BAKER	MARIE BURDESS	MENTAL HEALTH MATTERS	UK
BARBATO	ANGELO	WORLD ASSOCIATION OF PSYCHOSOCIAL REHABILITATION	ITALY
BARDOT	ANNE	LUNDBECK	FRANCE
BARRUBÉS	JOAN	ANTARES CONSULTING	
BERMEJO	MIGUEL ANGEL	UNIDAD DE PSICOSIS REFRECTARIA	SPAIN
BLUKA	IVETA	HEALTH PROMOTION CENTRE	LATVIA
BORG	EDWARD	MOUNT CARMEL HOSPITAL	MALTA
BREIER	PETER	GENERAL HOSPITAL RUZINOV	SLOVAKIA
BREZOVSKY	PAVEL	MINISTRY OF HEALTH	CZECH REP.
BROOK	RICHARD	MIND	UK
CANNY	LOUISE	MENTAL HEALTH MATTERS	UK
CARDEA	ROBERTO	MINISTRY OF HEALTH	ITALY
CEBALLOS	ANA	CONSULTA PRIVADA	SPAIN
CLABBERS	FRANS	MINISTRY OF HEALTH, WELFARE AND SPORT	NETHERLANDS
CONSTANTOPOULOS	ATHANASSIOS	MENTAL HEALTH CENTRE	GREECE
COSTIGLIOLA	VINCENZO	EUROPEAN MEDICAL ASSOCIATION	BELGIUM
COX	ANDY	MENTAL HEALTH MATTERS	UK
CZABALA	CZESLAW	INSTITUTE OF PSYCHYARY AND NEUROLOGY	POLAND
CHRISTENSEN	LENE	MINISTRY OF THE INTERIOR AND HEALTH	DENMARK
DALGARD	ODD STEFFEN	DEPT COMMUNITY MEDICINE, UNIV OSLO	NORWAY
DAVIDONIENE	ONA	STATE MENTAL HEALTH CENTRE	LITHUJANIA
DE GRAAF	LEO	MENTAL HEALTH EUROPE	NETHERLANDS
DEFTERAS	IRIS	MENTAL HEALTH SERVICES/MINISTRY OF HEALTH	CYPRUS
DERNOVSEK	MOJCA Z.	INSTITUTE OF PUBLIC HEALTH	SLOVENIA
DIAUX	JOSE LUIS	EUGAMED	SPAIN
DOORNKATE	GERARD	GENEVA INITIATIVA ON PSYCHIATRY	NETHERLANDS
DOWRICK	CHRISTOPHER	DEPT. PRIMARY CARE, UNIV. LIVERPOOL	UK
EVERS	SILVIA	UNIVERSITY MAASTRICHT/BEUZ	NETHERLANDS
GAUGER	ANDREA	BRUECKE	GERMANY
GEISLER	RUDOLF	BRUECKE	GERMANY
GEORGALIS	MARIANNA	CEFEC	GREECE
GERITS	POL	MINISTRY OF PUBLIC HEALTH	BELGIUM
GOEDHART	FRANCISCA	GENEVA INITIATIVE ON PSCHIATRY	NETHERLANDS
GOMBOS	GABOR	ENUSP	HUNGARY
GRAHAM	MARK	MENTAL HEALTH MATTERS	UK
GRANHOLM	BIRGITTA	HÄSSELBY-VÄLLINGBY PYCHIATRIC UNIT	SWEDEN
GRANT	IAN	MENTAL HEALTH MATTERS	UK
GUMPLMAIER	HELGA	INTEGRAL - INSTITUTE FOR LABOUR AND LIFE	AUSTRIA
HALSTEINLI	VIDAR	SINTEF UNIMED	NORWAY
HAMILTON	RON	MIDDLESEX UNIVERSITY	UK

HÄNNINEN	ESKO	STAKES	FINLAND
HANSON	JERKER	THE BOARD FOR MEDICAL QUALITY AUDIT	SWEDEN
HARRIS	RUTH	MENTAL HEALTH MATTERS	UK
HENDERSON	GREGOR	SCOTTISH MENTAL HEALTH DIVISION	UK
HENDERSON	JOHN	MENTAL HEALTH EUROPE	UK
HENDERSON	ROB	MENTAL HEALTH MATTERS	UK
HILL	HUGH	SCOTTISH ASSOCIATION FOR MENTAL HEALTH	UK
HÖSCHL	CYRIL	PRAQUE PSYCHIATRIC CENTER	CZECH REP.
