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**EUROPEAN MENTAL HEALTH AGENDA: FUTURE PERSPECTIVES  
16–18 NOVEMBER 2000, HELSINKI, FINLAND**

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<b>Abstract</b> <p>The European Mental Health Agenda: Future Perspectives seminar, which was held in Helsinki on 16–18 November 2000, was the concluding seminar of the projects 'Putting Mental Health on the European Agenda' and 'Establishment of the Indicators for Mental Health Monitoring in Europe'. These projects were financially supported by the European Commission, and were co-ordinated in Finland by the National Research and Development Centre for Welfare and Health (STAKES) and by the Ministry of Social Affairs and Health. The projects can be regarded as important cornerstones of the European Mental Health Agenda, which is an ongoing long-term process with the principal objective of bringing more value and visibility to mental health issues in the public health actions of the EU.</p> <p>Significant progress has been made in the course of the European Mental Health Agenda process. The high-level European Conference on Promotion of Mental Health and Social Inclusion was held in Tampere in October 1999 as part of the official programme of the Finnish Presidency of the EU, and on 18 November 1999, drawing on the conclusions of the conference, the European Council of Health Ministers passed a resolution on the promotion of mental health. Consequently, several European conferences with mental health themes have taken place during the EU Presidencies of Portugal (Health Determinants in the EU, March 2000, and Violence and Promotion of Children's and Young People's Mental Health, June 2000) and of France (Prevention of Youth Suicide, September 2000, and Unemployment and Mental Health, November 2000).</p> <p>The present seminar brought together 60 participants from the EU Member States, the EEA countries, the Applicant Countries, Canada, New Zealand and the USA, and from the European Commission, the European Parliament, intergovernmental organisations (WHO and ILO) and non-governmental organisations (ENUSP, EUFAMI, GAMIAN and MHE). This report reviews the contents of the plenary sessions and the panel discussion, and presents the conclusions of the workshops.</p> <p>This seminar aimed at evaluating the progress made in the two specific projects and at contemplating consequent developments. Draft reports, produced in connection with the projects, were presented for commentaries and discussion. Moreover, the synergy between the European initiatives and several respective developments in Canada, New Zealand and the USA was discussed. The workshops looked at future actions required to further develop and strengthen mental health issues in the context of the European Union and also more globally.</p> <p>Central themes discussed were, for example, priority setting, interdisciplinary action, political commitment, strengthened co-operation, mental health impact assessment, human rights and improved knowledge and information.</p>			
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## PREAMBLE

The European Mental Health Agenda: Future Perspectives seminar was held in Helsinki on 16–18 November 2000. It was the concluding seminar of the projects Putting Mental Health on the European Agenda and Establishment of the Indicators for Mental Health Monitoring in Europe. These projects were financially supported by the European Commission and co-ordinated in Finland by STAKES (National Research and Development Centre for Welfare and Health) and by the Ministry of Social Affairs and Health. The projects can be regarded as important cornerstones of the European Mental Health Agenda, which is an ongoing process with the objective of raising the value and visibility of mental health issues in the public health actions of the EU.

Significant progress has been made in the course of the European Mental Health Agenda process. The high-level European Conference on Promotion of Mental Health and Social Inclusion was held in Tampere in October 1999 as part of the official programme of the Finnish Presidency of the EU, and on 18 November 1999, drawing on the conclusions of the conference, the European Council of Health Ministers passed a resolution on the promotion of mental health. Consequently, several European conferences with mental health themes have been held during the EU Presidencies of Portugal (Health Determinants in the EU, March 2000, and Violence and Promotion of Child and Young People Mental Health, June 2000), and of France (Prevention of Youth Suicide, September 2000, and Unemployment and Mental Health, November 2000).

The seminar brought together 60 participants from the EU Member States and the EEA countries, from the Applicant Countries, Canada, New Zealand and the USA, and from the European Commission, the European Parliament, intergovernmental organisations (WHO Euro and ILO) and non-governmental organisations (ENUSP, EUFAMI, GAMIAN and MHE).

This seminar aimed at evaluating the progress made in the two projects and at contemplating consequent developments. Draft reports *Public Health Approach on Mental Health in Europe* and *Minimum Data Set of European Mental Health Indicators* were presented and commented in the two first plenary sessions, respectively. In the other plenary sessions, the synergy between the European initiatives and respective developments in Canada, New Zealand and the USA was discussed, and the global challenges were addressed. The workshops looked at future actions required to further develop and strengthen the status of mental health issues in the context of the European Union and also more globally.

This report reviews the contents of the plenary sessions and the panel discussion, and presents the conclusions of the workshops.

We want to take this opportunity to warmly thank all participants of the seminar who contributed to making it a truly enthusiastic and successful event. Moreover, the support given to the projects by the European Commission and the members of the European Network on Mental Health Policy (ENMHPO) is gratefully acknowledged. And finally, the eventual success of these projects would not have been possible without the close involvement of all the national partners, who deserve our sincerest thanks.

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## EXECUTIVE SUMMARY

### **Mental health is everyone's concern**

The European Mental Health Agenda process was initiated in 1995. Since then, this process has encompassed a wide range of activities aiming to raise the value and visibility to mental health in the European context. As a result of this, some topics that have been brought up during this process are already becoming quite deeply rooted in the European way of thinking. For example, the importance of regarding mental health as a broad concept that includes both positive and negative aspects has been highlighted, and the slogan '*There Is No Health Without Mental Health*' has been strongly advocated such that it has become well-known throughout Europe.

Through these and a large number of related activities the scope of mental health action has also been widened to cover human rights and promotive, preventive and curative approaches, as well as prevention of mortality. This is crucial in building alliances with stakeholders in different fields in order to smoothen the way for integrating mental health in all relevant policies, which is a vital future priority.

### **Knowledge and information as the currency of public discourse**

Feasible and useful indicators to monitor the state of mental health at the population level need to be urgently developed and implemented. Therefore, in answer to this need, a comprehensive proposal for a valid set of mental health indicators was presented in this seminar.

Dissemination of information is becoming more important as it seems obvious that knowledge and information are the currency of public discourse. Therefore, the establishment of permanent and effective feedback loops between the various actors should be facilitated. Any information on mental health has to be formulated and disseminated in consonance with the legitimacy and logic of political life so that it can be used at the political level.

Naturally, there is a need for strong political commitment and for the user organisations to give a push to the politicians. Furthermore, it is unrealistic to expect significant progress to be realised overnight. A rationale exists, however, for comparing investments made in mental health against the costs – direct and indirect – of not making such investments.

There are good possibilities for creating an *intelligent interface* within the mental health community with the opportunities provided by the information society. Such a structure could be initiated from the mental health field. This opportunity should be vigorously pursued.

### **Mental health on the global agenda**

Mental health issues are challenges not only in the EU but all over the world. There is an urgent need for thinking more widely and more globally. In many cases mental health is not a priority in health service systems and mental health issues are not much discussed in public. Unfortunately, when they are, they are mainly seen in a negative, tragic or scandalous light. There are also a

number of risk groups to which we need to pay more attention.

The global mental health agenda, social capital and the need for global governance in environmental, health and social policies were among the themes that arose in the presentations and discussions of this seminar. Huge challenges lie ahead concerning health monitoring, and concerning the production and dissemination of better information, just to name a few. That is why efforts must be put into building capacities, advancing R&D activities and developing improved ways to set priorities in the field of mental health. Moreover, the role of the consumer movement needs to be that of a meaningful participant, and close collaboration between the European Union and the WHO, as well as with other relevant stakeholders, needs to be maintained.

The concept of *mental health impact assessment* (MHIA) was heavily discussed in the seminar. There arose a strong consensus that at the moment, the methodology for conducting such assessments is not

good enough: it needs to be carefully considered for whom MHIA should eventually be conducted and a more systematic approach and iterative processes should be developed.

### **Keep the momentum**

Mental health *is* on the European agenda. Mental health is also on the agenda in Canada, New Zealand, in the United States and elsewhere. Today, mental health is seriously considered and supported by the activities of the European Commission and the World Health Organization: for example, in the new EC action plan in the field of public health, in the various events geared to World Health Day and in the World Health Report on Mental Health for 2001. Moreover, non-governmental organisations are increasingly concerned with mental health issues and mental health is advocated in the European Parliament.

This crucial momentum must not be lost.

## OPENING OF THE SEMINAR

In the opening session **Dr Jarkko Eskola** from the Ministry of Social Affairs and Health warmly welcomed all participants, whether already familiar to the process or 'newcomers' from the Applicant Countries and EEA countries, as well as the guests from overseas, to the seminar.

Dr Eskola emphasised the great importance of collaboration between all actors and the need to exchange information. He reviewed the developments that have taken place within the European Mental Health Agenda process and highlighted that mental ill-health is a global burden. Dr Eskola strongly stressed – among other things – the fact that the increasing prevalence of depression is one of the contemporary public health scourges that has to be addressed and combated. He also underlined the importance of mental health to the human, social and economic capital of nations.

Dr Eskola closed his speech by wishing that the two-day seminar would be fruitful and effective so as to delineate priorities and visions for future actions and thereby continue to raise the value and visibility of mental health in Europe and in a wider context.

The next speaker, **Dr Matti Rajala** from the DG Health and Consumer Protection of the European Commission, reminded the audience of the fact that mental health problems and their determinants form complex multilayered strings and networks. He went on to challenge the common notion that health is largely determined by individual choice and maintained that health behaviours are,

in fact, socially patterned and reinforced by culture, subcultures, media and groups. Therefore, there is a need to focus on population, group and setting strategies, instead of those aimed at individuals only. Measures and policies that give the needed support and enable people to protect and promote their health are required.

Furthermore, socioeconomic status, social connectedness and inclusion all play important roles in mental health. Regarding the European dimension, Dr Rajala mentioned that the real potential to promote mental health at the EU level lies in the fields of education, social affairs, environment, employment and communications. Thus, real gains are often to be made – not in the health care systems only – but in our education systems, housing provision, employment policies and in how society perceives mental health. Examples of these are the European Social Fund that provides assistance towards the reintegration of, e.g. mentally disadvantaged persons, and the emphasis on the human dimension of the Fifth Framework Programme on Research and Development. Therefore, all Community policies should be closely monitored for their potential contribution to mental health.

Dr Rajala closed his speech by referring to the Health Council resolution on the promotion of mental health that invited the Commission to consider issues such as information exchange and experiences of good practices, and production of a mental health report, possible recommendations and a health impact assessment relating to mental health in education, social and employment policies.

## PLENARY SESSION I

At the beginning of the first plenary session, **Dr Eero Lahtinen** (Ministry of Social Affairs and Health) presented a report entitled *Public Health Approach on Mental Health in Europe*. First, the development of the public health agenda of the EU was briefly reviewed starting from the Maastricht Treaty up to the Amsterdam Treaty. The emphasis was on the extended possibilities for actions on public health that are provided by the Treaty of Amsterdam in the fields of health promotion and prevention of disorders.

Dr Lahtinen then went through the practical issues leading to the preparation of the report and those that have taken place during its development. The history reaches as far back as 1995 and the initiative of the Finnish health minister at the Health Council in 1997. Dr Lahtinen presented briefly the previous reports prepared in this context. Furthermore, he highlighted the invaluable role of the European Network on Mental Health Policy (ENMHPO) and its Executive Group in this process. The contribution of leading European experts on some special points and the consultations of international organisations such as WHO Euro, the consumer movement and the World Federation for Mental Health were pointed out as was the role played by the Secretariat of the network at the National Research and Development Centre for Welfare and Health of Finland (STAKES).

As to the purpose of the report Dr Lahtinen explained that it may, first of all, further clarify the concepts in mental health. It may also function as a background for any future considerations on mental health within the EU public health activities. In addition, the report widens the scope of mental health work to prevention as well. One objective of the report is to consider the links between mental health and other policies. Thus, the emphasis of the Treaty of Amsterdam is given due consideration.

The report has been divided in two parts: the first part is aimed at everybody and intends to be informative for anyone interested in mental health. The background part, on the other hand, discusses these issues in more detail and presents elaborated descriptions of the most central mental health problems as well as of interventions and models of good practices.

Dr Lahtinen went on to present the contents of the two parts of the report and to give his views on the concepts of mental health. Clear concepts are essential in such pioneering work in order to reach a consensus on what the most relevant and acceptable terms are in speaking about mental health in a wide context. What followed was a detailed description of the concepts used in the report.

In conclusion, he addressed the three main approaches considered most essential in the report: bringing mental health from isolation into the broadest sphere of public health; the need for shifting emphasis from individuals to strengthening population mental health; and the deliberate emphasis on positive mental health at the expense of exclusively considering negative mental health and mental health problems.

This presentation was followed by two invited comments. The first commentator, **Ms Meni Malliori** (Member of the European Parliament from Greece), underlined the European initiatives in the field of mental health that have been carried out in the past 10 years. The European Commission has been financing some important projects in the field. More recently, mental health has also been included in the official programmes of the Finnish, Portuguese and French Presidencies of the EU. She stressed that mental health is – for the first time – mentioned in the proposal for the new programme of Community action in the field of public health (2001–2006) as a

health determinant. Ms Malliori also mentioned that 11.66 MEURO of the overall budget of 300 MEURO of this programme will be allocated to mental health. Regarding the decision-making process in the European Parliament it was noted that the proposal would still be discussed during the year 2000. She also considered that the aims of this seminar are highly relevant in view of the subsequent actions to be taken in this area.

Ms Malliori presented some points considered to be crucial for the future in the context of the proposed Community action programme. First of all, when speaking of a European programme, which is initially decided upon by politicians, a theoretical approach may not be the most relevant for all as there are different ways of informing the public and health professionals. Also, a different kind of information is needed for policy-makers. One important point is how to use the collected information in practice through different indicators and through different monitoring systems. As to the rapid reaction to health problems, there needs to be a means to answer to the emerging challenges. Regarding health information systems, Ms Malliori maintained that the collection of indicators should lead to a European policy in the different fields of public health and to a common policy on mental health.

In the second commentary **Dr Marc Servaes** from the Flemish Ministry of Health (Belgium) underlined several points. As a member of the Executive Group of the European Network on Mental Health Policy, Dr Servaes started by acknowledging the support and collaboration during this project and emphasised the importance of keeping mental health in the focus of our health and social policies and of policy-makers'

attention. All the efforts and support, received from a wide variety of actors, helped the networking process happen throughout Europe. This itself contributes to the development of a social and healthy Europe; the more we can discuss, the more there is a common language and a common vision through which we can reach a common set of values, and build a common culture and a common future.

Dr Servaes considered that the *Public Health Approach on Mental Health in Europe* offers an instrument and a powerful tool for good policy-making but it does not, however, contain concrete examples for action, which should be worked out at a suitable political level. This lack is, however, compensated for by offering an instrument, a powerful tool which is ready for adaptation to each country's own policy-making needs.

Then, he compared the report to that recently published by the Surgeon General of the US and found that the fundamentals (the vision for and concepts of public health and the population-based approaches) are the same, but there is a certain difference in the communication strategy: the US document speaks to the public while the European report is principally intended for policy-makers. Further, on the communication of the European report, Dr Servaes suggested that it should also be used in informing and empowering the public, the citizens, our ultimate 'clients'.

Finally, to continue with the Agenda process, there is a need for further leadership, support and new projects, as well as for evaluation of the activities in order to see whether the goals are achieved. Nevertheless, Dr Servaes felt that with the present report we have definitely taken a step forward in the Agenda process.

## PLENARY SESSION II

In this session **Professor Ville Lehtinen** from the National Research and Development Centre for Welfare and Health, STAKES, introduced the report entitled *Minimum Data Set for European Mental Health Indicators*, produced within the project Establishment of the Indicators for Mental Health Monitoring in Europe.

The background for this project has been the fact that mental health issues can be seen as a major public health concern and that more and more attention has been paid to these issues during the 1990s. Hence, mental health has been given high priority in the action plans of the European Commission. Nevertheless, a lack of commonly agreed-upon indicators in the field of mental health has been evident. To overcome this shortage, the development of good mental health indicators – able to measure the situation, able to allow comparisons between countries and regions, able to look at time series – has been receiving serious consideration.

The current project has received financial support from the European Commission. The tasks have been to collect all the relevant existing information in different Member States and/or provided by WHO and OECD or from the scientific literature. Definition of a proper and feasible set of indicators was the second task of this project. The 'active partners' performed most of the work in this project supported by national contact points.

Professor Lehtinen continued by defining the criteria for the indicators, of which special weight should be put on population-oriented assessments as well as promotion of mental health. The system to be developed should also be clearly integrated in a Community health monitoring system and the possibilities of information technology (telematics) should be considered in this context. Being able to provide data for planning and political decision-making, and for international

comparisons, was also emphasised in this context.

Professor Lehtinen described issues related to the different concepts of mental health. The meaning of the term indicator was defined as a 'measure of the state of mental health'. Thus, it should be a variable, or a measure, that has been proved to be actually related to mental health, and it should indicate a priority or a problem. As to the question of what we really want to know, the answer according to Professor Lehtinen was data pertinent to the relevant mental health targets which are able to measure the situation in the general population.

The main areas to be covered with the indicators were demographic data, social stress, social interaction, positive mental health, subjective experiences (concerning well-being and quality of life), the service sector (need, supply, use, demand), morbidity, disability and even mortality. It turned out during the project that there were not much data readily available beyond that on suicide mortality and on health care resources and use (from e.g. Eurostat and ECCMDA).

In this project, the same grouping of indicators was used as in the project on defining European Community health indicators (ECHI), co-ordinated in the Netherlands. The four categories were demographic and socioeconomic factors, health status in the population, determinants of health, and health systems. The proposal includes altogether 36 indicators. Professor Lehtinen brought up the question whether this is too many indicators and whether all important aspects have been covered. There were also some problems with differing definitions in different Member States, which compromises the comparability (as to the list of the specific indicators, the full report is downloadable from [www.stakes.fi/mentalhealth](http://www.stakes.fi/mentalhealth)). The different indicators were then presented in more

detail. In his conclusions, Professor Lehtinen emphasised the need for a pilot implementation project to ensure the comparability and usefulness of these data. He also highlighted the need for further harmonisation, especially of some indicators in the category of health systems. Provision of guidelines for collecting a minimum set of data in the Member States was also regarded as essential by Professor Lehtinen.

In his comments, **Mr John Bowis** (Member of the European Parliament from the United Kingdom) referred to the European Conference on Promotion of Mental Health and Social Inclusion in Tampere in October 1999, to the Health Council of November 1999 and to the *Communication on the health strategy of the European Community* delivered by the European Commission in May 2000. He maintained that a lot has been done already but that we still have not achieved enough. He went on to briefly review some of the developments that were not quite as efficient as they could have been. Lack of money was seen as the major obstacle in advancing health issues in Europe. For example, figures on the support given to the tobacco industry were presented and compared against those on the resources allocated to health programmes.