HUITINK	CLEMENS W.	GGZ NEDERLAND	NETHERLANDS
IRUIN	ALVARO	OSAKIDETZA	SPAIN
JACOB	BERNARD	EUROPSYREHABILITATION	BELGIUM
JENKINS	RACHEL	INSTITUTE OF PSYCHIATRY	UK
JESPERSEN	MARIANNE	NATIONAL BOARD OF HEALTH	DENMARK
JEZZARD	ROBERT	DEPARTMENT OF HEALTH	UK
KÄRKKÄINEN	HILKKA	GAMIAN-EUROPE	FINLAND
KATILA-NURKKA	ULLA	STAKES	FINLAND
KATSCHNIG	HEINZ	LUDWING BOLTZMANN INSTITUT SOZIALPSYCHIAT	AUSTRIA
KIESELBACH	THOMAS	UNIVERSITY OF BREMEN	GERMANY
KITTEL	FRANCE	UNIVERSITÉ LIBRE DE BRUXELLES	BELGIUM
KLEIN	JUDITH	OPEN SOCIETY INSTITUTE, BUDAPEST	HUNGARY
KLOPPENBURG	HORST	EUROPEAN COMMISSION	LUXEMBOURG
KLOSINSKI	WOJCIECH	MINISTRY OF HEALTH	POLAND
KNAPP	MARTIN	LONDON SCHOOL OF ECONOMICS	UK
KOKKO	SIMO	WHO REGIONAL OFFICE FOR EUROPE	FINLAND
KOVES	VIVIANE	MGEN, FOUNDATION FOR PUBLIC HEALTH	FRANCE
KUHN	KARL	FEDERAL INSTITUTE OCCUP. HEALTH AND SAFETY	GERMANY
LAHTINEN	EERO	MINISTRY OF SOCIAL AFFAIRS AND HEALTH	FINLAND
LAVIKAINEN	JUHA	STAKES	FINLAND
LEHTINEN	VILLE	STAKES	FINLAND
LEHTMETS	ANDRES	WEST-TALLINN CENTRAL HOSPITAL	ESTONIA
LITTLE	PATRICK	PENUMBRA	UK
LOPEZ	ITZIAR	C. SALUD MENTAL SALAMANCA	SPAIN
LUBOMIR	OKRUHLICA	CENTRUM PRE DROGOVÝCH ZÁVISLOSTÍ	SLOVAKIA
LUND	THOMAS	NIOH	DENMARK
MACHIN	NURIA	MIDDLESEX UNIVERSITY	UK
MAGUNACELAYA	AITOR	RONDA, 33 5C	SPAIN
MAKINDE	TAOFEEK A O	CENTRE FOR HEALTH DEVELOPMENT	NIGERIA
MARTINEZ	MARIA DEL MAR	ANTARES CONSULTING	SPAIN
MARUSIC	ANDREJ	INSTITUTE OF PUBLIC HEALTH	SLOVENIA
MCAID	DAVID	LONDON SCHOOL OF ECONOMICS	UK
MEHLUM	LARS		NORWAY
MEIER	RENE	SYNERGO	LIECHTENSTEIN
MELTZER	HOWARD	OFFICE FOR NATIONAL STATISTICS	UK
MEULENBERGS	LEEN	FPS PUBLIC HEALTH	BELGIUM
MICOVIC	RADOJKA	GENERAL HOSPITAL	MONTENEGRO
KALASIC	ALEKSANDRA	CITY INSTITUTE FOR GERONTOLGY & HOME CARE	SERBIA
NEEDLE	CLIVE	EUROHEALTHNET	BELGIUM
NIC AONGUSA	BAIRBRE	DEPARTMENT OF HEALTH AND CHILDREN	IRELAND
NILSSON	INGER	EUFAMI	SWEDEN
O'RORKE	JIM	SCOTTISH ASSOCIATION FOR MENTAL HEALTH	UK
OZAMIZ	J. AGUSTIN	GOBIERNO VASCO	SPAIN

PANAGIOTA	VOURA	PSYCHIATRIC HOSPITAL OF PETRA OLYMPUS	GREECE
PANI	PIER PAOLO	SERVIZIO TOSSICODIPENDEZER (SER T.)	ITALY
PARKER	CAMILLA	OPEN SOCIETY INSTITUTE, BUDAPEST	HUNGARY
PAVLOVSKY	PAVEL	CHARLES UNIVERSITY, PSYCHIATRIC CLINIC	CZECH REP.