Mr Bowis stressed that health systems in the EU will crumble under pressure due to, on one hand, demographic facts such as higher life expectancies and, on the other hand, due to the pace of scientific advances in medicine, as new drugs and new treatments are often very expensive.

The well-informed public also poses specific challenges. According to Mr Bowis, the challenge is to aim at improving the health of the public with more and better trained professionals, with state-of-the-art hospitals, with a shift to more community services, and with improved management and resourcing so that health delivery has an affordable price. He stressed the importance of health

promotion and mental health promotion strategies. We can make a difference in the longer term in various fields through health promotion.

Mr Bowis continued by saying that unlike with other health issues such as heart disease, cancer, TB, and AIDS, there is no understanding in mental health of what can be done or what needs to be done – this is why the mental health indicators are so important. There is no constant public and media pressure on governments and health services to do more, to spend more, to achieve more in mental health and mental health promotion. There are few measurements available to help people understand this. According to Mr Bowis, a key question is to make the ministers understand that investments in mental health will bring health benefits, and to make them understand that such investments in mental health promotion now will produce cuts to their budget later.

Nevertheless, Mr Bowis accentuated the fact that the indicators within the mental health field must be easy to interpret. There are some expectations of the effects of enlargement of the EU and the implications that can have for Europe, e.g. more years lived with disability and lower life expectancy. However, describing the extent and the many facets of the challenge is part of the solution, and another part is to show what can be done about it. Mr Bowis closed his speech by stressing the need to show the cost of doing this and – even more frightening to a politician – to show the cost of *not* doing it.

**Dr Helena Silfverhielm** (National Board of Health and Welfare, Sweden) took up some problems concerning the *Minimum Data Set of European Mental Health Indicators*. The aim of the document is to monitor mental health by measuring the state and the course of mental health in the general population. However, if an indicator then shows deterioration it must be accompanied by an action plan. Then, the indicator must be

used again in order to evaluate whether this action has had an effect on the mental health status of the population. She went on to mention that in addition to the population level, there are also organisational and individual levels.

The individual level was emphasised as a very important level although it was not included in the project. For example, it is only possible to measure the patient's empowerment and changes in it on an individual level. This refers to the patient's rights, as for example in Sweden there exists legislation that requires ensuring that a patient agrees on a treatment, and if not, explaining the reasons for this.

The presented indicators are difficult to compare in different countries: an example is discharge from inpatient care, as this aspect of care may be highly different from

one country to the next. The same criticism applies to the definition of psychiatric beds and psychiatric services.

Dr Silfverhielm also found the number of indicators to be very high and she warmly welcomed prioritisation of the indicators and presented her own preferences. A further problem with a population-level approach is that, normally, such information is based on registers. The implementation of the indicators was presented as another significant problem that poses a huge challenge for all of us.

Finally, it was regarded of utmost importance that such a document has been produced and that the European nations see the importance of this matter. It is also important that work on these matters continues.

## PANEL DISCUSSION

The theme of the panel discussion of the seminar was Overseas Experiences in Promotion and Monitoring of Mental Health with panel participants from the United States, Canada and New Zealand.

The first speaker, **Dr Thomas Bornemann** (Department of Health and Human Services, USA), set the scene by highlighting the fact that we are in a truly historic time in our field in that we have the world's attention: our issue is getting on the world's agenda. This development started in the mid-1990s with the World Bank report *Global Burden of Disease*. This document was pivotal to beginning to identify mental health issues as legitimate, relevant and highly important. In 1999 in the US there was a White House conference on mental health for the first time in a president's administration. This was followed by the Surgeon General's report on mental health. Another report focusing on psychiatric and neurological disorders in the developing world was due to be published in January 2001, and on April 7 the theme of World Health Day will be mental health. Moreover, the World Health Report of 2001 will focus on mental health.

Regarding the Surgeon General's report on mental health, Dr Bornemann first explained that 140 people were involved in its production, which he described as a 'life-changing' event. It was a collaborative effort between the Department of Health and Human Services (DHHS) and the National Institute of Health (NIH) that provided an efficient opportunity to open communication between these two organisations. In the United States mental health is a huge public health problem about which the entire nation needs to be concerned. As to the rationale for producing such a report, Dr Bornemann highlighted the long history of these reports (amounting to some 60 altogether) beginning in 1964 with the report on smoking and health. These reports are

important scientific documents, not policy documents: they are documents for the nation, and are way of speaking to the citizenry about important issues which are of public health concern to all people in the country. Therefore, one challenge is to write the reports in a way that is accessible to the general public.

Producing the report on mental health served in a way to invite mental health professionals back into the public health community. Mental health has developed in a parallel fashion, not in an integrated fashion, with the rest of public health. The overarching message intended to be communicated by the report was that mental health is fundamental to health and indispensable to personal well-being. Some other messages directed at the general public are that mental disorders are in many ways similar to somatic disorders, that science has advanced our understanding and that we know a lot more about how to treat people effectively, particularly in their communities and families. In addition, there is a tremendous gap between what we know and what constitutes usual practices. However, the DHHS functions as a place where research meets practice.

Dr Bornemann continued by explaining the US health system. He maintained that the US has a decentralised system, where the states and local governments have wide authority, particularly in service delivery. The Federal Government has several different roles. One of the most important is that of builder of meaningful intersectorial partnerships. In an example of this, Dr Bornemann mentioned that there are people who come into contact with the criminal justice system, the social welfare system, the housing systems and a

variety of other systems. Thus, there is a need to relate to those systems in meaningful ways and build services that make sense for people. In addition, a development process has been started by the Federal Government with the consumer and family organisations which they are currently funding.

About mental health expenditure, Dr Bornemann explained that there are public and private sectors in the US. Thus, the private sector accounts for over 42% of the total revenues in an enterprise which is over 70 billion dollars annually in direct costs alone. It is estimated that with indirect costs included, the total is about 320 billion US dollars. More than half of it is in the public sector and this amount is divided in a number of different ways. The real responsibility and authority have been delegated to several programmes such as Medicare for the elderly, Medicaid for the poor, and other groups like the Veteran's Administration etc.

Dr Bornemann closed his speech by describing the national challenges in health insurance and stressed the fact that there is knowledge but not resources. Regardless, there is a need for much more work in moving from research to practice in a more timely and systematic way, and in getting the message to go in both directions. There is a need to improve the intersectorial links across all sectors such as education, employment and labour, criminal justice etc. Advancing knowledge, engaging people in continuing education relevant to them, issues of accountability – all these were considered highly important. Dr Bornemann concluded by mentioning the large number of issues common to the US and Europe.

**Dr Natacha Joubert** (Mental Health Promotion Unit, Health Canada) started her presentation by describing the role of the Mental Health Promotion Unit in the Canadian health system. Mental health services in Canada are under provincial and territorial jurisdiction. As mental

health has been for a long time considered from a disease-oriented and service-oriented viewpoint, the reasoning at the federal level was that this is a matter to be handled at the provincial level. There was a need for an enbroadening of the understanding on mental health, so as to include positive mental health in the spectrum. Then, within this broader view there arose the need to talk about promotion, prevention, research, surveillance and policy at the federal level. Health promotion had in a way paved the way for this development. The mandate of the Unit is to contribute to healthy public policy, facilitate knowledge development and research projects, and promote and foster mental and spiritual health and well-being. The areas of relevance to the Unit are policy, partnerships and networks, projects and programmes, knowledge development and research. The development of extended partnerships with NGOs, community networks, and professional associations, has proved to add significantly to the briefing of decision-makers on what mental health is and how important it is in the life of every Canadian. Many of these have taken the form of alliances. Dr Joubert explained that the Unit is pushing mental health issues from the 'inside' whereas the partners in turn, are pushing it from the 'outside'.

The clarification of concepts was important in the first stages of creating the Mental Health Promotion Unit. Among these have been the questions of what mental health is, what mental health promotion is, differences between mental health and mental illness, differences between mental illness and human suffering, individual vs. population mental health, stigma and the best strategies to fight it, cultural differences and universal communities. The Unit was initially created by Dr Joubert together with two of her colleagues at a stage where the department was being restructured. One of the first things to do was to document mental health in Canada – to look at the

mental health status of Canadians. The economic cost of mental health problems considers treated and non-treated mental health problems. There was no federal policy on mental health and the only relevant policy dealt with the criminal code and dangerousness. The Unit has also been looking at best practices, the work for which has been carried out in several sectors at the same time.

Dr Joubert moved on to describe the role of the Government as a facilitator of citizen engagement in the process of looking at mental health issues, mental health priorities and how they would like to address them in the different regions. This role allows for the performance of (in addition to a regional survey) a national survey. It seems clear that a national plan to promote mental health will not be successful without the involvement of the people living in these communities. The people's input has to be included early in the process.

As to measuring population mental health Dr Joubert referred to a handout, the highlights of which are representative population mental health surveys and psychosocial determinants. Most of the surveys have been carried out by the federal government. Until today, the mental health surveys in Canada have been part of comprehensive surveys on health status in general. However, the next survey to be carried out in 2002 will be the first one to deal exclusively with the mental health of the Canadian population. In 1994–1995, a longitudinal population health survey was created that will go on perhaps 20 years or so. Both positive and negative mental health indicators are included in this survey. However, the community survey will be cross-sectional whereby data from each province on mental health will be gathered.

Then, Dr Joubert gave a thorough description of the details of the surveys conducted so far. In 1996 and 1999, Health Canada – together with the provinces – produced two big reports of the health of

Canadians. The data on mental health have mainly been used in briefing notes and in internal government operations. Nevertheless, these data have proved to be one of the major tools to convince decision-makers about how important mental health is. All documents are available to the public at [www.mentalhealthpromotion.com](http://www.mentalhealthpromotion.com). The collaboration with Statistics Canada was also mentioned as highly relevant in this context.

**Mr Todd Kriebel** (Ministry of Health, New Zealand) outlined the recent progress with mental health policy in New Zealand. New Zealand has been seen as something of a social experiment from the 1930s. The political system of the country is simple: there is just one House, which always makes for a 'winner takes all' situation. So it can happen, for example, that the health system is re-organised every three years. Now, there is a move towards establishing local-government based, health board systems in 21 districts.

Regardless of the organisation of the health system, it is still very much about relationships between the government, providers, consumers and various organisations. Mental health has always been a public domain.

In the 1990s there has been a transition to community care, in which all but one of the psychiatric hospitals have been closed down. A 24-hour crisis service is now running, and major improvements in access and quality have been achieved. A new act on mental health is in force and with that, development of a consumer movement has taken place. There is also a transition from an illness model towards a wellness and recovery model.

As to the more recent efforts to promote mental health – some of them happening in the last couple of months – Mr Kriebel emphasised first of all the fact that there is a kind of a renaissance taking place in the mental health field. For example, there has been an increase of 80% in the funding for

a mental health strategy. This reflects a strong political commitment which clearly outstrips any other initiatives currently going on in the world. There is also an ad-hoc Mental Health Cabinet Committee in the Government and another on youth suicide. Furthermore, a Mental Health Commission has been established to support the Cabinet Committee. The Commission supports the mental health strategy and has also published a report stressing the implementation of these policies.

Mr Krieble stressed that regionalisation of some mental health services is also taking place in the 21 district health boards. However, the key point behind this development is that one should not take a 'one size fits all' approach to mental health. Currently, a major destigmatisation campaign is underway in New Zealand. The campaign is a several million dollar nationwide campaign consisting of media education, TV and radio advertisements,

posters, postcards etc. The idea is to try to normalise mental health as a topic as much as possible. This campaign will be evaluated in 2001.

The public health emphasis has been accentuated, e.g. by a report on mental health from the public health perspective. Mr Krieble emphasised that building alliances between the public health community and the mental health community has been effective. This alliance has been very valuable in advancing mental health policy. Engagement in intersectoral co-ordination (combining social welfare, the justice system, and the education system) has allowed these units to speak as one unit within health, has proven to be important and powerful. Finally, Mr Krieble said that as for putting mental health on the agenda, we do want mental health on a public policy agenda. Meanwhile, we should also go as far as to consider mental health as *underpinning* that public policy agenda.

## PLENARY SESSION III

This session was dedicated to contemplating (1) future perspectives and (2) global challenges that we are faced with in the field of mental health. Future perspectives were approached from a political point of view, from an NGO viewpoint, and from the transversal nature of public health issues. Global challenges were addressed from political, economic and organisational angles.

Starting the second day of the seminar, **Mr Alain Lefebvre** (from the Permanent Representation of France to the EU) spoke about mental health perspectives from a more political point of view. He started by referring to the difficulties of predicting the future concerning among other things, the evolution of the European Union. For example, 10 years ago, public health was not on the agenda; today, there is new public health legislation, article 152, which, however, can be interpreted in many different ways. There is also a new health programme which probably will be adopted during either the Swedish or the Belgian EU Presidency in the year 2001. Considering mental health, the new programme is important. Furthermore, new countries will accede the Union, as will new ideas. Moreover, we have also seen that the Commission and its organisation have changed, too.

Regarding mental health in the EU, Mr Lefebvre maintained that a lot has been done to improve promotion and prevention aspects of mental health and that the reports presented in this seminar are very important. Concerning the influences of the Finnish initiatives on mental health it was stressed that in the French Ministry of Health, there is now a Unit on Mental Health and Mental Health Promotion. However, consumers rights have not been covered yet. In the sector of mental health services and relations with other sectors, there is not a lot being done at the EU level. Mr Lefebvre then spoke about the mental health workforce, including caregivers, for which the situation is very different in different countries. He also mentioned the differences in the health

care systems in the Member States. Concerning research and evaluation there are many possibilities and activities in the EU. However, regarding mental health, the opportunities offered by the Fifth Framework Programme could be better used, possibly by the networks, which could apply for this programme.

The resolution of the Council of Ministers (18 November 1999) put forward several important issues such as integration of mental health activities in the new EU health programme, the mental health component in the EU health monitoring system, mental health impact assessment of EU activities (e.g. agriculture) and the recommendation of the Council. Mr Lefebvre referred also to the Finnish EU Presidency report and highlighted points like the visibility of mental health, better funding for mental health research and promotion, using new technologies for an EU information system on mental health, support for EU networks, and new ministerial conferences. Of these, the meetings between ministers are a way to push the subject forwards, therefore such meetings should be held every one or two years.

Considering the new health programme, it consists of three strands: information and knowledge, responding to health threats and action on health determinants. Mr Lefebvre went on to describe the contents of these strands in more detail. With regard to mental health, some of the most important aspects of the new programme are the health monitoring system, mechanisms for analysis, advice, reporting and information consultation, the impact of other policies and the networks in place to

monitor and analyse use of new technologies, clinical guidelines and good practices. However, it was emphasised that this is not expected to lead to harmonisation of the health care systems.

As to the action on health determinants, the strategies and measures on mental health (including measures in all Community policies), on health inequalities, on the environment and on genetic determinants are of relevance to mental health.

Referring to the work to come, Mr Lefebvre stressed the following tasks: the building of information systems by national centres, the exchange of networks' experiences through new technologies, dissemination of good practices in mental health promotion, and production of clinical guidelines. Moreover, research needs have to be defined, and projects that evaluate the impact of other policies are needed as is the development of new fields (e.g. patients' rights connected to free movement). The training of health professionals was brought up as a priority as was the coherence between actions. This means that there should be a global strategy on mental health that includes exchange of information in order to avoid, for example, duplication of work in research and in the work of various networks. Furthermore, links to WHO were considered of utmost importance by Mr Lefebvre, as was exchange between other regions of the world.

Mr Lefebvre closed his speech by conveying a positive view of the future that entails organising conferences, supporting new projects, strong support from the Member States and the Commission, and setting mental health as a priority of the WHO.

Continuing the theme of future perspectives, **Mr Clemens Huitink** (European Network of (ex-)Users and Survivors of Psychiatry, ENUSP) began his presentation with the notion that mental health *is* already on the European agenda. An example of this is the White Paper of the Council of Europe on the protection of people with disabilities that addresses, for example, the issue of involuntary treatment. The network represented by Mr Huitink is also concerned with the charter of fundamental rights, which had not been mentioned earlier in this seminar, as well as with the European Parliament's approval of the pharmaceutical industry's promotion of the second-generation neuroleptic drugs.

ENUSP is involved in an anti-stigma campaign run by WHO. They have also dealt with the new public health programme of the EU and its third strand, which Mr Huitink described as a kind of a shopping list with drugs, alcohol and mental health. He then predicted that if there is another mad cow episode in Europe within the next few months, the programme will change dramatically and this will again make mental health a low priority.

If the user movement could ask for a set of indicators, they would ask for indicators developed with users participating on an equal footing. They would ask for treatment that is respectful, tailor-made and diverse. They would also ask that services be consumer driven instead of provider driven. Finally, Mr Huitink expressed his strong belief that the above-mentioned issues will constitute the future of European mental health policy.

The next speaker, **Mr Esko Hänninen** from the Provincial State Office of Southern Finland, described the transversal nature of public health issues at the EU level and emphasised the need for taking health issues into account at different policy levels. He presented the three different policy field programmes from the point of view of the Member States: the European Structural Fund (ESF) programmes, programmes that need to be implemented with the help of international partnerships (EU community initiative programmes), and research and development programmes done in co-operation with representatives of the fields of education and the information society.

Mr Hänninen explained that the ESF programme (2000–2006) contains different objectives that need to be taken into account by the Member States at national, regional and local levels. There are good chances to include health strategies as integral parts of those programmes. However, in most of the Member States, the task of implementation has partly been given to the central government, partly to regional authorities and partly to local authorities, which has yielded increased bureaucracy. Mr Hänninen continued that in practice it is, however, possible to include in the programme different kinds of projects which promote public health policy and also mental health policy issues. He went on to mention the need to create good projects concerning Objective 3 (development of human resources and social inclusion) of the current ESF programme.

Referring to the European Community Initiative programmes, he introduced the new programme called EQUAL. Based on good experiences obtained in the previous programmes to develop mental health field activities, EQUAL contains *tools* for implementing the activities. Two kinds of international partnerships will probably be

created within this programme: *regional partnerships* between all kinds of actors involved, e.g. in social inclusion issues, and *thematic national partnerships* concentrating on certain specific issues.

Mr Hänninen also mentioned the Fifth Framework Programme for Research and Development (1998–2002). The most important programmes therein are Quality of Life and Management of Living Resources (LIFE), and User-Friendly Information Society (IST). In both of these it is possible to create research and development projects concentrating on public health issues and also on mental health. There are other programmes such as LEONARDO DA VINCI, SOCRATES and YOUTH which concern educational and training issues and offer good possibilities for creating European co-operation structures.