PEREDA	AMADA	UNIVERSIDAD AUTONOMA MADRID	SPAIN
PETROVA	GALIA	DINAMIKA OUTPATIENT PSYCHIATRIC SERVICE	BULGARIA
PLETTE	RICHARD	NATIONAL INSTITUTE OF OCCUPATIONAL HEALTH	HUNGARY
POULLOU	LYGIA	MENTAL HEALTH SERVICES	CYPRUS
PULL	CHARLES	CENTRE HOSPITALIER DE LUXEMBOURG	LUXEMBOURG
PURAS	DAINIUS	VILNIUS UNIVERSITY	LITHUANIA
RADULESCU	ROXANA	MENTAL HEALTH EUROPE	BELGIUM
RAITASALO	RAIMO	THE SOCIAL INSURANCE INSTITUTION	FINLAND
RAMIREZ	MARTA	HOSPITAL DE LA PAZ	SPAIN
RICKA	REGULA	POLITIQUE NATIONALE SUISSE DE LA SANTÉ	SWITZERLAND
RODRIGUEZ	BEGOÑA	NATIONAL INSTITUTE OF SOCIAL SECURITY	SPAIN
RÖNNGREN	BENGT	MINISTRY OF HEALTH AND SOCIAL AFFAIRS	SWEDEN
ROSKAR	SASKA	INSTITUTE OF PUBLIC HEALTH	SLOVENIA
RUTZ	WOLFGANG	WHO, REGIONAL OFFICE FOR EUROPE	DENMARK
RUUD	TORLEIF	SINTEF UNIMED	NORWAY
SALAMI	ADEYEMI G	CENTRE FOR HEALTH DEVELOPMENT	NIGERIA
SALIZE	HANS JOACHIM	CENTRAL INSTITUTE OF MENTAL HEALTH	GERMANY
SALVADOR	LUIS	UNIV. CADIZ, DPTO. NEUROCIENCIAS	SPAIN
SILFVERHJELM	HELENA	NATIONAL BOARD OF HEALTH	SWEDEN
SILVA	VIVIANE		SPAIN
SIPILÄ	MARIANNE	HUCH, PEIJAS HOSPITAL	FINLAND
SMITH	JOHN	MENTAL HEALTH MATTERS	UK
SOHLMAN	BRITTA	STAKES	FINLAND
SOLER	DOLORES	CENTRO DE SALUD MENTAL	SPAIN
SUERO	MARIA TERESA	MINISTERIO DE EDUCACION Y CIENCIA	SPAIN
TAIPALE	VAPPU	STAKES	FINLAND
TERAUDS	ELMARS	MENTAL HEALTH CENTRE OF RIGA	LATVIA
TIBALDI	GIUSEPPE	CENTRO STUDI E RICERCHE IN PSICHIATRIA	ITALY
TUDORACHE	BOGDANA	ROMANIAN LEAGUE FOR MENTAL HEALTH	ROMANIA
TZIAFERI	MARIA	PSYCHIATRIC HOSPITAL OF PETRA OLYMPUS	GREECE
VALLÉE	MICHEL	AGENCE NATIONALE POUR L'AMELORIATIN	FRANCE
VAN DEN HEEDE	PASCALE	MENTAL HEALTH EUROPE	BELGIUM
VAZQUEZ	JOSE LUIS	UNIVERSITY OF SANTANDER	SPAIN
VERSTRAATEN	SOPHIA	TRIMBOS-INSTITUUT	NETHERLANDS
VINAR	OLDRICH	NATIONAL INSTITUTE OF PUBLIC HEALTH	CZECH REP
WAHLBECK	KRISTIAN	STAKES	FINLAND
WAHLBERG	HENRIK	WHO, EHA, OFFICE FOR OPT	FINLAND
WALBURG	JAN	TRIMBOS-INSTITUUT	NETHERLANDS
WALLER	MIKE	CITY UNIVERSITY	UK
WALLER	SETA	HEALTH DEVELOPMENT AGENCY	UK
WASSERMAN	DANUTA	CENTRE FOR SUICIDE RESEARCH	SWEDEN
WHYTE	CHRISTINE A.	NATIONAL DISABILITY AUTHORITY	IRELAND
XERRI	RAY	MINISTRY OF HEALTH	MALTA
YANNULATOS	PETROS	ATHENS PSYCHIATRIC HOSPITAL	GREECE
ZACHARIAS	VAGELIS	MINISTRY OF HEALTH	GREECE
ZOËGA	TÓMAS	DEPARTMENT OF PSYCHIATRY	ICELAND