With regard to mental health, programmes on anti-discrimination, on social inclusion and the new initiative aiming to increase social responsibility were brought up. The concept of corporate social responsibility (CSR) was approved at the Lisbon summit in March 2000. Special European structures are being developed to implement this approach. This initiative opens certain possibilities also for the promotion of mental health, especially in working life and workplaces.

As the final point in his commentary, Mr Hänninen highlighted that the *e*Europe 2002 action plan contains several parts relevant to health promotion and mental health promotion in particular. For example, work against info-exclusion is important in creating different kinds of information and communication technology (ICT) applications. A programme called *e*Health also includes using ICT in the field of mental health, both in mental health care and in promotion of mental health.

**Professor Rachel Jenkins** (Institute of Psychiatry, UK) opened the session on global challenges. Professor Jenkins first addressed some problems of war. She pointed out that the peace movement has had an important role, supported by the fact that there has not been a war in the European Union for decades. Unfortunately, the rest of the world, especially poor countries, has seen multiple wars, and this could be one of the issues the network might like to start to think about at some stage. This could be done especially by considering how to bring EU mental health knowledge and expertise into this arena. Once a war ends, the transition to peace is never easy. This period is characterised by insecurity, uncertainty and repeated violence: 30 countries have had more than 10% of their population displaced by violence; 90% of the casualties of war are civilians. This has caused immense psychological impact on victims and witnesses. Landmines are of particular issue as 100 million landmines cause continuing casualties and block movement, agriculture and economic development. A current estimate is that it is going to take 100 years to clear Cambodia of its landmines. Negative consequences of conflict and post-conflict aftermath to human, social and economic capital are enormous and devastating.

Considering physical illness, in the aftermath of wars there is very high mortality and morbidity from totally preventable and treatable diseases, such as measles, malaria and TB. It is known that the presence of psychosocial disorders contributes to low compliance to vaccinations, and to efforts to provide nutrition, to oral rehydration etc. Paying attention to the psychological problems in the aftermath of war has a key role not only on its own right, but also in tackling the physical illnesses.

Particular issues for women and children are those of being witnesses to or forced participation in murder, rape, and infection with AIDS, and the subsequent

rejection from their families. Especially in Africa, children have been abducted as child soldiers and the rehabilitation of them afterwards is very difficult.

Some reconstruction traps do exist: one, for example, is that of trying to reconstruct economies – thinking that after doing this everything else will follow – while forgetting to address social dislocation and the need to rebuild social relationships. Cutting back expenditure such that it weakens education and health has proved to be counter-productive in that it jeopardises the country's recovery and may contribute to the re-emergence of civil conflicts.

In the face of these issues the challenge for us is to ensure that mental health becomes and remains a key international priority. We also have to make sure that for each country it is a key national priority, and that national mental health strategies are integrated with general health strategies and general policies. We are on the way of securing mental health as a key international priority and are also on the way of getting it on each country's national agenda. Nevertheless, we've still got a long way to go in properly integrating mental health with general health and with overall general policies.

In terms of the international agenda, Professor Jenkins referred to the year 1995 when the Harvard Mental Health Report was launched. She quoted Mr Boutros Boutros-Ghali, who said on that occasion that 'Mental health must be regarded as a foremost challenge ... we need an international campaign and ... to secure mental health for people of the world must be one of the objectives of the UN in its second half century.' The UN should be reminded of this.

There are some terrific economic challenges across the world and in Western Europe as well. Of these, unemployment, high job insecurity, growing income inequality and difficulties or even inability to pay for housing, education, medical care and care for the elderly were highlighted.

All these are accompanied by a lack of resources and inefficient use of resources, and a lack of cost-effectiveness data which takes into account the indirect social costs of illness. With regard to this, the question of not doing something re-emerged.

In reference to globalisation, some key issues were brought up such as the fact that human populations are becoming more connected to each other and integrated in relation to trade, culture and information sharing. This seminar, in fact, is part of this process. However, there are some negative aspects as well. For example, the last 20 years have shown that while global income has increased, absolute poverty has also increased. Poverty has exacerbated malnutrition, infectious diseases, occupational hazards and injuries. For example, as international mobile capital acquires greater power relative to labour, it weakens labour markets, can lead to job insecurity, low wages, and low occupational health and safety. The globalisation of trade also contributes to pollution, land degradation and damage to our environment. Moreover, in some poor countries the upward trends in health and education have reversed. Even now, some countries are being urged to subordinate environmental, health and social welfare programmes to the goal of economic development.

There are also some major organisational challenges concerning, for example, co-ordination, and communication. There is also a need for some form of global governance for the environment, and for health protection and promotion, particularly for mental health. Co-ordination of activities and working in concert with each other is of great importance.

As to the social challenges, Professor Jenkins first discussed the problem of social stigma, which is currently being addressed by, e.g. the World Federation for Mental Health and the World Psychiatric

Association. Stigma can lead to a lack of attention to mental health issues from ministers and the public, decaying institutions, lack of leadership, lack of resources, inadequate information systems and inadequate legislation. Social exclusion in one area often leads to exclusion in another. For example, exclusion of a group is bad not only for this group but also for the mental health of the society as a whole. We need to make sure that our specialist services are not a jumping-off point for exclusion but are rather designed as stepping stones to inclusion.

The important issue of human rights was brought up in connection with prisons, and in particular with the recent development taking place in Georgia, where a minister has been newly appointed for the prison system. Mental health services in prisons all across Europe are poor, and in all countries much must be done to improve this situation. In a way, prisons need to be a combination of a hospital and a school rather than a major punishment setting.

Professor Jenkins made a strong point about the need for forming partnerships with those who try to tackle physical illnesses. She also stressed the importance of being aware of the challenges of ageing population and reminded participants of the demographic time-bomb we are faced with.

As to the way forward, health monitoring including epidemiology was seen as an essential component. The research architecture, information for use, better ways to set priorities, long-term commitment and leadership were also introduced as very important future issues. The leadership issue should be seen as empowering rather than control, and we should remember that good leaders produce good leaders. Therefore, there is a need to educate for leadership, innovation and development.

The commentator, **Dr Wolfgang Rutz** from the World Health Organization Regional Office for Europe, first delivered to the audience the greetings of Dr Marc Danzon, the regional director of WHO Euro, who is familiar with the development that has taken place during the Finnish initiative to bring mental health to the European agenda. Dr Rutz presented his views under the title 'Mental Health in Europe. The WHO Perspective: Diversities, Possibilities, Shortcomings, Challenges'.

The year 2001 has been dedicated by the United Nations and the WHO to mental health. We have started to understand the psychobiology of depression, aggression and self-destructive behaviour, helplessness and love, insight, happiness, existential emptiness and other emotions. We are learning about the amazing neuroplasticity of the brain, are finding out how physiological well-being creates physiological strength but are also learning how adverse psychological, social and existential environments can create structural weakness and long-lasting vulnerability. As an outcome of this knowledge we today find that curative, protective and mental-health promoting strategies have become feasible, realistic and necessary when we use the possibilities of interdisciplinary co-operation and teamwork that engages all sectors of society.

However, we live in a time of great and increasing burden and distress caused by helplessness and loss of control. This is further influenced by social exclusion, loss of identity, and a lack of coherence and meaning, just to name a few. The consequences of, e.g. aggressive behaviour and destructive lifestyles have become a great health burden both economically and in terms of suffering that affects individuals, families and societies. This is often the case particularly in countries experiencing a heavy societal transition.

In its Health for All policy and in taking its role as the 'health conscience' to

governments and decision-makers, the WHO stresses mental health as a human right. It underlines the need for multidisciplinary and intersectoral partnership and co-operation for evidence-based strategies and for community-based primary healthcare-oriented approaches close to the individual and his/her social and psychological environment. In its policy paper 'Health 21', ratified by the governments of Europe, WHO has targeted the reduction of suicide and depression as one of its main goals. To realise this, a main possibility and responsibility lies in further developing of a type of comprehensive evidence coming from integrative research.

The European WHO Programme on mental health focuses first on the need for assessments and national mental health audits, respecting the diversity throughout Europe (regarding services, lifestyles etc). Secondly, it focuses on stress and helplessness-related morbidity and mortality resulting from depression, suicide, self-destructive lifestyles, and thirdly, on the need for destigmatisation and for counteracting discrimination.

It is to be noticed, that nothing creates fear as much and easily as ignorance. This is why stigma, taboo and the consecutive social exclusion is laid on disadvantaged mentally vulnerable populations. This is also the greatest obstacle for early intervention and for easy, open monitoring and treatment. This obstacle can be tackled by increased knowledge and by disseminating this knowledge.

In 2001, the Year of Mental Health, there will be some important events dedicated to mental health: World Health Day on April 7 will be committed to mental health; the World Health Assembly in May gathers the decision-makers of the world to address this theme and the World Health Report on Mental Health gives evidence and calls for action. The messages from all of these are that mental health can be promoted by intelligent political action based on scientific

evidence, that political and societal interventions' impact on mental health must be considered, and that no country can afford not to invest in mental health. Another message according to Dr Rutz is that due to stigma, taboo and lack of knowledge, mental disorders are often underestimated, under-recognized and under-treated. Mental disorder is a heavy burden which can afflict anybody, but is avoidable, preventable and treatable. Hence, the year 2001 offers a good

possibility to get mental health on the political and public agendas of European countries. There is a chance to have an impact and bring dignity to the issue of mental health. To realise this, common efforts and co-ordinated synergistic actions are demanded by all good forces in research, clinics and development, and in the field of mental health promotion as well as mental disorder prevention and management in Europe.

## PLENARY SESSION IV

There were four workshops in the seminar with the following titles:

1. Integrating mental health in public health
2. Tackling determinants of mental health
3. Uses of improved mental health information
4. Feasibility of the suggested set of indicators

The time allocated in this seminar to the workshops was 4 hours (2 hours/day), and the participants were divided into the workshops according to their own preferences. For each workshop, a set of questions was prepared in advance. However, the decision of whether to construct the work according to these questions, or in some other way, was left to the workshops themselves.

**Ms Bairbre Nic Aongusa** (Department of Health and Children, Ireland) presented the conclusions of Workshop 1. The first question discussed in the group was *how to consider mental health in all policies*. Policy-making is conducted at two different levels: at the vertical level, e.g. in the mental health sector at all different stages from primary care through secondary and tertiary care, and at the horizontal level, which involves interaction with other services and networking etc. The group felt that it was important to address both levels. It was agreed both that working at the horizontal level is important, while at the same time focusing too much on the horizontal level may lead to mental health losing its identity. There was also an agreement on the importance of working at the vertical level as well. In order to achieve visibility of mental health in all policies it was judged important that somebody should be responsible – have the lead responsibility in pursuing certain objectives. This agency would take the initiative to develop strategic plans with other agencies. One means of getting this implemented would be to have such strategic plans approved by governments. This issue was also referred to as *virtual links* with other agencies and departments involved in public policy. Having an assessment of every public policy decision

from the point of view of mental health was also regarded as a good model.

The second question of *do we need mental health impact assessments* received an affirmative answer. Some reservations were, however, expressed as the methodologies for conducting mental health impact assessments are not developed sufficiently. It needs to be improved so that it can be used systematically. There is a strong foundation which needs to be developed further by means of pilot projects, e.g. in the field of education.

At whom should the mental health impact assessments be aimed? Population groups or particular client groups? Are they for citizens or for the policy-makers? This would need to be clear and obviously it depends on the circumstances. The empowerment of citizens – the population as a whole – was considered an important topic as they should be involved in defining the parameters for this assessment.

Once these assessments are in place it needs to be ensured that they do not become just paper exercises, and that we actually make use of them. They should be used in research and evaluation. There also needs to be a 'before and after' evaluation of these assessments. The assessments should contribute to further development

of policy. Hence, they could increase awareness across the spectrum of public policy of the importance of mental health issues.

The third question was *how to achieve the balance between mental health promotion and the development of services*. The group agreed on the complementary role between these two and that they are interdependent. Many of those working in services do not see mental health promotion as part of their remit. This concerns particularly those working in secondary care services and in more specialised services. Changing this is a challenge. The way to achieve a correct balance would be to respond to the needs and the demands of the population. When talking about resources the group felt that targeted funding needs to be reserved for mental health promotion. Linked to this, spreading of the responsibility for mental health promotion beyond the health services would lead to other sectors seeing mental health promotion as part of their remit. In order to achieve this we need to emphasise the wider determinants of mental health, the burden of mental ill-health for society, and the benefits of mental health promotion activities for everyone concerned.

*Whether European mental health recommendations would benefit the field* was the fourth question discussed in Workshop 1. The members of the group were all agreed that the Council resolution of 1999 was of major benefit in putting mental health on the agenda for Europe. Moreover, if we would get Council recommendations, this would consolidate the concepts and possibly achieve clarity and more consensus on where we need to go. Another benefit of Council recommendations would be that a consensus among the European Member States could contribute to advancing the cause of mental health on the wider stage, on the global agenda.

The caveats were that we need to be aware of the differences in culture and

terminology within Europe and also within individual Member States. For example, the term 'community' mental health services can mean something very different in different countries. There are also differences in people's expectations of government's responsibility to bring about change in their environments, in their health circumstances and so on. Applicability issues were discussed, leading to the conclusion that whatever recommendations there might be, need to be applicable in all countries while avoiding being too prescriptive. The question of timespans showed that it will take 2 to 5 years to get something done at a political level within the Union, but then it can take 10, even 15 years before the decision or recommendation becomes a reality and translates into actions and activities on the ground.

The last question was *what the future challenges are in European mental health policies*. The major point was that it is very important to keep up the momentum that has been developed over the last five years, meaning ensuring that mental health does not drop off the agenda again. Another point was that we need to look at ways in which we can support Member States in integrating mental health into public health. Within the existing Member States there is the issue of involving citizens, users and organisations in the policy-making process. Addressing the stigma of mental health, the group considered that a European-wide programme may not be as useful in this. However, stigma could be addressed by facilitating national initiatives and national programmes by disseminating good practices and information. This also highlights the value of the various networks. The final issue dealt with the need for an 'intelligent interface' for mental health within Europe. Statistics and data are available, but perhaps a formal European structure would be needed to monitor what is going on. This structure would basically intelligently assess all the information that is coming at

us to have as a resource. Here, a reference to the initiative on drugs was introduced. This structure might be something that could be brought about in the next 5 to 10 years.

The conclusions of Workshop 2 were introduced by **Dr John Loudon** (Department of Health, Scotland) who first explained that the workshop had adopted a kind of a tool-kit approach to tackle the determinants of mental health. Concerning mental health impact assessment it was noted that there should be no health impact assessment without mental health impact assessment. The group had discussed a systemic approach (whole-systems approach) and the need to take a long-term perspective. As to the iterative process there is no proper kit to do a mental health impact assessment for major environmental changes, but there is a need for developing one. Not having a kit is not, however, a reason not to start. In the European context there is a need to have a benchmarking approach: what one country does well, other countries need to learn from.

In terms of settings, there is a specific need to work in schools and workplaces. The workplaces would include, e.g. the military and possibly other agencies of state, such as the police and public servants. Prisons, the people who are most likely to be prisoners, and what happens to them during their confinement were considered highly important in talking about settings. Minority communities, displaced individuals, general communities, health care settings and social care settings were also labelled of prime importance. As to health care settings, a particular issue is how we are moving away from an individual treatment focus to looking at mental health promotion in populations. We must not forget the need to help individuals learn about their own health.

Referring to age groups (children, adolescents, young adults, adults, older

people, retirees, very elderly people) the issue of transitions was brought up with the notion that adverse circumstances may impair the management of these transitions. However, there are certain ways to help people to adapt to these transitions. The topic of the various levels – individual, local, regional, national and international – was also highlighted in this context.

Discussing the maturation of countries across Europe and the Applicant Countries, there are a range of differences in the sophistication of systems and organisations. There are countries with very low income and those with less low income but still a lot less than others. In addition, there are relatively simple and overcomplex bureaucracies depending on, e.g. the number of people in the country. For example, it is much more difficult to achieve one's goals in a country with a population of 30–50 million than in a country of 3–5 million people. Dr Loudon explained that because of the transparency of boundaries, there is a need to maintain a pluralistic approach and a tolerance of diversity, something in which the media could play a role.

In addition, the various dimensions (biological, social, psychological, spiritual, environmental, cultural, political) seem to be extraordinarily important in acting as a kind of *set of awarenesses* of what needs to be kept in mind.

Next, Dr Loudon focused on the issue of information. He maintained that there are several individual services that produce information and as a result, the information may be of variable quality because delivering good quality data may not always be a local investment which is given high priority. The answer to this is to emphasise the need for early sharing of the data so that there is a joint understanding of the situation. Information and knowledge should become the *currency of public discourse*. Moreover, there is a need to build alliances so that a single view cannot prevail in a complex and

sophisticated system. There also has to be an understanding of the need for action and of the costs of inaction.

As to the limits and advantages of legislation, Dr Loudon stressed the question of whether, eventually, having specific mental health legislation could be stigmatising. Legislation in this context means the whole complex of behaviours which should surround the application of legislation to individuals – the need for advocacy, the need for protection, the need for rights to intervention if intervention is needed. The law and the excess use of the law was seen as a very blunt instrument to force a way through complex circumstances. Therefore, the management of change demands skill of the highest order and needs to be developed further. Those skills concern managing change through systems but also sharing in the dissemination of best practice.

In bringing up mind sets and cognitive sets and perceptions of individual professions, Dr Loudon referred to the group's discussion in which it was felt that there is high probability that professionals of all kinds will tend not to recognise problems if by recognising that problem they are confronted with a situation with which they feel unable to cope. This will result in a threat to their own pride and sense of personal integrity. The corollary of this is that to take on a task, all professionals need to be skilled and empowered to tackle this particular task. Empowerment does not come only from one's own perceptual role: it comes from the organisation's perception of what they are employed to do and comes from a social perception of what that professional role is. It is also influenced by the professional association as a guild, as an organisation which protects a certain role and function for a profession. Therefore, all professionals need multidimensional training, preferably in a multidisciplinary context.

This workshop also discussed NGOs as a source of inspiration to beneficial change

in service provision, the power of the pharmaceutical industry and the gap between evidence and change in professional practice.

Dr Loudon concluded by saying that there is a tension between focusing efforts for mental health promotion at high-risk groups while it seems to be much better to focus on the population at large. A practical awareness was raised that the people in prison, children who have been brought up in institutions because of parental difficulties, and people who are overwhelmed by life circumstances (people who experience disasters, individuals who lack sources of support) need to be supported during that specific time. While looking at high-risk groups provides some information about what happens to human beings in terms of mental health and mental ill-health, there is also something to learn from the people who have survived a high-risk environment.

**Professor Heinz Katschnig** (University of Vienna, Austria) highlighted the discussions in Workshop 3, and explained first that groups 3 and 4 were, in fact, combined. This turned out to be useful as the question about indicators is closely related to the more basic question of what information is available in the field. Hence, both groups eventually profited from the other's topic. Basic issues such as what types of information there are, how useful they are, what monitoring is, were discussed first. These issues have been already illustrated by the indicator project.

The first question was *how improved information can be used in mental health policy*. Politicians usually have difficulties in understanding the concept of mental health. It would be dangerous just to present figures for something and say to them that this is the problem, please do something. Thus, when going to politicians with this issue, perhaps alongside with such information (on the prevalence of mental disorders) we must give more

concrete information. The World Bank report discusses disability and the burden of mental illness in terms of DALYs (*Disability Adjusted Life Years*). Here, the burden proved to be very heavy compared to that of a number of other diseases. For example, in the age group between 18 and 45 years, mental disorders constitute 8 of the 10 most common disorders. Consequently, information concerning disability burden could be more useful. Moreover, individual suffering and distress are examples of measures that need to be communicated. Another type of information regarded as essential in delivering the message to politicians is to point out how many of the other problems that politicians have to solve are affected by mental health problems. Road accidents provide one good example here, as they often are connected to alcohol problems or mental disorders. Furthermore, the general mortality is raised by mental disorders. If we want to fight mortality and health problems in general, we have to consider and communicate to the politicians that mental health – by some reason or mechanism – contributes to increased morbidity and mortality from somatic disorders. Finally, in informing politicians the cost issues need to be brought up. This includes the indirect costs – lost jobs, early pensions –, too. We should also be very clear, open and honest in what we say. An example of this was the fact that in the indicator project, some items categorised as mental health determinants could also be regarded as the consequence of poor mental health.

The second question was about the issue of *better use of information in mental health services*. Here, the group discussed about more basic things such as whether untreated morbidity data should be used in the fictitious situation of building services from scratch. In the European context, services need to be improved. Again, the question was what type of information about disorders and dysfunction is appropriate. Improving services would

perhaps require turning to the media and being more direct instead of doing research all the time. An intermediate position between using the data on health services use such as inpatient episodes, number of psychiatric beds etc. which show how great the unmet need is, would be to look beyond psychiatric services. There is a large group of patients suffering from mental disorders who are in the general health care system.

Discussing the future needs for further improvement of mental health monitoring, the group first brought up the question of what is meant by 'monitoring'. Different viewpoints were presented. As to the purpose of collecting data it was noted that usually, for example, in intensive care medicine, bodily functions are monitored and there are certain limits. There is some theory behind monitoring, and we should be cautious to not just collect data that are easily collectable, such as suicide rates. As for this specific issue, it was mentioned that there are statistics available from over more than 200. The theory of Emile Durkheim was also briefly addressed in this context. Simple measures may, in fact, reflect data collection procedures, which are very different in different countries, more than they reflect true differences in suicide rates.

Finally, discussing the required improvement in the information that is provided, it was maintained that information needs to be more evidence-based. However, while this perspective is important it may often be too restrictive. In this context the issue of randomised controlled trials (RCTs) in research was dealt with. It was found that very few people eventually are included in RCTs and that there are certain risks in generalising from such studies to the general public. So there is a need to be cautious here, too.

**Dr Jyrki Korkeila** (STAKES) described the conclusions of Workshop 4. First, it was mentioned that some of the readily available data are not very informative to be used as specific indicators for mental health. For example, in the EU Member States, there are no data on patients visiting outpatient care, the only available and usable data being on the overall number of visits. Therefore, there is a need for including new variables in the databases. Fourteen of the new indicators suggested by the indicator project are based on survey data, and their comparability should be better.

The number of indicators was not regarded a fruitful subject for discussion. Dr Korkeila highlighted the fact that in one EC project outlining general health indicators, a list of 2–200 different indicators was drafted. The possibility of having 'key indicators' was discussed, but it seems that a small number of indicators is unable to adequately express the mental health situation in Europe, as there are varying interests as well as different activities with different kinds of targets and aims. Thus, a small number of indicators could only cover specific areas, and there would need to be a correct balance between complexity and simplicity.

Regarding the purpose of the set of indicators, Dr Korkeila emphasised that the health monitoring programme of the EU aims to cover the health situation for policy purposes. Three purposes were considered essential in the monitoring of mental health. These were to follow the threat to mental health in the society, to follow the quality of mental health policy and to follow the process and quality of services. This way it is possible to 'keep an eye on mental health'.

As to the question of whether the relevant topics have been covered by the selected set of indicators, Dr Korkeila stressed that some other factors not included in the set had been mentioned in the seminar. Empowerment was one factor, although it is more relevant in view of special populations, not with the population as a whole. Outpatient care, psychogeriatric psychiatry, and the mortality of psychiatric patients due to causes other than suicide are among these factors too. However, there seemed to be no demands to essentially increase or cut down the number of the suggested indicators.

Cultural differences were referred to in the context of the reliability of the suicide data. Concerning the number of beds and psychiatrists, it was maintained that Eurostat has a project which has drafted a report on psychiatric beds, and is also developing ways to harmonise the data.

There are other projects that aim to develop the reliability of the health care information. Concerning the data on health systems and on the use of services, there will be difficulties in the data comparability as the databases differ from each other, as do the services. An example of this are the differences found between public and private services. Dr Korkeila also referred to the fact that there is some dissatisfaction concerning the headings provided by the European Community Health Indicator (ECHI) project.

Dr Korkeila finished his report by suggesting that the present set of indicators could pave the way for the Member States to start collecting data more actively. In the future, more harmonisation concerning the health systems data is needed. However, once mental health is monitored, the monitoring system itself has to be monitored and adjusted when needed.

## CONCLUSIONS AND CLOSING OF THE SEMINAR

**Dr Vappu Taipale** (Director-General of STAKES) briefly reviewed the developments related to the European Mental Health Agenda process. She said that the process started six years ago with a small group of experts, and that the theme of mental health has been on the official agenda of the European Union since 1997. In 1999, the Council of Health Ministers passed a resolution on the promotion of mental health partly based on the results of the European Conference on Promotion of Mental Health and Social Inclusion (held in Tampere on 10–13 October 1999). Subsequently, the Portuguese and French Presidencies of the EU have shown their commitment to the topic by organising influential conferences on the theme of mental health. The Presidencies of Sweden and Belgium have also promised to proceed with the Mental Health Agenda.

The European Parliament, especially the Committee on Environment, Consumers and Public Health, has often focused on mental health issues in their meetings. Of particular importance has been the commitment of individual MEPs to bringing up and advancing mental health. Also the increasing attention of the European Commission and its activities on mental health issues have to be acknowledged – especially the DG Health and Consumer Protection and the new public health programme of which mental health is becoming an integral part.

Dr Taipale continued by briefly describing activities of two projects which have been financed from the current public health programme. According to her, the first project, 'Putting Mental Health on the European Agenda', has shown that some topics are already quite deeply rooted in the European way of thinking. The work of the project has emphasised the importance of regarding mental health as a broad concept that includes both positive and negative aspects. The project slogan, 'There Is No Health Without Mental

Health', has become known in all European Union Member States. Moreover, the scope of mental health action has been widened. Today, it covers human rights, promotive, preventive, and curative approaches, as well as prevention of mortality. This is beneficial in seeking for allies in different fields of activities. Furthermore, it is very important to integrate mental health and health in general in all policies. One issue that was thoroughly discussed in this seminar was the coupling of mental health impact assessment with health impact assessment.

The second project, 'Establishment of the Indicators for Mental Health Monitoring in Europe', has concentrated on the issue of whether it is possible to develop feasible indicators to monitor the state of mental health in the population. Indicators are needed and welcomed, but it has proved to be somewhat complicated to develop a set of indicators for various reasons. This has not been an easy task for the working groups and experts working in the field.

Dr Taipale underlined the fact that mental health issues are challenges not only in the EU but all over the world. Often, mental health is not a priority in the health service systems and mental health issues are not much discussed in public. Unfortunately, when they are, they are mainly seen in a negative, tragic or scandalous light. This is one of the reasons why there is a need for thinking more widely and more globally. The overseas guests in this seminar have given the audience a wider perspective by presenting some of the most interesting achievements from their own countries.

Of the contents of the seminar, Dr Taipale highlighted the importance of developing a vision for the global agenda, the need to focus on social capital and the quest for global governance in environmental, health and social policies. It was mentioned that future work and

outcomes in these may perhaps become an achievement one day for all of us. At the political level, essential points were, e.g. the free movement of ideas, future tasks in health monitoring, information services, capacity building, R&D activities, and priority setting. The role of the user movement as a meaningful participant and the issue of the charter of fundamental rights were also brought up. Dr Taipale also highlighted the close collaboration between the European Union and the WHO.

The following points of the lively and many-sided discussions in the seminar were emphasised by Dr Taipale:

**At the political level:**

- European Union health-monitoring processes and their complexity
- political commitment
- the user movement in its role of activating politicians
- good examples and practices from many countries at the political level
- the limits of legislative processes

**At the policy level:**

- mental health included in all policies
- the concept of lead responsibility
- the ways to approach policy
- strengthening the promotive approach (e.g. in working life)

**At the practical level:**

- settings
- mind set.

Information was another highly relevant topic in this seminar. Dr Taipale emphasised that there are outstanding possibilities to create an *intelligent interface* with the support of the information society. The mental health field, instead of lagging behind, could be an initiator in this. This was seen as an opportunity not to be wasted.

Moreover, the need for more evidence was underlined as our knowledge base is not sufficient at the moment. Here, the

concept of *mental health impact assessment* (MHIA) was elaborated. However, at the moment the methodology is not good enough, there is a need for a more systematic approach, and iterative processes need to be developed. Furthermore, it needs to be considered for whom should MHIA be conducted.

The dissemination of information and information feedback loops were underlined as it seems that knowledge and information are increasingly becoming the currency of public discourse. Dr Taipale concluded her speech by stressing that we have to disseminate and formulate information on mental health in consonance with the legitimacy and logic of political life so that it can be used at the political level.

In his closing speech **Dr Jarkko Eskola** (Ministry of Social Affairs and Health) thanked all the participants for the strong commitment and the enthusiasm which were evident during this seminar. It is this commitment and enthusiasm that will also carry the issues of mental health into the future. Now is a particularly good time to tackle mental health questions. There are different reasons for this, but one that has not been made so clear, is the personal commitment which comes from the strong feeling that you have been experienced something that has touched the very root of your own life. There is a sense that some of the leading persons among mental health supporters have openly expressed this. Therefore, Dr Eskola encouraged publicising one's personal experiences.

Dr Eskola thanked the organisers of the seminar and the whole mental health network, the role of which has proven to be crucial. The European Commission has been supportive, and thanks were given to them for their commitment. In many ways, the future is also in the hands of the Commission. He also acknowledged the political support coming from the European Parliament through the MEPs dedicated to the issue.

The Member States and the Applicant Countries have been strongly involved and there is a good chance to go forward. The experts who have shared the best knowledge available and the NGOs, crucial to the public health and mental health movement, deserve warm thanks. Dr Eskola also thanked the overseas guests who contributed so valuably to the seminar.

He went on to say that the Finnish Government is committed to help the mental health process go forward. The Government is looking forward to the next EU Presidencies continuing with the mental health initiative, and is ready to strongly support the WHO. There is also a hope that WHO and the European Commission will work very closely together. There is also the particular task of strengthening the three-part initiative with the Council of Europe, which is basically responsible for the one of the major issues in mental health, human rights.

In this seminar, the representative of the Commission stated that the Commission will support the mental health initiative in the coming years. Also one of the goals of the WHO is to look very carefully at mental health in the future in Europe. Dr Eskola closed the meeting by saying that Finland is going to support the EU and WHO on these issues.

## FURTHER INFORMATION

The reports prepared in connection to the projects can be accessed (and downloaded) at [www.stakes.fi/mentalhealth](http://www.stakes.fi/mentalhealth). This site also contains links to the information on the European Conference on Promotion of Mental Health and Social Inclusion, and on the European Mental Health Agenda: Future Perspectives.

Other relevant websites include

European Commission - Directorate General of Health and Consumer Protection	<a href="http://europa.eu.int/comm/health/index_en.html">europa.eu.int/comm/health/index_en.html</a>
European Parliament - Environment, Public Health and Consumer Policy	<a href="http://www.europarl.eu.int/comparl/envi/default_en.htm">www.europarl.eu.int/comparl/envi/default_en.htm</a>
World Health Organization - <i>Regional Office for Europe</i>	<a href="http://www.who.int/mental_health">www.who.int/mental_health</a> <a href="http://www.who.dk">www.who.dk</a>
Health Canada - <i>Mental Health Promotion Unit</i>	<a href="http://www.hc-sc.gc.ca/hppb/mentalhealth">www.hc-sc.gc.ca/hppb/mentalhealth</a> <a href="http://www.mentalhealthpromotion.com">www.mentalhealthpromotion.com</a>
Ministry of Health New Zealand	<a href="http://www.moh.govt.nz/moh.nsf">www.moh.govt.nz/moh.nsf</a>
Surgeon General's Report on Mental Health	<a href="http://www.surgeongeneral.gov/library/mentalhealth">www.surgeongeneral.gov/library/mentalhealth</a>
European Federation of Associations of Families of Mentally Ill People (EUFAMI)	<a href="http://www.eufami.org">www.eufami.org</a>
World Federation for Mental Health (WFMH)	<a href="http://www.wfmh.org">www.wfmh.org</a>
Mental Health Europe – Santé Mentale Europe (MHE - SME)	<a href="http://www.mhe-sme.org/mhe-sme/index.html">www.mhe-sme.org/mhe-sme/index.html</a>
European Network of (ex-)Users and Survivors of Psychiatry (ENUSP)	<a href="http://www.clientenbond.nl/enusp/main.html">www.clientenbond.nl/enusp/main.html</a>

## PROGRAMME

### **Thursday 16 November 2000**

19.00–21.00 *GET-TOGETHER RECEPTION*

### **Friday 17 November 2000**

09.00–09.30 **OPENING OF THE SEMINAR**

Dr. Jarkko Eskola, Ministry of Social Affairs and Health (FI)  
Dr. Matti Rajala, European Commission, DG Sanco

09.30–11.00 **PLENARY SESSION I**

*Chairperson* Prof. Odd Steffen Dalgard, University of Oslo (NO)

PRESENTATION OF THE REPORT *PUBLIC HEALTH APPROACH ON MENTAL HEALTH IN EUROPE*

Dr. Eero Lahtinen, Ministry of Social Affairs and Health (FI)

INVITED COMMENTS

Dr. Meni Malliori, European Parliament (GR)

Dr. Marc Servaes, Flemish Ministry of Health (BE)

GENERAL DISCUSSION

11.00–11.30 *COFFEE BREAK*

11.30–13.00 **PLENARY SESSION II**

*Chairperson* Prof. Viviane Kovess, Mutuelle Générale de l'Éducation Nationale (FR)

PRESENTATION OF THE PROPOSAL FOR EUROPEAN MENTAL HEALTH INDICATORS

Prof. Ville Lehtinen, STAKES (FI)

INVITED COMMENTS

Dr. John Bowis, European Parliament (UK)

Dr. Helena Silfverhielm, National Board of Health and Welfare (SE)

GENERAL DISCUSSION

13.00–14.00 *LUNCH*

14.00–15.30 **PANEL DISCUSSION**

OVERSEAS EXPERIENCES IN PROMOTION AND MONITORING OF MENTAL HEALTH

*Chairperson* Dr. Jarkko Eskola, Ministry of Social Affairs and Health (FI)

*Discussants* Dr. Thomas Bornemann, Dept. Health and Human Services (US)

Dr. Natacha Joubert, Health Canada (CA)

Mr. Todd Kriebel, Ministry of Health (NZ)

GENERAL DISCUSSION

15.30–16.00 *COFFEE BREAK*

16.00–18.00 **WORKSHOPS**

## **Saturday 18 November 2000**

### **09.00–10.30 PLENARY SESSION III**

*Chairperson* Ms. Pirkko Lahti, World Federation for Mental Health (FI)

#### FUTURE PERSPECTIVES

Mr. Alain Lefebvre, Permanent Representation of France to the EU (FR)

#### INVITED COMMENTS

Mr. Clemens Huitink, European Network of (ex-)Users and Survivors of Psychiatry ENUSP (NL)

Mr. Esko Hänninen, Provincial State Office of Southern Finland (FI)

#### GLOBAL CHALLENGES

Prof. Rachel Jenkins, Institute of Psychiatry (UK)

#### INVITED COMMENT

Dr. Wolfgang Rutz, World Health Organization Regional Office for Europe

#### GENERAL DISCUSSION

10.30–11.00 *COFFEE BREAK*

11.00–13.00 **WORKSHOPS**

13.00–14.00 *LUNCH*

### **14.00–16.00 PLENARY SESSION IV**

*Chairperson* Prof. Vappu Taipale, STAKES (FI)

#### WORKSHOPS' REPORT

Ms. Bairbre Nic Aongusa, Department of Health and Children (IE)

Dr. John Loudon, Ministry of Health Scotland (UK)

Prof. Heinz Katschnig, University of Vienna (AT)

Dr. Jyrki Korkeila, STAKES (FI)

#### GENERAL DISCUSSION

#### **CONCLUSIONS AND CLOSING OF THE SEMINAR**

Prof. Vappu Taipale, STAKES (FI)

Dr. Jarkko Eskola, Ministry of Social Affairs and Health (FI)

## **WORKSHOPS**

### **WORKSHOP 1: INTEGRATING MENTAL HEALTH IN PUBLIC HEALTH**

*Chairperson* Mr. Pierre Campagna, Ministry of Health (LU)

*Rapporteurs* Ms. Bairbre Nic Aongusa, Department of Health and Children (IE)  
Dr. Juha Lavikainen, STAKES (FI)

### **WORKSHOP 2: TACKLING DETERMINANTS OF MENTAL HEALTH**

*Chairperson* Prof. France Kittel, Free University of Brussels (BE)

*Rapporteurs* Dr. John Loudon, Scottish Ministry of Health (UK)  
Dr. Timo Tuori, STAKES (FI)

### **WORKSHOP 3: USES OF IMPROVED MENTAL HEALTH INFORMATION**

*Chairperson* Dr. Hans Joachim Salize, Central Institute of Mental Health (DE)

*Rapporteurs* Prof. Heinz Katschnig, University of Vienna (AT)  
Dr. Sakari Lankinen, Ministry of Social Affairs and Health (FI)

### **WORKSHOP 4: FEASIBILITY OF THE SUGGESTED SET OF INDICATORS**

*Chairperson* Dr. Rob Bijl, Trimbos Institute (NL)

*Rapporteurs* Prof. Michael Madianos, University of Athens (GR)  
Dr. Jyrki Korkeila, STAKES (FI)

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